

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Chalet of Niles, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 911 S 3rd St Niles, MI 49120	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</p> <p>This citation pertains to Intake Number MI00147372</p> <p>Based on interview and record review, the facility failed to prevent resident to resident abuse in 1 of 5 residents (Resident #104) reviewed for abuse, resulting in Resident #104 experiencing physical abuse from Resident #103.</p> <p>Findings include:</p> <p>Resident #104:</p> <p>Review of an Admission Record revealed Resident #104 was a male with pertinent diagnoses which included Alzheimer's disease, weakness, cervical disc degeneration (condition affecting the neck's spinal discs causing pain and discomfort), cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language) and back pain.</p> <p>Review of current Care Plan for Resident #104, revised on 9/19/24, revealed the focus, .(Resident #104) has severe barriers related to poor memory, cognition, and comprehension. He has a history of Alzheimer's . with the intervention .Nursing staff to provide reminders, support, and simple logical communication to promote (Resident #104's) quality of life to resolve comprehension and memory deficits .</p> <p>Review of Nursing Progress Note dated 9/15/2024 at 1:43 PM, revealed, .The resident (Resident #104) was approached by another resident (Resident #103) in dining room, and was flipped over in his chair, threats were said from this resident to the other to resident and vice versa, removed resident from the situation, and police were called, assessment and vital done .</p> <p>In an interview on 10/23/24 at 3:48 PM, Certified Nursing Assistant (CNA) M reported Resident #104 was a character, he likes to fix things and some of the residents get irritated when he messes with their table cloths and his arranging. CNA M reported most times he was easily redirected and would have him move to another area.</p> <p>Resident #103:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Admission Record revealed Resident #103 was a male with pertinent diagnoses which included dementia, anxiety, and traumatic hemorrhage of cerebrum (a brain bleed that occurs due to a head injury).</p> <p>Review of Care Plan for Resident #103, revised on 9/16/24, revealed the focus, .(Resident #103) expresses maladaptive behavioral symptoms related to dx of anxiety, depression, and dementia with mood disorder. He has had several outbursts and arguments with other residents and staff. He quickly escalates from verbal arguments to aggressive behavior . with the intervention .Explain the desired behavior to (Resident #103). Remind him that he is expected to behave respectfully & with maturity. Review rules/behavior expectations to help him improve judgment & self-control .Use behavior management techniques to promote & shape the desired behavior such as: controlling the environment to the degree possible to moderate stress. Reduce noise, over-stimulation, commotion, movement, crowds, close contact. Direct (Resident #103) to stay away from persons who appear to increase his agitation. Provide opportunities for him to have space and fresh air . Teach stress/anxiety, psychiatric symptom & sobriety management techniques to help (Resident #103) cope w/ anger, poor ability to deal with frustration, impulsivity, hallucinations & delusions, etc .</p> <p>Review of Incident dated 9/10/24 at 12:15 PM, revealed, .Res in DR (dining room) for lunch. Had verbal altercation w/another res. Was heard yelling and cursing @ other res. This res attempted to pick up walker and swing it at @ other res, resulting in this res falling. Both res heard yelling profanities @ each other. States other res was at my table, messing with the tablecloth States, I was going to beat his a**. I don't play that and he was going to find out real quick . This incident indicated a history of resident to resident altercations.</p> <p>Review of Incident dated 9/15/24 at 2:17 PM, revealed, .The resident (Resident #103) approached another resident (Resident #104) in dining room and flipped them in the chair, threats to resident and staff continued with agitation, policed called and emts escorted the resident too (sic) hospital for evaluation, expected return this evening. The resident approached another resident in dining room and flipped them in the chair, threats to resident and staff continued with agitation, policed (sic) called and emts escorted the resident too (sic) hospital for evaluation, expected return this evening .Immediate Action Taken: Description: The resident approached another in the dining room and flipped them in the chair, threats to resident and staff continued with agitation, police called and emts escorted too (sic) hospital for evaluation, expected return this evening .</p> <p>Review of Social Service Note dated 9/16/2024 at 2:15 PM, revealed, .IDT met to review resident's behavior that occurred on 9/15/24. Behavior: Resident was involved in a resident to resident is altercation Root Cause Analysis: Involved resident was sitting at this resident's table prior to lunch. Residents had a verbal altercation, and this resident tipped other resident out of his w/c. Intervention: staff separated residents immediately and removed involved resident from the situation. Resident placed on 1:1 supervision and sent to ER for evaluation. Returned from ER with no new orders and 1:1 re-instated. SSD (Social Service Director) working on evaluation at inpatient psych. Care plan reviewed and updated as appropriate .