STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235088	A. Building B. Wing	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Traverse Pavilions	1000 Pavilions Circle Traverse City, MI 49684

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that fall interventions and safety devices were in place to prevent falls for three Residents (#50, #56, and #73) out of eight reviewed. This deficient practice resulted in falls and the potential for injury. Findings include: Resident #50 On 8/1/22 at approximately 1:20 p.m., Resident #50 (R50) was observed standing up from his wheelchair in the dining room. Two Certified Nurse Aides (CNA BB and GG) were observed to go to R50 and assist him in walking. R50 was observed to be very unsteady on his feet and attempted to squat down to the floor. A review of R50's progress notes revealed a note dated 8/1/22 Resident had a fall this shift at 1225 (12:25 p. m.); resident lowered self to floor in center of pavilion hallway while walking with CNA to be weighed; did not have gait belt on at time of fall; no injury was noted; resident did not show or say he was in pain . will remind staff to utilize gait belt at all times when resident is up/if resident is willing due to sometimes resident resisting care/to also have either a FWW (four wheeled walker) or wheelchair nearby for safety. A review of R50's medical record revealed he admitted to the facility on [DATE] with diagnoses including dementia, difficulty walking, and [CONDITION(S)]. A review of his 5/26/22 Minimum Data Set (MDS) assessment revealed he scored 3/15 on the Brief Interview for Mental Status (BIMS) assessment, indicating severely impaired cognition and had two or more falls with injury since the last assessment. On 8/4/22 at 10:39 a.m., R50 was observed sitting in his room in a chair by himself. R50 was looking around the room and when asked how he was, he reported he didn't know what to do. A review of R50's 2/4/19 Activities of Daily Living (ADL) care plan for falls revealed, . Please redirect me out of my room unless I am laying in bed . 2 staff with GB (gait belt) for transfers and ambulation . Resident #56 (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/22 at approximately 12:10 p.m., Resident #56 (R56) was observed sitting in her wheelchair in the common area sleeping. A review of R56's medical record revealed she admitted to the facility on [DATE] with diagnoses including dementia, anxiety, and [CONDITION(S)]. A review of her 6/1/22 MDS assessment revealed she was assessed by staff to be severely cognitively impaired and had two more falls since the last assessment. A review of R56's progress notes revealed a note dated 4/25/22, Resident was heard crying Help! and observed on the floor on her bottom beside her bed. Resident had been extremely sleepy and put into bed to rest, however, sensor light had been replaced with a push button light and remaining staff were not aware. Resident was assessed for pain and injuries, none observed, resident moved at baseline. Resident brought out to common area to be monitored. Family will be notified at a more appropriate hour. A review of the facility policy titled, Fall and Injury Reduction dated 7/25/22 revealed, Purpose: To prevent or minimize resident falls and injury, while promoting the highest level of resident independence possible . Resident #73 Review of Resident #73's face sheet revealed Resident #73 was admitted to the facility on [DATE], with diagnoses including dementia, stroke, physical debility, cognitive disorder, and [CONDITION(S)] (irregular heart rhythm). Review of Resident #73's Minimum Data Set (MDS) assessment, dated 06/07/2022, revealed Resident #73 required supervision with transfers, walking, dressing, and toileting. Resident #73 was always continent of bowel and bladder. The Brief Interview for Mental Status (BIMS) assessment revelaed a score of 12/15, which indicated Resident #73 had moderate cognitive impairment. The pain assessment revealed no pain during the review period. The fall review showed Resident #73 had two non-injury falls since admission, and one fall with minor injury, unspecified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with 08/01/22 at 1:52 p.m., Resident #73 stated, I had a fall today. Resident #73 described a fall he had this morning at 6:00 a.m., when he transferred without assistance to the toilet which had a raised toilet seat, with rails attached to the plastic commode seat, in his bathroom. Resident #73 explained when he tried to stand up from the toilet with raised toilet seat and reach back for the call light, the raised toilet seat armrest on his left side moved away from the base, causing him to fall into the space between the toilet and the sink. Resident #73 wheeled his wheelchair into his bathroom, positioned his wheelchair in front of the toilet with raised toilet seat, demonstrated the fall, and showed surveyor how the left armrest of the raised toilet seat remained broken. Surveyor observed the