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 12/05/2024
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47955 Based on observation, interview, and record review the facility failed to ensure professional standards of nursing were maintained during administration of an enteral feeding (also known as a tube feeding- the delivery of nutrients through a feeding tube directly into the stomach) for 1 (Resident #4) of 1 resident reviewed for professional nursing standards, resulting in an inaccurate administration of daily nutrition. Findings include: Resident #4 Review of an Admission Record revealed Resident #4 had pertinent diagnoses which included: dysphagia (difficulty swallowing) following cerebral infarction (stroke) and gastrostomy status (feeding tube inserted directly into the stomach used to provide nutrients directly into the stomach). Review of Order Summary for Resident #4 revealed NPO (nothing by mouth) diet. Enteral Feed Order every shift Vital 1.5 (formula brand) @ (at) 75cc/hr (cubic centimeters (milliliters) per hour) x (for) 20 hours, on at 1500 (3:00 pm) off at 1100 (11:00 am) with a start date of 11/15/2024. During an observation on 12/3/24 at 9:47 AM., Resident #4 was in bed and her tube feeding pump located next to her bed in her room was noted to be powered off. During an observation on 12/4/24 at 8:41 AM., Resident #4 was in bed tube feeding pump located next to her bed in her room was noted to be powered off. Review of Care Plan for Resident #4 dated 10/14/24 revealed Focus, Goals, and Interventions to include: is receiving all of her nutrition and hydration through the gastrostomy tube (also known as a feeding tube); will maintain nutritional status; the feeding tube will be utilized in compliance with current clinical standards of practice . Review of Dietary Progress Notes for Resident #4 dated 11/13/24 revealed Resident is being reviewed .due to tube feeding and weight loss X 30d (days). Tolerating tube feeding without any concerns. Recommend to increase to Vital 1.5 at 75ml/hr x 20 hours . During an observation on 12/4/24 at 10:23 AM., Resident #4 was in bed and her feeding pump located next to her bed in her room was noted to be powered off. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/24 at 10:27 AM., Licensed Practical Nurse (LPN) O reported Resident #4's tube feeding was started on second shift, and it was turned off on day shift at 10:00 AM. During a telephone interview on 12/4/24 at 11:57 AM., Registered Dietitian (RD) X reported Resident #4's tube feeding should be started at 3:00 PM and should end at 11:00 AM. RD X stated the total amount of formula Resident #4 should receive each day is 1500 ML. RD X reported her expectation regarding Resident #4's tube feeding was the nurses start the feeding at 3:00 PM and turn it off at 11:00 AM, and the total volume of formula administered be documented in Resident #4's medication administration record (MAR). In an interview on 12/4/24 at 2:34 PM., LPN M reported that Resident #4's tube feeding did not start until 6:00 PM. During an observation on 12/4/24 at 4:10 PM., Resident #4 was in bed and her feeding pump located next to her bed in her room was noted to be powered off. During an observation on 12/5/24 at 7:40 AM., Resident #4 was in bed and her tube feeding was running via a feeding pump at 75cc/hr with a total volume administered at that time was noted on the pump to be 943 ml. During an observation on 12/5/24 at 9:21 AM., Resident #4 was in bed and her tube feeding was not running, the total administered volume noted on the pump was 1043 ml. The formula bottle and tubing set were noted to be empty with several air bubbles in the tubing and feeding pump was alarming. During an observation on 12/5/24 at 9:45 AM., Resident #4's feeding pump was heard alarming from the hallway outside of her room. LPN O was observed entering Resident #4's room, powering down her feeding pump and exiting the room. In an interview on 12/5/24 at 9:47 AM., This surveyor asked LPN O if Resident #4's feeding was completed and LPN O stated her feeding is done for me now, I don't do anything else with her feeding, she is done for the day. This surveyor asked LPN O if she ever hung a second bottle of formula for Resident #4 and LPN O stated I have never hung a bottle of formula for Resident #4, her formula is hung on second shift. Review of Medication Administration Record for the months of November and December of 2024 for Resident #4 revealed no documented actual start or stop time nor the total volume of tube feeding formula administered. Review of Medication Administration Record for Resident #4 for the date of 12/3/24 revealed LPN M documented starting Resident #4's enteral feeding at 15:00 PM as ordered and on 12/4/24 LPN O documented ending Resident #4's enteral feeding at 11:00 AM as ordered. During an interview on 12/5/24 at 12:48 PM., Director of Nursing (DON) B reported her expectations were that Resident #4's tube feeding should be started at 15:00 and turned off at 11:00 as per the order. DON B reported Resident #4 should receive a total of 1500 ml of formula, 1 and 1/2 bottles of the 1000mL bottles of Vital 1.5, for every feeding. DON B reported if the nurses did not hang a second bottle of formula, Resident #4 was not getting enough of her food.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on observation, interview and record review, the facility failed to ensure assistance with activities of daily living (ADL) were provided for 3 residents (Residents #46, Residents #27, Resident #38) of 4 residents reviewed for ADL care potentially resulting in dissatisfaction with care and hygiene concerns. Findings include: Resident #46 (R46) Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R46 admitted to the facility on [DATE] with diagnoses including type 2 diabetes, cellulitis (bacterial skin infection) and need for assistance with personal care. Brief Interview for Mental Status (BIMS) reflected a score of 13 out of 15 which indicated R46 was cognitively intact (13 to 15 cognitively intact). During an interview on 12/03/2024 at 11:17 AM, R46 sat in his room watching television. R46 stated that he only had a couple of showers since he was admitted to the facility. R46 stated that his preference was to have showers instead of bed baths and he wanted to receive 2 showers a week. Review of the shower schedule revealed R46 should receive showers on second shift on Wednesdays and Sundays. Review of R46's Skin Monitoring: Comprehensive CNA Shower Review sheets revealed that R46 had a shower on 11/13, 11/20 and refused a shower on 11/27. Review of R46's 30-day record of showers/sponge baths revealed he received a sponge bath on 11/12 and 11/21 and showers on 11/13, 11/20 and 