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of History and Physical Examination dated 9/17/24, revealed, .HISTORY OF PRESENT ILLNESS: This is a [AGE] year-old male with BPH, hypertension, glaucoma, seizure disorder, and TBI, a resident at a nursing facility, who has had increased aggression and agitation towards peers. He approached another resident during meals and flipped the resident over in the chair .He was yelling and verbally threatening to peer and staff. Police were called and they brought the patient to emergency department. The patient apparently returned to the facility since there was no incident in the emergency department, but upon arrival, he began verbally threatening people again. He is not sleeping at night. He is requiring hospitalization for stabilization .</p> <p>In an interview on 10/23/24 at 1:58 PM, Licensed Practical Nurse (LPN) Z reported she witnessed (Resident #104) in the dining room around the tables and moving them like he does. LPN Z reported she was at the medication cart, on the wall in front of the dining room doors on the right side entry. (Resident #103) entered the dining room and walked to the back part of the dining room and then she heard a Thud sound. LPN Z reported she put the items way she was working with, locked the cart, and a family member walked up to me and reported (Resident #103) had just flipped (Resident #104) over in his chair. LPN Z reported she proceeded to the back half of the dining room area, (Resident #104) was on the floor and his wheelchair was flipped on it's right side. LPN Z assessed (Resident #104) and got him up and placed him back into his wheelchair. LPN Z reported she removed (Resident #104) from the dining room for his safety. She reported she completed a skin assessment, did his vitals and there was no skin tears and his vitals where within normal limits. LPN Z reported (Resident #103) had wrapped a belt around his hand, he was aggressive and threatening, and we had to call the police to come and assist with (Resident #103) going back to his room and he was sent out to a psychiatric hospital. LPN Z reported she had been informed after there had been an incident the prior weekend that was not reported to her when she came on shift.</p> <p>In an interview on 10/23/24 at 3:27 PM, Visitor KK reported (Resident #104) was straightening tables like he always did and was at (Resident 103)'s table. Visitor KK reported (Resident #103) told (Resident #104) he needed to move away from his table and was being kind of cranky with him. He then stepped away from his walker and flipped (Resident #104's) wheelchair over.</p> <p>Review of policy, Abuse Prevention Program dated 10/22/22, revealed, .1. Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, mental anguish or deprivation by an individual .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637</p> <p>Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for one resident (Resident #102) of five residents reviewed for abuse.</p> <p>Findings include:</p> <p>Resident #102 (R102)</p> <p>Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R102's original admitted was 2/11/2021 with diagnoses including schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly), anxiety, depression, dementia (thinking and social symptoms that interferes with daily functioning) and aphasia (language disorder that affects the ability to communicate). Brief Interview for Mental Status (BIMS) was not completed since R102 was not understood.</p> <p>During an interview on 10/23/2024 at 9:40 AM, Certified Nursing Assistant (CNA) Y stated on 8/17/2024 she was in R102's room changing her brief with CNA EE. CNA Y stated that R102 was standing up by the bed and she was on the left side of R102 and CNA EE was on the right side. Then, CNA Y said she bent down to grab R102's brief and saw CNA EE was holding R102's breast.</p> <p>Review of the MI (Michigan) FRI (Facility Reported Incident) submitted by Nursing Home Administrator (NHA) C regarding R102 revealed that the incident occurred on 8/17/2024 at 3:45 PM and it was reported to the charge nurse and then to the NHA. NHA C submitted the initial report on 8/17/2024 at 5:28 PM and Law Enforcement was not notified.</p> <p>During an interview on 10/23/2024 at 3:19 PM, NHA A stated that she wasn't sure if this incident was reported to Law Enforcement since she wasn't the NHA at the time. NHA A stated that she would report an incident like this to Law Enforcement.</p> <p>During an interview on 10/24/2024 at 9:55 AM, Director of Nursing (DON) D stated that she wasn't sure if the incident was reported to Law Enforcement. DON D reported that she would report an incident like this to Law Enforcement since it's an abuse allegation.</p> <p>During an interview on 10/24/2024 at 11:00 AM, NHA B stated that Law Enforcement was not called for this incident. NHA B said that she would have called Law Enforcement if she was the NHA at the time since this was an abuse allegation.</p> <p>Review of the Abuse Prevention Program Policy dated 10/22/2022 revealed, Procedure: When an alleged or suspected case of abuse or neglect is reported to the Administrator, the Administrator, or person in charge of the facility, will notify the following persons or agencies of such incident immediately . 