left armrest of the white plastic raised toilet seat with attached plastic armrest with metal rail rotated 3 away from the raised toilet seat, at the armrest anchor. Surveyor asked if staff were aware of his fall, and the raised toilet seat armrest moving away from the raised toilet seat and toilet bowl where it sat. Resident #73 reported he had told nursing staff, including the Assistant Director of Nursing, ADON K. It was also observed the plastic encasement for the toilet paper holder was broken, with Resident #73 reporting when he fell he hit this and broke it when he hit the floor. Resident #73 reported his back was hurt, and he pulled a muscle in his arm, both of which had been hurting since the fall on 08/01/22. Resident #73 showed Surveyor over his clothing how the right side of his lower back was hurting (beneath the ribs and above the pelvis), but could not quantify the pain. Resident #73 reported he had received pain medication, and had no other interventions since the fall. Resident #73 denied hitting his head. During an interview on 08/01/22 at 1:33 p.m., ADON K was asked about Resident #73's fall. ADON K reported they were aware of the fall in the bathroom. ADON K reviewed Resident #73's accident and incident report with Surveyor which revealed Resident #73 fell when I grabbed the handlebar [of the commode] and it moved. Report further revealed Resident #73 was observed with his right bicep [a large muscle on the upper arm] in between the toilet tank and handle on the toilet, sitting on the floor. When [Resident #73] fell his back hit the toilet holder and broke it. Denies head involvement . Descriptions of injury revealed, Abrasions to the back and redness to the back and bilateral bicep . ADON K was aware Resident #73 was having pain since the fall which was being addressed. ADON K denied any other tests or interventions at that time. During an observation on 08/01/22 at approximately 1:45 p.m. with ADON K and the Environmental Services Director, Staff L, Resident #73's bathroom and plastic raised toilet seat were observed, and it was noted the left arm (if seated on the commode) of the raised toilet seat (with armrests attached from the commode plastic seat to under the plastic and over the toilet bowl) was wobbly, and moved 3 side to side. This could easily contribute to a fall when a person was transferring on and off the commode, and presented a current safety concern. Staff L with ADON K acknowledged the concern, reported both sides of the commode were unstable, and said they would replace the commode seat immediately, as it was not safe for Resident #73 to use. It was noted Resident #73's bathroom call alarm was approximatley 6 behind the toilet seat on the wall, which would not be readily accessible to Resident #73 during a commode transfer. Staff L also noted this concern. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/02/22 at 02:50 p.m., Resident #73 reported he had hip/back pain on his right side of 8/10, which improved with medication (acetaminophen) he had requested but did not resolve. Resident #73 confirmed there had been no interventions other than medication, and he had not seen a physician or nurse practitioner since the fall. It was observed Resident #73 had a bedside commode (stationary commode or toilet safety frame) over his toilet, with extended supports to the floor, unlike the prior less stable raised toilet seat over the toilet. The toilet safety frame had the armrests attached to the toilet frame, verses the raised toilet seat, for improved stability and safety. Resident #73 reported he was happy with the new toilet safety frame, and felt it was stable for transfers. During an interview on 08/03/22 at 10:05 a.m., Resident #73 was in his room up in his manual wheelchair. Resident #73 showed Surveyor how he could only sit at midline (90 degree angle), and demonstrated how if he moved his trunk forward or back he experienced high level of hip pain, and stated, Here's where it catches (pointing to his right hip and back). I think I need an x-ray. Resident #73 reported he told everyone (nursing staff) about the pain and what happened, and [ADON K] had been in [to his room] daily and was aware. Resident #73 stated staff would say it's a pulled muscle. He reported his pain was a 2 to 3 (with 10 being the highest) on Tylenol but it increased to very high with movement. Resident #73 reported he had to sleep on his back and not his side, and placed a pillow under his hip to sleep. Resident #73 then left his room and was observed wheeling down the hall in his wheelchair to the nurses station, reportedly to ask for an x-ray. During an interview on 08/03/22 at 11:33 a.m., Resident #73 nurse, Registered Nurse (RN) M, was asked about Resident #73's pain and any interventions. RN M reported they had made a note on 08/02/22 of the hip discomfort and pain in Resident #73's right lower back, and placed him on the provider list to request review of pain. During an interview on 08/04/22 at 11:44 