12/2. Review of R46's care plan revealed (R46, resident name omitted) requires maximal assistance from staff with showers. During an interview on 12/04/2024 at 8:27 AM, Certified Nursing Assistant (CNA) T stated that all residents should get 2 showers a week and CNAs should document when refusals occur. During an interview on 12/04/2024 at 8:51 AM, CNA P and CNA R stated that the shower schedule for residents should be 2 showers a week and CNAs need to document refusals on the shower sheet and in the electronic medical record. During an interview on 12/04/2024 at 2:11 PM, Director of Nursing (DON) B stated that everyone should receive at least 2 showers a week unless they want it more often. DON 'B verified that R46 should be receiving showers 2 times a week on Wednesdays and Sundays. DON B reported that there weren't any staffing issues in the last month that would have prevented him from receiving his scheduled 2 showers a week. 46999 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27 Review of an Admission Record revealed Resident #27 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: mild cognitive impairment of unknown origin, unspecified lack of coordination, history of falling, and weakness. Review of a Minimum Data Set (MDS) assessment for Resident #27, with a reference date of 9/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #27 was moderately cognitively impaired. Section GG of the MDS revealed Resident #27 required supervision or touching assistance to complete a shower/bathe self. Review of a Care Plan for Resident # 27, with a reference date of 9/25/24, revealed a focus/goal/interventions of: Focus: (Resident #27) requires staff assistance with ADL's (activities of daily living) d/t (due to) impaired balance, and poor activity endurance. Goal: (Resident #27) will maintain current level of self-care ability through the next review. Interventions: . (Resident #27) requires maximal assistance with showering. In an interview on 12/3/24 at 12:29am, Resident #27 was asked about the assistance he received with bathing, but he did not respond. In an interview on 12/3/24 at 2:22pm, Family Member (FM) EE reported she was concerned that Resident #27 was not being assisted with showers and nail care often enough based on his appearance when she visited him. FM EE reported Resident #27 would not initiate self-care without encouragement and cueing and he appeared disheveled and had long fingernails during visits. In an interview on 12/4/24 at 2:58pm, Certified Nursing Assistant (CNA) S reported nail care should be done for a resident on their shower days, but sometimes nailcare was missed. During an observation on 12/4/24 at 3:04pm, Resident #27 was observed while in a group activity, his hair appeared greasy and disheveled, his fingernails extended beyond his fingertips and had brown debris on their underside. During an observation on 12/5/24 at 12:31pm, Resident #27 was observed while eating lunch in the dining room. Resident #27's hair appeared greasy, and his fingernails remained long with brown debris on their underside. Review of a shower schedule provided by the facility revealed Resident #27 was scheduled to receive assistance with showering on Thursday and Saturday of each week. Review of Resident #27's shower sheets for the last 90 days, provided by the facility, revealed the resident was offered a shower on 16 of 27 scheduled opportunities during that period. Resident #38 Review of an Admission Record revealed Resident #38, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: aphasia (inability to express self verbally), cerebral infarction (stroke), and major depressive disorder (persistent depressed mood or loss of interests causing significant impairment in daily living). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for Resident #38, with a reference date of 9/5/24 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #38 was cognitively intact. Section E revealed Resident #38 had no episodes of refusing care. Review of a Care Plan for Resident # 38, with a reference date of 5/28/24, revealed a focus/goal/interventions of: Focus: (Resident #38) requires staff assistance with ADL's (activities of daily living) related to impaired balance, poor activity endurance, and debility (overall deconditioning). Goal: (Resident #38) will maintain current level of self-care ability though the next review. Interventions: (Resident #38) requires maximal assistance from 1 staff for .showering .and personal hygiene. During an observation on 12/3/24 at 1:59pm, Resident #38 sat in the hallway with a peer. It was noted that Resident #38's fingernails were soiled with a dark brown substance under several nails. During an observation on 12/4/24 at 3:05pm, Resident #38 was in group activity. It was noted that several of her fingernails were soiled with a dark brown substance under several nails. In an interview on 12/4/24 at 3:27pm Therapy Director (TD) H reported Resident #38 very accurate with expressing her wishes when asked yes/no questions. In an interview on 12/4/24 at 3:29pm, Resident #38 indicated through the use of yes/no questions, that she felt frustrated and embarrassed by the dirty appearance of her fingernails. Resident #38 reported she needed help from staff to maintain the cleanliness of her fingernails but sometimes it was not provided. In an interview on 12/5/24 at 9:28am, Family Member (FM) FF reported Resident #38's fingernails were often dirty when she visited, and the resident expressed a desire to have more assistance with keeping her nails clean.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47955 Based on observation, interview, and record review the facility failed to ensure that enteral feeding (also known as a tube feeding- the delivery of nutrients through a feeding tube directly into the stomach) was administered as ordered to 1 (Resident #4) of 1 resident reviewed for enteral feeding, resulting in the potential for weight loss, dehydration, and/or an overall deterioration of wellbeing. Findings include: Resident #4 Review of an Admission Record revealed Resident #4 had pertinent diagnoses which included: dysphagia (difficulty swallowing) following cerebral infarction (stroke) and gastrostomy status (also known as G-tube) a feeding tube inserted directly into the stomach used to provide nutrients directly into the stomach). On 12/3/24 at 9:47 AM., Resident #4 was in bed and her tube feeding pump, located next to her bed in her room, was noted to be powered off. A bottle and tubing set with approximately 200 ml (milliliters) of noted formula was hanging from the pole with the tubing inserted into the pump for feeding administration. The feeding tubing was not connected to Resident #4's G-tube. During an observation