STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235361	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation includes intake MI 436 Based on interview and record review the facility failed to prevent staff to resident abuse and protect residents from the potential for further abuse, failed to immediately report allegations to administration resulting in the potential for continued abuse of residents for 1 of 5 sampled residents (Resident #101), from a total sample of 5 residents, resulting in staff to resident abuse for Resident #101. Findings include: Review of the Abuse Prevention Program received on 6/30/3030 revealed, .Abuse Reporting Policy: For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: 1. Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. 4. Physical Abuse: Hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment. IV. Identification Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the Administrator. ****IF YOU SUSPECT ABUSE: ? Separate the alleged perpetrator and assure all residents safety ? Notify a Supervisor/Nurse Immediately ? Notify the Administrator and Director of Nursing, or the person in charge of the facility by page or telephone. ? Complete the documentation of the incident in the EMR under the Risk Management section. ? DO NOT LEAVE the building until above is completed. ? The Administrator or designee utilizing the Michigan Department of Health Incident Report form/process and will be immediately notify per state and federal requirements. Upon report of such occurrences, the Nursing Supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the Administrator or in the absence of the Administrator, the designee. If the resident complains of physical injuries or if resident harm is suspected, the resident's physician will be contacted for further instructions. V. Investigation o The Charge Nurse must complete an incident report and obtain a written, signed and dated statement from the person reporting the incident . Review of an Admission Record revealed Resident #101 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 5/11/2020 revealed a Brief Interview for Mental Status (BIMS) score of 8 out of a total possible score of 15, which indicated Resident #101 was moderately cognitively impaired. During an interview on 6/26/2020 at 01:28 PM, Certified Nursing Assistant (CNA) I revealed (Resident #101) reported to her that her head hurt. CNA I reported (Resident #101) informed her CNA G hit her in the back of the head the other night. CNA I reported (Resident #101) stated the Licensed Practical Nurse (LPN) U saw and CNA G hit her in the back of the head like this (gestured open hand slap hitting with the inside of the hand). CNA I reported CNA G was rough with residents and she was not pleasant with the residents especially (Resident #101) as you could tell she got on her nerves. CNA I reported the Resident (#101) told her she was sitting by the nurse's station (on the left side if facing the nurse's station from the front door and towards the end of the 500 Hall) where she always does and LPN U would be able to see what happened while waiting for someone to let her in the door from the breezeway. CNA I revealed she reported the incident to Administrator A and MDS Coordinator AA. During an interview on 6/30/2020 at 02:51 PM, revealed she was not asked to write an incident report on what was reported to her by Resident #101. In an observation on 06/30/2020, this surveyor was in the breezeway and was able to observe activity at the nurse's station where Resident #101 usually is observed sitting by facility staff members. During an interview on 06/30/2020 at 11:45 AM, Licensed Practical Nurse (LPN) R revealed Resident #101 was sitting at the end of the 500 Hall by the Nurse's station when she was finishing up her shift on 05/10/2020. LPN R revealed, Registered Nurse (RN) U did not report during shift change report to her any incident she observed prior to the start of her shift between Resident #101 and Certified Nursing Assistant G. Review of the Investigation Summary/Actions Taken revealed incident occurred on 5/10/2020 at 07:15 PM. The incident was discovered on 5/13/2020 at 12:45 PM. Review of the Investigation Summary/Actions Taken revealed Resident (#101) states that CNA (Certified Nursing Assistant) made contact to the back of her head. Review of the Investigation Summary/Actions Taken revealed, Registered Nurse (RN) U stated she witnessed the hit and also heard the resident report the alleged abuse but did not report it or suspend the CNA (Certified Nursing Assistant) once the allegation was voiced. Review of Follow Up Investigation of Alleged Abuse, (Resident #101) Resident revealed interview on May 13, 2020 at 01:00 PM with Registered Nurse (RN) U. RN U reported, .I around 7:15 PM, I was in the vestibule looking through the window and I saw (CNA G) push an over the bed table away from (Resident #101) against the wall .I saw (CNA G) hit her on top of the head to the left side .I knocked on the window and (CNA G) saw me and came to let me in the front door .When I entered the front door (Resident #101) started yelling out to me China (she calls me China) she hit me in the head, she hit me in the head .(CNA G) turned around and said to (Resident #101) Liar, you are lying .I then went and punched in and when I came back, (resident #1010) said, She hit me in my head .I asked Where? (Resident #1010) then pointed to the left side of her head .(RN U) stated I could not tell how hard she hit her it could have been a tap. When asked why she did not say something or send CNA G home she stated, I forgot . Review of Confidential Witness Statement completed by Registered Nurse U revealed, she arrived around 7:15 PM, by window looking in @ nurse's station. .I saw (CNA G) push over bed table away from (Resident #101) and (hit/tap) her on the left side of the head .(CNA G) came to let me in when I tapped on the window .When I entered the front door (Resident #101) yelled out @ me and said China that is what she calls me, saying She hit me in my head, she hit me in my head .Then (CNA G) turned to (Resident #101) and said Lyer (you are lying) . After multiple attempts on multiple dates was unable to contact Registered Nurse (RN) U prior to exiting the facility.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement resident comprehensive care plan for 1 resident (Resident #102) reviewed for care planning, from a total sample of 5 residents, resulting in a lack of service for residents to maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Review of Fundamentals of Nursing (Potter and Perry) 8th edition revealed, Assessment is a continuous process that occurs each time you interact with a patient .after reassessing a patient, review the care plan and compare assessment data to validate the nursing [DIAGNOSES REDACTED]. If the patient's status has changed and the nursing [DIAGNOSES REDACTED]. An out-of-date or incorrect care plan compromises the quality of nursing care. Review and modification enable you to provide timely nursing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) interventions to best meet the patient's needs. Potter, P.A., Perry, A. G., Stockert, P.A., & Hall. A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. P. 256-257. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 1: Resident Assessment Instrument (RAI) revealed .The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being . The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status . Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident ' s written plan of care . Review of an Admission Record revealed Resident #102 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 5/29/2020 revealed a Brief Interview for Mental Status (BIMS) score of 4 out of a total possible score of 15, which indicated Resident #102 was severely cognitively impaired. Review of current Care Plan: for Resident #102, revised on 1/2/2019, revealed the focus, .I am at risk for falls R/T (related to) Cognitive Impairments, debility, diuretic use with incontinence . with the intervention .Transfer sit to stand X2 assist . Resident to wear brace anytime she does not have back support .Requires 1 person to assist with eating .Resident requires by 2 staff to turn and reposition in bed every shift and as necessary . In an interview on 7/1/2020 at 01:20 PM, Certified Nursing Assistant (CNA) K revealed, .She (Resident #102) didnt' fall and I lowered her and I went down with her we were going that way and I would rather hurt myself than hurt them .I am standing in front of the wheelchair, she is in the chair and I am lifting her with the gait belt counting 1,2,3 and when we went to pivot she was leaning to the side and we were going go down and I was going down with her and lowered her to the floor .Couldn't catch her otherwise I would have hurt my back trying .We didn't land hard, she wasn't hurt .She was on the bottom and she was on top of me .She fell more on me than on the floor .