STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235361	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chalet of Niles, LLC	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2588471 and #2594155.Based on interview and record review, the facility failed to ensure residents received care in accordance with professional standards and advance directives were honored in 1 resident (Resident #101) of 4 residents reviewed for quality of care, resulting in an immediate jeopardy when, beginning on [DATE] at approximately 3:00 PM the resident had a serious acute change of condition (shortness of breath) and staff failed to assess, monitor and act promptly by notifying emergency services, resulting in death from cardiac arrest. This deficient practice placed all residents at risk for serious harm, injury and/or death.Findings include:The facility failed to assess, monitor and promptly notify emergency services for Resident #101, who was a full code and reported by Certified Nursing Assistant (CNA) J to be experiencing respiratory difficulties on [DATE] beginning at approximately 3:00 PM. Resident #104 was identified by Registered Nurse (RN) C at approximately 9:00 PM unresponsive and displaying agonal breathing (gasping for air that sound like snoring or gurgling). RN C contacted hospice services at 9:04 PM, who returned the call at 9:24 PM and instructed RN C to call 911 due to Resident #101's full code status. EMS arrived to transport Resident #101 to the hospital at 9:28 PM, and the resident was pronounced dead 1 hour later in the hospital.The Immediate Jeopardy began on [DATE] when the facility failed to assess, monitor and act promptly, by notifying emergency services when Resident #101 complained of respiratory difficulties and was found unresponsive approximately 6 hours later. The Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy on [DATE] at 12:15 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at a scope of isolated and severity of actual harm that is not immediate jeopardy due to sustained compliance has not been verified by the State Agency.Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes and heart failure. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #13 was cognitively intact. Review of the Functional Abilities revealed that Resident #13 was dependent on staff to transfer out of bed. Review of Resident #101's Advance Directive dated and signed on [DATE] by Resident #101 and a physician indicated Code Status: Full code.Treatment Options: Intubation, IV fluids, Antibiotics, Feeding tube, Hospitalization, Dialysis. All options were marked Yes. Review of Resident #101's Care Plan revealed, Advanced Directives.date initiated: [DATE] Interventions: Nursing will honor my code status by initiating CPR. Full Code. Intubation, antibiotics, hospitalization, IV fluids, Feeding tube, Dialysis.Review of Resident #101's Hospital Records dated [DATE] revealed, .At 9:47 PM: BIBA (brought in by ambulance) unresponsive, IGEL (artificial airway inserted through the mouth) in place with bag mask ventilation. No pulse per EMS (emergency medical services), pulse check completed, no pulse, CPR (cardiopulmonary resuscitation) initiated. Per EMS has been unresponsive for over 1 hour.Time of death: 10:25 PM.In an interview on [DATE] at 1:04 PM EMS Responder (MM) reported that they arrived to the facility on [DATE] at 9:28 PM and received report from a Registered Nurse (RN). EMS MM reported that the RN could not tell them anything except for Resident #101 had been unresponsive and demonstrated agonal breathing for 45-60 minutes, and there had not been any reports that he was having any issues earlier that day. EMS MM reported that the RN kept saying that she was not familiar with Resident #101 because she had not worked the day before, but that he was on hospice and a full code (wanted all necessary life-saving medical treatment). When EMS MM assessed Resident #101, he was completely unconscious, his skin was pale and cool, he had no response to stimuli or sternal rub, he had a weak pulse, and he was taking sporadic (infrequent, irregular) agonal breaths.In an interview on [DATE] at 1:01 PM, RN-Hospice (RN-H) O reported that she had received a message from her hospice on-call triage nurse on [DATE] at 9:17 PM to notify her that RN C had called hospice requesting a nurse visit due to Resident #101 being unresponsive and in respiratory distress. RN-H O reported that she returned the call to RN C at 9:24 PM and explained that she would be arriving in about an hour; RN C responded frantically and stated, (Resident #101) is a full code.he will be dead by then! RN-H O replied by instructing RN C to call 911 immediately. RN-H O reported that when a hospice resident has full code advance directives and is in acute respiratory distress, they would expect that the facility staff implement their own emergency polices and procedure prior to calling hospice.In an interview on [DATE] at 10:21 AM, RN C reported on [DATE] around 9:00 PM she went to administer