on 12/4/24 at 8:41 AM., Resident #4 was in bed in her room, tube feeding pump located next to her bed was noted to be powered off. A bottle and tubing set with an unmeasurable (below the bottle marking for 100 ml of a total 1000mL volume bottle) amount of formula present was hanging from the pole with the tubing inserted into the pump for feeding administration. The feeding tubing was not connected to Resident's G-tube. Review of Order Summary for Resident #4 revealed NPO (nothing by mouth) diet. Enteral Feed Order every shift Vital 1.5 (formula brand) @ (at) 75cc/hr (cubic centimeters (milliliters) per hour) x (for) 20 hours, on at 1500 (3:00 pm) off at 1100 (11:00 am) with a start date of 11/15/2024. During an observation on 12/4/24 at 10:23 AM., Resident #4 was in bed in her room, and her feeding pump located next to her bed was noted to be powered off and no bottle or tubing set was present. During an interview on 12/4/24 at 10:27 AM., Licensed Practical Nurse (LPN) O reported Resident #4's tube feeding was started on second shift, and it was turned off on her shift at 10:00 AM. LPN O reviewed Resident #4's enteral feeding order and stated Oh, it should be off at 11 (am). LPN O reported she had taken care of Resident #4 for a long time, and she just knew when her feeding should be turned off. LPM O reported she had an hour before and after the scheduled time to stop Resident #4's tube feeding. Review of Dietary Progress Notes for Resident #4 dated 11/13/24 revealed Resident is being reviewed .due to tube feeding and weight loss X 30d (days). Tolerating tube feeding without any concerns. Recommend to increase to Vital 1.5 at 75ml/hr x 20 hours . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 12/4/24 at 11:57 AM., Registered Dietitian (RD) X reported Resident #4's tube feeding should be started at 3:00 PM and should end at 11:00 am. RD X stated the total amount of formal Resident #4 should receive each day is 1500 ML. RD X reported her expectations regarding Resident #4's tube feeding was that the nurses start the feeding at 3:00 PM and turn it off at 11:00 AM, and the total amount of formula should be documented in Resident #4's medication administration record (MAR). Review of Medication Administration Record for the months of November and December of 2024 for Resident #4 revealed no documented total volume of tube feeding formula administered. In an interview on 12/4/24 at 2:34 PM., LPN M reported that Resident #4's tube feeding did not start until 6:00 PM and she would start Resident #4's tube feeding between 5:00 PM and 6:00 PM. LPN M reported she had taken care of Resident #4 a while and her tube feeding had not changed. During an observation on 12/4/24 at 4:10 PM., Resident #4 was in bed in her room, and her feeding pump located next to her bed was noted to be powered off. No tube feeding bottle of formula or tubing present in the room. During an observation on 12/5/24 at 7:40 AM., Resident #4 was in bed and her tube feeding was running via a feeding pump at 75cc/hr with a total volume noted on the pump to be 943 ml. The formula bottle and tubing set with an unmeasurable (below the bottle marking for 100 ml) amount of formula present was hanging from the pole with the tubing inserted into the pump and the pump running. During an observation on 12/5/24 at 9:21 AM., Resident #4 was in bed and her tube feeding pump was on, alarming, and displaying a total volume administered 1043 ml. The formula bottle and tubing set were noted to be empty with several air bubbles in the tubing between the bottle and the feeding pump connection. During an observation and interview on 12/5/24 at 9:38 AM., Resident #4's feeding pump was heard alarming from the hallway outside of Resident #4's room. Certified Nurse Assistant (CNA) P entered the room and exited the room and said to this surveyor I know what that is, but the nurse has to turn off her feeding pump. During an observation and interview on 12/5/24 at 9:45 AM., Resident #4's feeding pump was heard alarming from the hallway outside of Resident #4's room. LPN O was observed entering Resident #4's room, powering down Resident #4's feeding pump and exiting the room. This surveyor asked LPN O if Resident #4's feeding was completed and LPN O stated her feeding is done for me now, I don't do anything else with her feeding, she is done for the day. This surveyor asked LPN O if she ever started a second bottle of formula for Resident #4 and LPN O stated I have never hung (started) a bottle of formula for Resident #4, her formula is hung on second shift. Review of Medication Administration Record for Resident #4 for the date of 12/3/24 revealed LPN M documented starting Resident #4's enteral feeding at 15:00 PM as ordered and on 12/4/24 LPN O documented ending Resident #4's enteral feeding at 11:00 AM. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/24 at 12:48 PM., Director of Nursing (DON) B reported her expectations were that Resident #4's tube feeding should be started at 15:00 and turned off at 11:00. DON B reported Resident #4 should receive a total of 1500 ml of formula, a bottle and a half of formula, as each bottle was 1000mL. DON B reported if the nurses did not hang a second bottle of formula Resident #4 was not getting enough of her food.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47955 Based on interview and record review the facility failed to ensure that gradual dose reductions (GDRs) for the ongoing use of psychotropic medications were completed for 1 (Resident #12) of 5 residents reviewed for unnecessary medications. Findings include: Resident #12 Review of an Admission Record revealed Resident #12 had pertinent diagnoses which included: major depressive disorder. Review of Order Summary for Resident #12 revealed Duloxetine (antidepressent) 60 mg HCL powder give 60 mg (milligrams) enterally (via g tube) one time a day related to major depressive disorder. Review of Psychotropic and Sedative/Hypnotic Utilization by resident dated 3/1/2024 to 3/6/2024, provided by Director of Nursing (DON) B revealed Resident #12 recommended next eval (evaluation) date (s) for the use of Duloxetine was March of 2024. In an interview on 12/5/24 at 12:32 PM., DON B reported that Resident #12's dosage for Duloxetine had remained the same for over a year. DON B reported Resident #12 had not had an attempted gradual dose reduction of her ordered Duloxetine at any time during 2024. By the time of exit the facility was unable to provide any documentation regarding Resident #12 undergoing a gradual dose reduction or any documented physician rationale against a gradual dose reduction for Duloxetine.