3. Law Enforcement Officials as per the Policy on reporting Reasonable Suspicions of a crime in LTC facility Section 1150B of the Social Security Act. Policy No (Number) 2.11a.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637</p> <p>This citation pertains to Intake: MI00147456 & MI00146518</p> <p>Based on observation, interview and record review the facility failed to: 1. minimize the risk of scalding and burns by allowing hot water to exceed 120 F (degrees Fahrenheit) and not monitoring hot water temperatures consistently resulting in an increased risk of injury among residents who reside in the facility, and 2. prevent an elopement for 1 resident (Resident #101) of 5 residents reviewed for elopement, resulting in Resident #101 exiting from the facility without staff knowledge and the potential for injury.</p> <p>Findings include:</p> <p>During an interview on 10/22/2024 at 1:51 PM, FF stated the facility has only one boiler that is currently working and the other one needs to be replaced. FF said it is difficult to keep the water temperatures below 120 F in some resident rooms.</p> <p>During a tour of resident rooms with Maintenance Director (MD) AA on 10/23/2024 at 10:20 AM, hot water was checked in several resident rooms and shower rooms with a digital thermometer. The following temperatures were observed in the bathroom sink in resident rooms and the shower room:</p> <p>room [ROOM NUMBER]- 121.6 F</p> <p>room [ROOM NUMBER]- 124.9 F</p> <p>200 Hall shower room- temperatures ranged from 117 F to 125.4 F</p> <p>During the tour, MD AA stated that the goal is for the water temperature to not exceed 120 F in resident rooms and 117 F to 118 F in the shower rooms.</p> <p>Review of the Domestic Hot Water Temperature Log Daily Check for the last 3 months revealed that August and October were missing.</p> <p>During an interview on 10/23/2024 at 4:20 PM, Nursing Home Administrator (NHA) A stated that they have a water temperature log for resident rooms for September but they couldn't find August, and the log for October wasn't started yet since the former maintenance director left at the beginning of October. NHA A stated MD AA was educated and will start recording temperatures this week.</p> <p>Observation of the boiler room with MD AA on 10/24/2024 at 2:00 PM found that the thermometer showed outgoing hot water to the hallways was at 122 F.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Monitoring of Water Temperatures Policy and Procedure revealed Purpose: To ensure that the facility provides an environment that is free from hazards and to provide water for personal care that is comfortable and home like. Policy: The facility maintenance director or designee will monitor water temperatures randomly on a weekly basis to assure that all water temperatures are maintained comfort for the resident during bathing, showering and other personal care procedures.</p> <p>41424</p> <p>Resident #101:</p> <p>Review of an Admission Record revealed Resident #101 was a male with pertinent diagnoses which included stroke, post-traumatic stress disorder (PTSD), dementia, lack of coordination, obsessive compulsive disorder (excessive thoughts that lead to repetitive behaviors), and cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language).</p> <p>Review of current Care Plan for Resident #101, revised on 10/16/24, revealed the focus, (Resident #101) has been identified as a high risk for elopement r/t (related to) cognitive impairment, wandering behavior, and previous attempts at elopement in WC (wheelchair) . with the intervention (Resident #101) should have a wander guard. Staff to check function and placement each shift .If (Resident #101) is wandering in a potentially unsafe are or situation, redirect to safer area and remain with him until safe .If (Resident #101) is missing from facility, follow elopement protocol, notify MD and family immediately and document .Monitor (Resident #101)'s location with frequent visual checks (Initiated on 2/15/24) .Monitor door when staff and visitors come and go .</p> <p>Review of Elopement Risk Review dated 7/2/24 at 2:15 PM, revealed, .Does resident have a diagnosis of Dementia/Alzheimer's or severe Mental Illness and or periods of confusion? Yes .Does resident pace or wander? Yes .Does resident try to get outdoors, to find family or friends? Do they perceive the need to be somewhere else, doing something other than what they are doing e.g., going to work or home, picking up children? Yes .Total Score: 16 .High Risk for Elopement .</p> <p>Review of Incident dated 8/1/24 at 11:54 PM, revealed, .Resident found outside @ 11:03 sitting in w/c (wheelchair) outside therapy door; 0 s/sx (signs/symptoms) of injury or distress noted; Resident told CNA he was trying to get back into the building but was stuck. Resident was assisted into the building and safety was ensured. Resident was fully dressed in a flannel shirt and pants .Resident Description: I went out this door. I was trying to get back in, but I was stuck. Immediate Action Taken: Resident was assisted into the building and head to toe assessment revealed 0 issues; 0 distress noted; Resident denies pain; VS WNLs (within normal limits); Keypad lock added to therapy door .Verified wander guard in place and functioning properly . Predisposing Physiological Factors: Confused .Predisposing Situation Factors: Wanderer .