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This pertains to intake #2592743.Based on observation, interview and record review the facility failed to prevent an elopement and ensure safety in 1 resident (Resident #104) of 4 residents reviewed for safety/supervision, resulting in an Immediate Jeopardy when on 8/15/25 at approximately 7:00 P.M., Resident #104 (who was a known elopement risk) exited the facility unbeknownst to facility staff through an emergency exit door and was discovered outside by another resident and EMS (emergency medical services) who notified facility staff. Resident #104 was approximately 350 feet from the facility driveway walking alongside the main road, when he was first attended by facility staff at approximately 7:15 PM. This deficient practice placed 6 residents, identified as at risk for elopement, at risk for serious harm, injury, and/or death. Findings include:The facility failed to provide adequate supervision to prevent elopement for an exit seeking resident, Resident #104, who had been actively exit seeking for 2 days, and ensure that door alarms are functioning as intended for the wanderguard system (a device that triggers an alarm when near a restricted area). Resident #104 was found by another resident and EMS approximately 350 feet away from the facility driveway, walking on the side of a 30 MPH (miles per hour) road. The Immediate Jeopardy began on 8/15/25 when the facility failed to supervise Resident #104 and he eloped from the facility between 7:00 PM-7:15 PM. Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy on 8/19/25 at 9:00 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 8/20/25, but noncompliance remains at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to sustained compliance has not been verified by the State Agency.Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia. Review of Resident #104's Wandering Risk Scale Assessment dated 8/12/25 at 3:43 PM revealed a score of 14, indicating a high risk for wandering. Further details were that Resident #104 cannot follow instructions, is ambulatory, has a history of wandering, has a medical diagnosis of dementia/cognitive impairment; diagnosis impacting gait/mobility or strength. Review of Resident #104's Social Services Note dated 8/13/25 revealed, Resident admitted to facility on 8/12/25 for long term care placement. Resident has severe complications with comprehension and memory.Resident's cognition assessed scoring a 03 on the BIMS Brief Interview for Mental Status exam. Resident assessed for wandering and confirmed an elopement risk. Wander guard placed. A BIMS score of 3, out of a total possible score of 15, indicated Resident #104 was severely cognitively impaired. Review of Resident #104's Progress Note dated 8/13/25 at 9:08 PM revealed, .No exit-seeking this shift, however resident was wandering up to doors stating he needs to leave and find his dad.Alarms are not functioning even though bracelet is in good working order.Review of Resident #104's Progress Note dated 8/15/25 at 2:55 PM revealed, .Resident is agitated and wants to see his son.Review of Resident #104's Progress Note dated 8/15/25 at 4:59 PM revealed, Resident ambulates independently on unit. Resident very anxious on shift and repeats that he is getting tire (sic) of this he has things to do and he is walking out of here. Staff redirected resident and ensured that his family is returning tomorrow, for family visited resident earlier and stated that they will be back tomorrow. Resident attempted to be redirected with activities, which is short lived.Review of Resident #104's Event Note dated 7:30 PM revealed, Resident wandering the halls of the facility. Resident baseline is confused. Resident is ambulate without assistive device. Ambulance personal (sic) came back into the building and stated that one of the residents is outside that is not supposed to be outside. The writer of this note exited the building and ran into one of the alert residents out on loa (leave of absence) in the parking lot that stated that the resident went down that why (sic) pointing to the left of the facility. The writer of this note followed after the resident. The writer of this note followed behind the resident and redirected and assisted the resident back into the building. In an interview on 8/18/25 at 3:01 PM, Licensed Practical Nurse (LPN) F reported that Resident #104 had dementia and in the evening it got worse; he talked about going home and pushed on doors. LPN F reported that she had noticed a while back that the doors did not alarm when the wanderguard bracelets were near them, and she was told by other staff that the managers were already aware of the issue. In an interview and observation on 8/18/25 at 3:52 PM, Maintenance Director (MD) LL reported that he had not checked doors or alarms since 8/15/25 because there were no extra wanderguard bracelets to use to engage the alarms. MD LL reported that prior to 8/15/25 he checked every door, every day, and was not aware of any issues. Review of