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 47955 Based on observation, interview, and record review the facility failed to maintain a medication error rate less than 5% (total error rate of 20%) in 4 residents (Resident #15, Resident #25, Resident #30, Resident #43) of 9 residents reviewed for medication administration resulting in improper injection location, late oral medication administration, missed dose of medication, and the potential for reduced medication effectiveness. Findings include: Resident #15 Review of an Admission Record revealed Resident #15 had pertinent diagnoses which included: diabetes mellitus (a disease that results in high blood sugar levels in the blood due to a body's decreased ability to produce insulin). Review of Order Summary for Resident #15 revealed insulin aspart injection solution 100 unit/ML (milliliter) (short acting insulin) inject as pre sliding scale : if 201-250 = 3 units; 251-300 = 5 units; 301-350 = 7 units; 351-400 = 9 units; 401-999 = 11 units, subcutaneously (administered just under the skin into the fatty areas of the abdomen, back of arms, or outer side of the thighs) three times a day related to diabetes, dated ordered 11/22/2024. Mounjaro subcutaneous solution auto-injector 7.5 mg/0.5ml (milligrams/milliliters) inject 7.5 mg subcutaneously in the afternoon every Wed (Wednesday) related to diabetes mellitus, date ordered 11/22/2024. On 12/4/2024 at 11:31 AM., Licensed Practical Nurse (LPN) L was observed administering a Mounjaro subcutaneous injection into the left arm deltoid (a thick triangular muscle that forms the rounded area of upper arm and the shoulder) area of Resident #15. On 12/4/2024 at 11:43 AM., LPN L was observed administering an insulin aspart injection into the right arm deltoid area of Resident #15. In an interview on 12/4/24 at 11:46 AM., when asked, LPN L reported that Resident #15's injections should be given subcutaneously. LPN L reported acceptable locations for subcutaneous injections were the deltoid muscle of the arm and the abdomen. In an interview on 12/4/24 at 4:11 PM., LPN M reported that insulin was a subcutaneous injection and could be administered in the arm, LPN M gestured to her own arm pointing to and touching the deltoid muscle as a demonstration of where a subcutaneous insulin injection should be given. In an interview on 12/5/24 at 12:32 PM., Director of Nursing (DON) B and Assistant Director of Nursing (ADON) C reported that subcutaneous injections should be given in the back of the arms, abdomen, and the outer side of the thighs into fatty areas. DON B reported it was not acceptable to give subcutaneous injections into the deltoid muscle of the arms. Resident #25 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #25 had pertinent diagnoses which included: nontraumatic intracerebral hemorrhage (stroke, not resulting from trauma). Review of Order Summary for Resident #25 revealed Baclofen 15mg give one tablet by mouth three times a day, ordered on 7/20/24. On 12/4/24 at 4:29 PM., LPN M was observed administering baclofen 15 mg tablet to Resident #25. Visualization of the computer Medication Administration Record (MAR) during the observation revealed an ordered time of administration of 15:00 (3:00 PM). When asked, LPN M reported that Resident #25's baclofen 15 mg tablet could be given an hour early (between 2:00 pm and 3:00 pm) or an hour later (between 3:00 pm and 4:00 pm) from the time it was ordered to be given. In an interview on 12/5/24 at 12:32 PM., DON B reported medication could be given an hour before and an hour after the ordered time. DON B confirmed a medication ordered at 3:00 pm and given at 4:28 pm was a late administration. Resident #30 Review of an Admission Record revealed Resident #30 had pertinent diagnoses which included: Type 2 diabetes with diabetic neuropathy (nerve pain). Review of Order Summary for Resident #30 revealed gabapentin capsule 100 mg give one capsule by mouth three times a day for neuropathy, ordered on 8/22/24. On 12/4/24 at 4:11 PM., LPN M was observed preparing medications for Resident #30. During medication preparations for Resident #30, LPN M reported Resident #30 did not have gabapentin 100 mg capsules available in the medications cart and Resident #30 would not get this dose. Resident #30 did not receive gabapentin 100 mg as ordered. In an interview on 12/4/24 at 4:18 PM., this surveyor asked LPN M if gabapentin 100 mg capsule was available from the facilities back up medication box, and LPN M reported she did not have time to deal with it right now. In an observation and interview on 12/5/24 at 10:15 AM., DON B accessed the facility's back up medication storage box and confirmed that gabapentin 100 mg was available for use if a resident's supply was gone, or a resident was waiting for a refill from the pharmacy. DON B reported her expectations were nurses pull a resident's missing medication from the backup medication box if available to ensure that residents did not miss a dose. Resident #43 Review of an Admission Record revealed Resident #43 had pertinent diagnoses which included: alcohol abuse. Review of Order Summary for Resident #43 revealed Acamprosate Calcium Oral Tablet Delayed Release 333 MG give 333 mg three times a day for reduce desire to drink alcohol, order started on 8/10/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chalet of Niles, LLC	911 S 3rd St Niles, MI 49120

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 11:47 AM., LPN L was observed preparing acamprosate calcium oral tablet delayed release 333mg tablet for Resident #43. During the observation LPN L stated Resident #43 takes his medications crushed. LPN L was observed crushing acamprosate and mixing the crushed medication with vanilla pudding and providing the mixture to Resident #43 who ate the mixture of crushed medications and vanilla pudding. In an interview on 12/4/24 at 11:50 AM., LPN L reported that acamprosate could be crushed. Review of Medication Label on Resident #43's acamprosate prescription supply revealed Do Not Crush. In a telephone interview on 12/5/24 at 9:02 AM., Pharmacist (P) Y reported that acamprosate was a delayed release medication and should not be crushed, it should be swallowed whole. P Y reported when Acamprosate was crushed, the medication absorption by the body was altered. In an observation and interview on 12/5/24 at 12:41 PM., DON B reported delayed release medications should not be crushed. DON B reported Resident #43 takes his medication crushed in pudding or applesauce. DON B accompanied this surveyor to the medication cart and was observed removing Resident #43's prescription supply of acamprosate from the medication cart and confirming the pharmacy's prescription label did indicate do not crush.