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Nursing Progress Note dated 8/1/2024 at 10:56 PM, revealed, .At approximately 2203 on 8/1/2024, Resident was found outside the back therapy door, sitting calmly in his w/c; CNA immediately went to Resident to ensure safety and assisted Resident into the building after oncoming nurse (who was outside coming in to work) assessed Resident; Resident stated I came out that door.(pointing to the outside therapy entrance door.). Resident stated I was trying to come back in, but I was stuck.; Resident denies pain and there are 0 s/sx of injuries; Resident wander guard is on his w/c and functional per order; Resident skin from head to toe has 0 issues noted; Resident Eyes are PERRLA; ROM intact to all extremities per usual; Resident VS WNLs per usual; Resident states I ain't in no distress.; Resident is calm and resting in bed with eyes closed at this time. Administrator and DON contacted; All parties aware .</p> <p>In an interview on 10/22/24 at 3:34PM, Certified Nursing Assistant (CNA) V reported she went on break outside at the service hallway exit door and was not able to see Resident #101 as there was a wall and an alcove to where the door to therapy was located. CNA V reported she happened to hear him talk and went around the corner and saw him sitting on the sidewalk in his wheelchair. CNA V reported she stayed with Resident #101 and there was another staff member there as well. CNA V reported she couldn't believe he was outside, and she was unsure how long he had could have been outside. CNA V reported it was thought that the therapy exit door was not locked when the last staff member from therapy left for the day. She reported now the therapy door was bolted shut and they put keypads on the entry doors from the hallway to therapy. CNA V reported the door was not alarmed like the other exit doors in the building.</p> <p>In an interview on 10/23/24 at 2:15 PM, CNA JJ reported she had exited out the service hallway door to take the trash out after her shift, she was walking to the dumpster, and she happened to see something different out of the corner of her eye, looked over and she saw Resident #101 seated in his wheelchair on the sidewalk by the air conditioning unit. He was facing out towards the left side of the building (when facing the back door).</p> <p>In an interview on 10/22/24 at 2:26 PM, Licensed Practical Nurse (LPN) Q reported Resident #101 was his usual self, wandering throughout the building. LPN Q reported he had exited out the therapy exit door that someone didn't lock that night. LPN Q reported he was located in the parking lot, someone went outside for break and discovered he was sitting right there trying to get back into the building. LPN Q reported there were no alarms on the door then, now have an alarm/lock. LPN Q reported he wants a task, something to do, he gets bored and with his dementia he forgets why he was in the facility.</p> <p>In an interview on 10/23/24 at 1:26 PM, Registered Nurse (RN) I reported she had just pulled into the parking lot, she worked 3rd shift that day, and CNA JJ and CNA V were out there with him.</p> <p>In an interview on 10/24/24 at 3:05 PM, CNA II reported she was assigned to work with Resident #101, and she last saw him after dinner in his room at approximately 6:00-7:00 PM.</p> <p>Review of Orders dated 7/30/24, revealed, .Debroz Otic Solution (Carbamie Peroxide (Otic)) Instill 3 drop in both ears two times a day for ear wax buildup for 5 days .Scheduled for 8/1/24 at 20:00 (8:00 PM) .</p> <p>Review of Medication Admin Audit Report dated 8/1/24, revealed, Resident #101 had no medications administered by facility staff from 2:30 PM until 8/2/24 at 00:12 AM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/23/24 at 10:49 AM, Director of Nursing (DON) D reported Resident #101 later at night had gone into the therapy dept, out the back door there and sitting out there on the sidewalk when the nursing staff brought him back into the building. There were keypads now to enter into the therapy dept and the door locked behind after entry but before the entry to therapy was keyed and would have to make sure to monitor and make sure the door shut and locked. DON D reported Resident #101 kind of hung around in the hallways or the dining room. DON D reported staff found him when they had gone out back to throw the trash away. She reported it was a hard angle as the therapy door was tucked back there.</p> <p>In an interview on 10/22/24 at 10:53 AM, LPN G reported he was unable to hear the alarm for the service hallway exit door while seated at the nurse's station. Note: On 10/23/24, Administrator A reported the alarm had been disabled to sound at the nurse's station and was now the wires were hooked back up to sound again.</p> <p>Review of Nursing Progress Note dated 9/17/24 at 1:54 PM, revealed, .Resident (#101) was at front entrance requesting to go outside. Administrator had one on one conversation with resident and assisted him to the courtyard to participate in activities. Resident (#101) was in courtyard with the activities department and other residents. Activities assistant had noted resident propelling down sidewalk towards the gate. Resident was able to press the button to release the gate and wheel through gate. As resident propelled w/c through the gate and into the back parking lot, the admissions director had pulled into the lot and re-directed resident back into the courtyard. Admissions director stayed with resident at this time while activities continued with other residents. Once activities were completed, resident was brought back into the facility and placed on 1:1 supervision. Wander guard remains in place and functioning .