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38905 Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food in the kitchen. Findings include: During the initial tour of the kitchen, at 9:40 AM on 12/3/24, observation of the walk-in cooler found a one-gallon container and a half gallon container both full of cooked roast beef. The roast beef was dated for 12/2 and was found covered with condensation and moisture on the inside tops of the containers. At this time, the surveyor took a temperature of the product with a Thermoworks Rapid Read thermometer and found the half gallon container was 40F and the gallon container was 43F. When asked what we should do to the product, Director of Housekeeping (DOH) F (Filling in for the Dietary Manager on Maternity leave) stated they should be discarded. When asked if there was a cooling log on the items, DOH F was unsure and was going to ask the cook after she was back from rounds. An interview with [NAME] GG, at 9:56 AM on 12/3/24, found that she didn't work last night and doesn't cool down or save food from meal service. [NAME] GG stated that they should have a log, but she's not sure where it is as its not in its usual spot. [NAME] GG stated that the cook who worked last night is new and has only been here a week or so. According to the 2017 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less . According to the 2017 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. Observation of the walk-in cooler, at 9:48 AM on 12/3/24, found the following items: sliced sausage dated 11/26, applesauce dated 11/25, orange slices dated 11/26, and a container of fruit cocktail with no date. Observation of the nourishment room, at 10:35 AM on 12/3/24, found a container of thanksgiving leftovers dated for 11/28 and another container of leftovers with no date. A sign on the front of the refrigeration unit states items are held for three days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . During a tour of the clean utensil drawers, at 10:00 AM on 12/3/24, it was observed that four mechanical scoops were found with dried stuck on food debris. During an observation of the drink station, at 10:02 AM on 12/3/24, it was observed that the underside of the coffee spout was heavily layered with an accumulation of coffee splash over time. Observation of the Microwave, at 10:10 AM on 12/3/24, found an accumulation of crusted debris on the top ceiling of the unit. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. During a tour of the kitchen at 10:05 AM on 12/3/24, it was observed that some of the ventilation filters on the cook line were found with excess grease accumulation. When asked if staff take these down and clean them, [NAME] GG stated they have a service that cleans them, but staff doesn't know how to take them down. During an observation of the three-compartment sink area, at 10:11 AM on 12/3/24, it was observed that the undershelf of the microwave table was found with heavy accumulation of yellow crusted debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean . During the initial tour of the kitchen, at 10:08 AM on 12/3/24, it was observed that the one compartment preparation sink, near the three-compartment sink, was found with no waste water line attached and set up in a manner that allowed water to dispense onto the floor. When asked about the sink, Dietary Aide HH stated that it's been that way for a while and staff just don't use it for now. During a tour of the chemical closet, at 10:29 AM on 12/3/24, it was observed that the sink was left on and connected to a pre-dispense chemical unit, allowing staff to just hit the button on the chemical unit for dispensing. This current set up of the mop sink faucet puts undue back pressure on the faucets internal vacuum breaker (VB) of which it is not rated to handle. During a revisit to the kitchen, at 12:10 PM on 12/3/24, it was observed that the water line to the garbage grinder would not shut off. When asked about the issue with [NAME] GG, she stated usually we just hit the stop button, but it doesn't seem to work. According to the 2017 FDA Food According to the 2017 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair. During a tour of the dish machine area, at 10:13 AM on 12/3/24, it was observed that Dietary Aide HH was doing dishes. When asked how the unit has been running, Dietary Aide HH stated good. Observation of the Dish Machine Log-Low Temp dated November 2024, found that the dish machine had been meeting the minimum requirements of 120F or higher for the wash and rinse temperatures and 50-100 parts per million of bleach as stated on the machines data plate. After running the machine three times, the water temperature never reached over 100F on the dish machines gauge or the surveyors thermometer. When asked if the dish gauge is the one that is used to record temperatures from, Dietary Aide HH stated Yes. According to the 2017 FDA Food Code section 4-501.15 Warewashing Machines, Manufacturers' Operating Instructions. (A) A WAREWASHING machine and its auxiliary components shall be operated in accordance with the machine's data plate and other manufacturer's instructions. During a tour of the dry storage room, at 10:27 AM on 12/3/24, it was observed that an open gallon of soy sauce was found on the dry storage shelf. A review of the manufacture's directions state Refrigerate After Opening. According to the 2017 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation of tray line, at 12:32 PM on 12/3/24, it was observed that [NAME] GG touched multiple baked potatoes with her bare hands while placing and opening up baked potatoes for meal service. In the beginning of service [NAME] GG used utensils and gloved hands to help slice, open, and sometimes scrap the baked potato onto the plate. After roughly 2/3rds of the meals were plated, [NAME] GG started to get away from regularly using utensils and gloves to handle the ready to eat food and was osberved using her bare hands to plate numerous meals. According to the 2017 FDA Food Code section 3-301.11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview, and record review, the facility failed to: 1. implement infection control practices during resident care for 5 (Resident #2, #4, #12, #11, and #299) of 12 residents reviewed for infection control, 2. maintain an ongoing infection control surveillance program, and 3. have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), resulting in the increased risk of transmission of pathogenic organisms and cross contamination between residents. Findings include: Review of a facility policy titled Guidelines for Infection Prevention and Control revealed: .The INFECTION PREVNTION and CONTROL PROGRAM is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This will be accomplished through preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, consultants, volunteers, visitors, and other individuals who provide services to residents in the facility . In an interview on 12/05/24 at 11:02am, Director of Nursing/ Infection Preventionist DON/IP B reported the facility relied on department managers to communicate to the Infection Preventionist when a staff member called in sick but often that information was not conveyed, and no tracking of employee illnesses had been completed. When further queried, DON/IP B reported the lack of tracking employee illnesses resulted in the potential for spread of illness for residents. In an interview on 12/05/24 at 11:02am, DON/IP B reported the facility had not completed ongoing hand hygiene or Personal Protective Equipment (PPE)audits to ensure staff were using proper techniques. DON/IP B reported no auditing had been completed since May 2024. When further queried, DON/IP B reported the lack of auditing created the potential for an increased likelihood of cross contamination between residents and/or staff to residents. 47955 Resident #2 Review of an Admission Record revealed Resident # had pertinent diagnoses which included: artificial left knee joint, and methicillin resistant staphylococcus aureus infection (MRSA). On 12/3/24 at 10:15 AM signage was noted on the door to Resident #2's room that indicated resident was in contact precautions and that anyone entering the room must clean their hands, including before entering and when leaving the room. Providers and staff must also put on gloves before entering the room, discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. use dedicated or disposable equipment. Clean and disinfect surfaces and equipment with a sporicidal agent. Review of Order Summary for Resident #2 revealed contact isolation related to MRSA in wound ordered on 11/28/2023. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Care Plan for Resident #2 revealed Goal : is on contact isolation due to MRSA in left knee . On 12/4/24 at 2:36 PM., Housekeeping Aide (HA) V was observed in Resident #2's room, removing trash from the bag in the trash can next to Resident #2's bed, picking up paper debris from the floor around Resident #2's bed, and exiting the room to dispose of gathered trash into the bag on her housekeeping cart in the hallway outside of Resident #2's room. HA 'V did not wear any PPE (personal protective equipment including gown and gloves) while in Resident #2's room. HA V was then observed applying gloves, HA V wore no other PPE, and gathering a rag, soaking the rag in a bucket of cleaning solution on her cart, and entering Resident #2's room and wiping off Resident #2's over the bed table with the rag. HA V then walked to Resident #2's roommates over the bed table and wiped the top of that table too. HA V then exited Resident #2's room, placed rag into the plastic bag on her housekeeping cart, removed, gloves. HA V did not perform hand hygiene before pushing her housekeeping cart down the hallway. In an interview on 12/4/24 at 2:42 PM., HA V reported she was a former certified nursing assistant, and the signage on Resident #2's door indicated Resident #2 was on contact precautions and PPE was to be worn by staff when Resident #2 received cares. HA V reported the signage did not apply to the housekeeping staff, only nursing. In an interview on 12/4/24 at 2:50 PM., Director of Nursing (DON) B reported Resident #2 was on contact isolation precautions and every staff member should wear PPE when encountering any item in her room. DON B reported contact precautions included housekeeping staff as well. In an interview on 12/4/24 at 2:59 PM., Director of Housekeeping (DH) F reported Resident #2 was the only resident on contact precautions. DH F reported contact precautions were for clinical staff only and did not apply to housekeeping staff. In an interview on 12/4/24 at 3:15 PM., Licensed Practical Nurse (LPN) L reported that Resident #2 was on enhanced barrier precautions (EBP) PPE was only required when providing direct care to Resident #2. In an interview on 12/4/24 at 3:20 PM., DON B Resident #2 was on contact precautions and her expectations was that all staff including housekeeping staff wear PPE when encountering anything in Resident #2's room. On 12/5/24 at 8:35 AM., Inservice Attendance dated 12/4/24 at 4:11 PM with a topic of EBP and contact precautions provided by the facility was reviewed and was noted to include signatures for 4 facility housekeeping staff members in attendance. Resident #4 Review of an Admission Record revealed Resident #4 had pertinent diagnoses which included: dysphagia (difficulty swallowing) following cerebral infarction (stroke) and gastrostomy status (feeding tube inserted directly into the stomach used to provide nutrients directly into the stomach). On 12/3/24 at 9:47 AM., Resident #4 was noted to have a G-tube present in her stomach and no signage was noted on the door to Resident #4's room to indicate she was in enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Order Summary for Resident #4 revealed pt (patient) receiving EBP (enhanced barrier precautions) due to Peg tube (g-tube) every shift, ordered on 5/29/2024. Review of Care Plan for Resident #4 revealed intervention of : Enhanced barrier precautions should be followed for all hands-on care with a revision date of 10/14/2024. On 12/4/24 at 4:10 PM no noted signage on Resident #4's room door to indicate the need for enhanced barrier precautions. Resident #12 Review of an Admission Record revealed Resident #12 had pertinent diagnoses which included: dysphagia (difficulty swallowing) following cerebral infarction (stroke) and gastrostomy status (feeding tube inserted directly into the stomach used to provide nutrients directly into the stomach). On 12/3/24 at 9:47 AM., Resident #12 was noted to have a G-tube present in her stomach and no signage was noted on the door to resident #12's room to indicate she was in enhanced barrier precautions. Review of Order Summary for Resident #12 revealed pt receiving EBP due to Peg tube (g-tube) every shift, ordered on 5/29/2024. Review of Care Plan for Resident #12 revealed intervention of : Enhanced barrier precautions while providing care to Resident #12 a revision date of 10/3/2024. On 12/4/24 at 4:10 PM no noted signage on Resident #12's room door to indicate the need for enhanced barrier precautions. In an interview on 12/4/24 at 2:17 PM., DON B reported EBP signage was to be posted on the door to the room for residents who were in enhanced barrier precautions. DON B reported nurses could access a resident's physician orders and see if there was an order for EBP, but certified nursing assistants would not know if a resident was in enhanced barrier precautions if there was no signage posted. DON B confirmed that Resident #4 and Resident #12 were both in enhanced barrier precautions but there was not signage posted on their doors to notify staff of enhanced barrier precautions. 