</p> <p>In an interview on 10/23/24 at 10:23 AM, Activities Supervisor (AS) S reported she was in her office and the administrator came in and suspended my Activity Aide (AA) R and reported Resident #101 had gotten through the gate of the fenced in area. AS S reported she had been outside prior doing Bible Study with residents and Resident #101 was brought out by the Administrator C. AS S reported when she came back inside AA R was outside with the residents and Resident #101 was out there still. AS S reported her staff had been trained to sit in a certain location when outside with residents so they could keep an eye on all the residents. The staff sat with their back to the fence gait on the sidewalk which wound around to the gait.</p> <p>In an interview on 10/23/24 at 10:26 AM, AA R reported there were a lot of residents outside and he was assisting other residents and he lost track of where (Resident #101) was and he got out the gait. AA R reported there were no other staff outside with him when Resident #101 made it out of the fenced in area.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/23/24 at 11:13 AM, Admissions Director (AD) P reported when she pulled into the parking lot, she did not observe Resident #101 in the parking lot but wasn't really paying attention as she was focused on parking in her spot. AD P reported she got out of her car and walked towards the back of her car and observed Resident #101 in the parking lot. She asked him what he was doing, he said he was leaving, and would not go back into the building. AD P reported she stayed out there with him, got him out of the parking lot and called in to the building to see if someone could assist with getting him back into the building. Staff were not able to get him back in the building, so she stayed out there with him talking to him before she was able to get him to go back in. AD P reported she parked near the entrance to the back parking lot and was not able to see passed the end of the fence or able to see the fence gait when she parked. AD P reported she didn't know how long Resident #101 was outside as she had just arrived.</p> <p>In an interview on 10/23/24 at 10:49 AM, Director of Nursing (DON) D reported on 9/17/24, Resident #101 had been exit seeking and he was outside with activities. DON D reported he was trying the back gait there and the admissions had to stay with him outside and he was getting aggressive, pushed his hands down on the wheelchair wheels. AD P would eventually be able to get him to get back in the facility. DON D reported the resident was trying the back gait and AD P was out there with him. DON D reported the facility did not report the incident as he had been accompanied at all times. Note: AD P reported she did not have eyes on the resident when she drove into the parking lot and AA R reported he had lost sight of the resident.</p> <p>Review of Drug Regimen Review dated 10/3/2024 at 10:41 AM, revealed, .Resident readmitted to facility following stay in neuropsych hospital. No medication changes upon readmission. Resident taking Haloperidol while inpatient but medication dc (discontinued) prior to readmission d/t (due to) no supportive diagnosis .</p> <p>During an observation on 10/24/24 at 3:00 PM Resident #101 was in the 200 hallway in his wheelchair and he had a wander guard placed on the back of his wheelchair on the right side frame back area.</p> <p>Review of Orders dated 10/17/24 at 2:30 PM, revealed, .Check placement and function of wander guard to wheelchair. every shift for Elopement Risk . Note: Review of orders revealed no order for a wander guard after admission on 10/2/24.</p> <p>Review of Treatment Administration Record (TAR) for October 24, revealed, no order or checks for a wander guard from 10/2/24 to 10/17/24 Eve (evening).</p> <p>In an interview on 10/23/24 at 11:08 AM, DON D reported Resident #101 admitted back to the facility on [DATE]. DON D reported Resident #101 had a wander guard placed on 5/23/22 and this order was discontinued on 9/18/24 when he had went out to a neuropsychiatric facility and was not put back in the orders. DON D reported the orders were entered manually. DON D reported the residents with wander guards should be checked the device was in place and functioning. DON D reported the devices were used to help maintain the resident's safety.</p> <p>Review of Guidelines for Alarms Used for Exit Seeking Residents dated 9/13/23, revealed, .Remember: a) Alarms cannot be a substitution for diligent care and observation of a resident .b) Alarms are not to give the staff a false sense of surveillance .c) Alarms are not in place to lessen the care and services and checking on a resident .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Chalet of Niles, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 911 S 3rd St Niles, MI 49120	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of policy, Missing Residents and Elopement provided on 10/24/24, revealed, .it is the policy of this facility that all residents are provided adequate supervision to meet each resident's nursing and personal care needs .At no time will any door alarm or personal safety device be deactivated without direct visual supervision of the exit .</p>