48637 Resident #11 (R11) Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R11 admitted to the facility on [DATE] with diagnoses including pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on skin), gastronomy tube (tube surgically inserted through the abdominal wall and into the stomach used for artificial nutrition, feeding tube), anxiety and depression. Brief Interview for Mental Status (BIMS) reflected a score of 14 out of 15 which indicated R11 was cognitively intact (13 to 15 cognitively intact). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 12/3/2024 at 10:30 AM, it was noted that R11's door had an Enhanced Barrier Precautions (EBP) sign on her door. The sign revealed Everyone must clean their hands, including before entering and when leaving their room. Providers and staff must also wear gloves and a gown for the following high contact resident care activities: dressing .device care or use: .urinary catheter, feeding tube . wound care: any skin opening requiring a dressing. Review of R11's physician orders revealed that R11 had an indwelling catheter, 2 pressure wounds-one on her right buttocks and 1 on her right trochanter (hip bone) and an enteral feeding (feeding tube). Review of R11's physician orders revealed that there wasn't an order for EBP. Review of R11's care plan revealed there wasn't a care plan for EBP. During an observation on 12/04/2024 at 8:41 AM, Assistant Director of Nursing (ADON) C and Certified Nursing Assistant (CNA) P went into R11's room with gloves on and no gown. ADON C stated to R11 that they were there to provide treatment to R11's wounds. R11's door was slightly ajar and surveyor observed wound treatment was performed. During an interview on 12/04/2024 at 8:55 AM, ADON stated that she was working with R11's wound and wasn't by her gastronomy feeding site on her body so she only wore gloves in R11's room. ADON stated that R11 was on EBP for her feeding tube and not for her wound. ADON reported that she is new to long term care and is still learning what needs to be done in relation to EBP. During an interview on 12/04/2024 at 9:11 AM, Director of Nursing (DON) B stated that any resident with a port of entry on their body such as a catheter, feeding tube and wounds should be under EBP. DON B said that staff should wear a gown and gloves when entering EBP rooms. During another interview on 12/04/2024 at 4:31 PM, DON B stated that physician orders and care plans should be put in the resident chart when they are under EBP. DON B reported that the admitting nurse or herself puts EBP physician orders in the chart and the Minimum Data Set (MDS) nurse puts the EBP care plan in. During an interview on 12/04/2024 at 4:31 PM, MDS nurse D verified that she did not see a physician order for EBP or a care plan for EBP in R11's chart. Resident #299 (R299) Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R299 admitted to the facility on [DATE] with diagnoses including end stage renal disease and kidney transplant. Brief Interview for Mental Status (BIMS) reflected a score of 14 out of 15 which indicated R299 was cognitively intact. Review of R299's physician order revealed Enhanced barrier precautions d/t (due to) dialysis port in right chest. During observations on 12/03/2024 at 11:15 AM and 12/04/2024 at 11:46 AM, there wasn't EBP signage on R299's door. (continued on next page)

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 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chalet of Niles, LLC	911 S 3rd St Niles, MI 49120

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/04/2024 at 2:04 PM, DON B reported that R299 should be under EBP with his chest port and she stated that she forgot to put the sign up. Review of the Guidelines for Enhanced Barrier Precautions (EBP) An Extension of Personal Protective Equipment (PPE) Policy with a revision date of December 2022 revealed Procedure: 2. Obtain a physician's order for the enhanced barrier precaution (EBP) and any additional precautions other than universal/standard precautions. 3. Ensure that proper signage is posted on the residence room door instructing those who plan to enter the room to check first at the nurses' station for education/instruction 6. Ensure that the resident's care plan is reflective of the resident's care regarding EBP or any additional precautions other than universal standard precautions as indicated. 38905 Observation of the facility, starting at 11:28 AM on 12/3/24 , found multiple stagnant lines, including a hopper, a wall mounted hopper spray, soiled utility room sink, the bathing tub, fixtures in the 500 hall bath (that's mainly used for just weights), the one compartment sink in kitchen with no waste water line, and a water line on the cook line of the kitchen that used to be used to fill equipment with water. During an interview with Maintenance (M) K and Director of Housekeeping (DOH) F, at 3:25 PM on 12/3/24, it was found that between the housekeeping and maintenance department, they do keep up on the flushing of water to resident fixtures as they clean and take water temperatures. When asked if there was a risk assessment or policy and procedure that had been done on the facility, M K and DOH F stated that they were both newer to the facility and would have to look on the computer to find that information. When asked how they knew to flush water lines on a regular basis, M K stated it came up on a weekly task list. When asked if there were other control measures and limits put in place, M K was unsure. During a review of the facility provided policy Water Systems - Legionella Risk Prevention, not dated, found that under the Procedure section it states Complete the worksheet titled Identifying Buildings at Increased Risk to determine if the entire buildings or parts of it are at increased risk for Legionella growth. No record review of the worksheet being completed was found. Following along on the procedure, the expectation is that the facility would create a building specific list of areas and equipment that should be monitored for as they are areas of risk associated with the growth of OPPP. The end of the policy gives directions on how to develop the water management plan: 1. Establish a Water Management Program Team 2. Describe the building water system using text and diagrams 3. Identify areas where Legionella could grow and spread. 4. Describe where control measures should be applied and how to monitor . No documentation was provided that showed that the plan was active and ongoing while fulfilling the requirements of the Water Management Plan.

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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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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 46999 Based on interview, and record review, the facility failed to maintain staff documentation of COVID-19 screening, education, offering and current COVID-19 vaccination status of one of one staff reviewed, resulting in increased risk for COVID-19 infections. This deficient practice has the potential to impact all residents within the facility. Findings include: Review of Infection Control Guidance: SARS-CoV-2 published 6/24/24 by the Centers For Disease Control, revealed: 1. Recommended routine infection prevention and control practices .Encourage everyone to remain up to date will all recommended COVID-19 vaccine doses .health care providers .should be offered resources and counseling about the importance of receiving the COVID-19 vaccine . Review of covid vaccination/education for Certified Nursing Assistant (CNA) DD revealed the staff member was last vaccinated for COVID 19 on 11/24/21. At the conclusion of the survey, the facility did not provide further documentation of annual offering of a covid vaccination or education related to the vaccination for this staff member. In an interview on 12/5/24 at 11:02am, the Director of Nursing (DON) who is also the Infection Preventionist (IP) B reported the facility had not offered staff members the COVID-19 vaccination for 2024 and had not tracked the immunization status or education of staff regarding COVID-19 vaccinations. DON B confirmed the facility was responsible to do so to reduce the risk of transmission to residents.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation and interview the facility failed to maintain a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living, affecting all residents. Findings include: During a tour of the nourishment room, at 10:34 AM on 12/3/24, observation under the sink found a large hole in the wall exposing the back of the wall and leaving an opening for pests. Further review found old moisture damage and a black staining-like substance on the back wall inside of the hole. During a tour of the facility, at 11:29 AM on 12/3/24, observation of empty resident room [ROOM NUMBER] found a large brown splash stain in the far right corner of the room. The wall in this corner of the room was bubbling from the ceiling to the floor. During a tour of the 200 hall bath, at 11:35 AM on 12/3/24, it was observed that five towels and six washcloths were stored open and exposed between the sink and the shower. Items were stacked on top of a cabinet laying on the floor. Further review of the bath found a large green shower chair with dried brown splash staining a white support bar below the seat. During a tour of the 200 Hall Soiled Utility room, at 11:40 AM on 12/3/24, it was observed that brown tinted water came out of the hot and cold water lines of the hoppers mop sink faucet. Further observation found the sink had a slow leak when turned on. Observation in the cabinetry below the sink found dilapidated wood swollen with moisture with a sprawling black stain covering most of the wood. The odor of the cabinet was noticeably musty. During a tour of the 300 Hall Soiled Utility room, at 11:48 AM on 12/3/24, it was observed that the [NAME] valve, for flushing the hopper, would leak onto the floor when the unit was used. Further observation found the hopper was not able to completely flush with debris staying in the basin of the hopper. Further review found that the sink in the 300 hall Soiled Utility room was not operational, leaving a stagnant line that is not able to be flushed. Under the sink counter was found to have a disconnected wastewater line and a large hole on the back of the cabinet exposing the back wall. During a tour of the 200 hall Janitors closet, at 12:40 AM on 12/3/24, it was observed that a chemical pre dispense system was in place and that staff leave the faucet on and just use the pre dispense to run when needed. This set up puts undue back pressure on the faucets internal vacuum breaker (VB) of which will ruin the integrity of the mechanism. At 2:15 PM on 12/3/24, Observation of the boiler room with Maintenance (M) K found that one of the two water heaters was down and not operational. When asked about the issue, M K stated he has only been in the position a month but its something he would like to get fixed. When asked if they can keep up with current demand for hot water, M K stated yes. (continued on next page)

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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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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the 500 hall bath, at 2:50 PM on 12/3/24, observation found an 8 inch by 12 inch piece of floor where the tile was smashed and missing. An interview with M K found that the floor was like that way when he started. M K went on to state that staff only use this bath to weigh residents on the scale. Further review of the two shower beds found excess debris and staining under the mats and an accumulation of hair caught on some of the structural tubing of the bed. A tub in the back of the room was found with two crayons along with dirt and debris. When asked if the tub is used or flushed, M K stated he didn't think it was used and wasn't something that was regularly flushed. 46999 During an observation on 12/4/24 at 4:24pm, the north wall of the facility's lobby area had 35 damaged areas in the dry wall. The damaged areas ranged from 1cm to 5 cm's in length, some exposed the brown underside of the drywall, and the damage extended across a 5ft wide section of the wall. 2 residents sat in the lobby area during this observation. During an observation on 12/5/24 at 1:49pm, bubbled up wallpaper that had been painted over was present on the east wall of the dining room, under the windows. Painted over wallpaper was bubbled up along the south wall of the dining room, near the ice machine, as well as along the north wall, under the 3rd window. The floor vent under the window on the east wall of the dining room was rusted across 75% of its surface, with the remaining 25% of the surface covered in chipped paint. During an obervation on 12/5/24 at 1:55pm, brown, built up debris was present around the door frames throughout the dining room and around much of the room.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observations, and interviews, the facility failed to maintain an effective pest control program resulting in presence of live pests (ants), resulting in the potential for food infestation and resident discomfort. Findings include: During an observation on 12/3/24 at 9:43am, seven live ants were noted on the bathroom floor of room [ROOM NUMBER]. During an observation on 12/3/24 at 10:15am, several open food containers with resident food inside were stored on the floor of room [ROOM NUMBER]. During an observation on 12/3/24 at 2:47pm, 2 live ants were noted on the hallway floor outside room [ROOM NUMBER]. In an interview on 12/3/24 at 2:48pm, housekeeping aide (HSK) W confirmed 2 live ants were on the floor outside room [ROOM NUMBER]. During an observation on 12/4/24 at 1:21pm 4 live ants were noted on the floor outside room [ROOM NUMBER]. During an observation on 12/4/24 at 4:18pm, 25 live ants were noted on the floor of the visitor restroom in the 200 hall. In an interview on 12/5/24 at 1:51pm, Housekeeping aide (HSK) V reported she saw ants everywhere in the building. HSK V reported she regularly saw many ants gathered around crumbs on the floor in resident areas throughout the building. In an interview on 12/5/24 at 2:20pm, Maintenance Assistant (MA) K reported the facility had a pest control service that came out monthly to treat the facility and that MA K could chemically treat the building for ants between visits, but he had not done so. 48637 During an observation on 12/04/2024 at 3:27 PM, the visitor bathroom contained a pile of ants on the floor by the toilet. The corner wall by the toilet had a small pile of dirt that appeared to be an ant hill. During an observation on 12/04/2024 between 3:30 PM and 5:00PM, staff were seen going in and out of the visitor bathroom. During an observation on 12/04/2024 at 5:00 PM, the visitor bathroom still had a pile of ants on the floor by the toilet and the small pile of dirt in the corner. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/05/2024 at 9:55 AM, the visitor bathroom contained several ants on the floor by the toilet. The corner wall by the toilet still had a small pile of dirt in the corner. During an interview on 12/5/2024 at 12:00 PM, Nursing Home Administrator (NHA) A stated that she was unaware of an ant issue in the visitor bathroom. When this surveyor brought to her attention that there were ants in the visitor bathroom for a few days and that staff uses that bathroom too, NHA A said she was unaware of it.