a.m., ADON K was asked about Resident #73 and his reported hip/back pain. ADON K reported an order had been put in for a pelvic and lumbar x-ray by the facility nurse practitioner, but had not yet completed. ADON K reported Tylenol was helping pain, and a [brand name] pain patch was ordered. Review of Resident #73's fall Care Plan, accessed 08/03/22 at 1:30 p.m., revealed, Problems: I had a FALL: FALL AEB [as evidenced by] observed sitting on floor in bathroom. Active. Monitor for subsequent injury x 72 hours. Status: Active. Goal date: 08/03/22. Update CP [Care Plan] .as needed, i.e. change in transfer status, interventions implemented . The Care Plan included monitoring of Resident #73 post fall but did not include reasons for fall risk or specific interventions implemented after the 08/01/22 fall. Review of Resident #73's August 2022 Medication Administration Record (MAR), accessed 08/03/22 at 9:21 a.m., revealed Resident #73 received acetaminophen 325 mg tablet oral as needed every four hours, starting 04/13/2022, order date 04/13/2022 .[for] pain unspecified. Record review revealed acetaminophen was adminstered five times after Resident #73's fall: - On 08/01/22 at 14:17 [2:17 p.m.] pain 6/10 designated as generalized. - On 08/01/22 at 20:20 [8:20 p.m.] pain 7/10 designated as generalized. - On 08/02/22 at 10:11 [a.m.] pain 5/10 right hip. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 08/2/22 at 14:11 [2:11 p.m.] pain 5/10 right hip. - On 08/03/22 at 5:25 [a.m.] pain 8/10 generalized. Review of Resident #73's July 2022 MAR, prior to this fall, did not reveal any doses of acetaminophen were administered. Review of the Electronic Medical Record (EMR) revealed no x-ray results for the pelvic and lumbar x-ray by the end of the survey, and no provider (physician visit) report. The facility nursing management reported they had not yet received the x-ray results or the provider report by the time of survey exit on 8/04/22 end of day. Surveyor requested a policy for equipment safety from the Director of Nursing (DON) during the survey. It was confirmed via email from the DON on 08/04/22 the facility did not have a policy for equipment safety respective to bathroom equipment or durable medical equipment.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. This citation pertain to intake MI 685 Based on observation, interview, and record review, the facility failed to consistently provide meals in a timely manner and provide a nourishing snack to all 132 residents. This deficient practice resulted in the potential for resident to not have a hot meal or to have more than 14 hours between a substantial evening meal and breakfast the following day, decreased oral intake, and the potential for weight loss. Findings include: On 8/1/22 at 12:07 p.m., an interview was conducted with Resident #122 who was laying in her bedroom. Resident #122 stated that the meals provided by the facility are constantly late and expressed frustration having to wait. Resident #122 stated that it normal to wait over an hour to receive meals. On 8/1/22 at 1:27 p.m., Certified Nurse Aide (CNA) S was observed using the microwave to warm up the lunch meal for residents in the main dining area. CNA S stated that she needed to reheat the meal because it had been sitting out so long and was cold. Three residents in the main dining area were waiting for their meals to be reheated. On 8/2/22 at 9:17 a.m., an observation of the small dining room located inside the Dogwood hallway noted eight residents waiting for their breakfast meal. On 8/2/22 at 9:40 a.m., an observation of the same small dining room located in Dogwood showed the same eight residents currently waiting for their breakfast meal. On 8/2/22 at approximately 10:00 a.m., the breakfast meal cart was in front of the small dining room of Dogwood with staff members passing out the trays to residents. An interview was conducted with Registered Nurse (RN) T regarding the meal service. RN T stated, This is awful. I have some residents who prefer to have their medication with meals, so now med (medication) pass is delayed. They (residents) will either skip their lunch meals or will just refuse this breakfast. During a group meeting to review the Resident Council task on 8/02/22 at approximately 3:30 p.m., group residents were asked if they received evening snacks, with responses as follows: Confidential Resident C1: Resident C1 reported sometimes there were not any evening snacks, and the aides had to go to other halls to look for snacks. Resident C1 reported this had been since about May (2022) when [new kitchen vendor] started. Resident C1 explained she was speaking of dry snacks primarily, such as tortilla chips or similar items. Resident C1 reported they had brought the concerns to the dietary department manager (Certified Dietary Manager (CDM) B) and other managers during resident council meetings, with no improvement. Resident C1 reported the kitchen was closed at 7:00 p.m., which was confirmed by other group meeting participants. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Electronic Medical Record (EMR) revealed Resident C1 scored 15/15 on the Brief Interview for Mental Status (BIMS) cognitive assessment, which revealed Resident C1 was cognitively intact. Confidential Resident C2: Resident C2 reported sometimes there were no evening snacks, and they were supposed to be put in the unit refrigerator. Resident C2 explained she wanted yogurt and it was often not there, and there were no protein snacks available such as eggs, cheese, or sandwiches with protein. C2 explained she was speaking of refrigerated snacks primarily. Review of the EMR revealed Resident C2 scored 13/15 on the BIMS assessment which revealed Resident C2 was cognitively intact. During an interview 8/03/22 at 11:55 a.m., the Assistant Director of Nursing, (ADON) K, was asked if there was a shortage of snacks for residents. ADON K confirmed during June (2022) staff were struggling to obtain evening snacks for residents, due to the transition from the former to new kitchen services vendor. During an interview on 8/03/22 at 12:00 p.m., CDM B was asked about the reports of snack shortages by resident council residents. CDM B reported they provided yogurt however eggs or cheese would require too much monitoring, and staff were too short on units to monitor this (dates of expiration). CDM B reported they did provide peanut butter and jelly to unit refrigerators for staff to make sandwiches, but confirmed there were no ready made sandwiches on the unit. Other sandwiches could be requested before the kitchen closed in the evening. CDM B reported the kitchen did not close until 8:00 p.m., which was a later time than residents reported during the group meeting. CDM B reported they provided the snacks to the unit, and floor nursing staff (aides) distributed the snacks. CDM B acknowledged in June (2022) during the transition from the former kitchen food vendor to their company there was a few days they were unable to obtain pudding, but did not recall any other snack shortages. CDM B confirmed there were snacks their company was unable to provide which residents have requested, such as cheese and crackers packets, however they provided appropriate substitutes such as peanut butter and crackers. CDM B reported they had not been able to get some of the same snacks as the other kitchen vendor had been, and understood the residents' concerns. They reported there should be evening snacks available on the units, as the kitchen stocked the unit kitchens daily. It was unclear to them why there would not be enough snacks available on the units. During an observation on 8/03/22 at 12:18 p.m., Certified Nurse Aide (CNA) Y showed surveyor the snack room on a nursing resident care unit, which contained a variety of dry snacks, breakfast bars, canned soups, yogurt, pudding, and beverages. There were no cheese snacks, cheese and crackers, eggs, or sandwiches; CNA Y reported they could make residents peanut butter and jelly. They reported the unit residents had preferences the other vendor provided, such as large [vendor name] specialty cookies, and other preferred snack brands. CNA Y reported they heard residents complaining they don't like the types of snacks provided. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/03/22 at 12:39 p.m., Resident C-1 reported she preferred a snack around 9:00 or 10:00 p.m., and was currently being told by the nursing staff, her aides, that there were no snacks available per her preferences. She reported her aides told her they looked on other units, and found the same. Resident C-1 reported yesterday evening (8/02/22) she asked her aide to get her one of the dry bagged snacks (either tortilla chips or another type) and again was told none was available. Resident C-1 said this made her feel frustrated, and she would ask for snacks earlier in the day now, since none were consistently available at night. Resident C-1 reported she was diabetic and ate five times per day per her medical needs, and this was distressing to her. She reported when you send the aides to other units and they can't find these snacks anywhere, this was an issue. She stated, Now I understand it is my right (to get an evening snack). Review of the Resident Council Meeting minutes dated 7/27/22 for [resident care unit] revealed Confidential Resident #9 commented .No one has offered me snacks. I love popcorn. I will ask for popcorn; the staff leave the room and tell me they don't have popcorn . Resident C-9 expressed this same concern in Resident Council meeting on 6/21/22, and the minutes reflected popcorn was available as a snack. Review of [name of unit] Resident Council minutes from 6/21/22 showed Resident C-10 reported, With nighttime snacks, it depends on the CNA if they are offered. Review of the policy, Nourishments, received on 8/04/22, revealed, To provide supplements in addition to food at mealtimes. Replace nutrients not consumed at mealtimes. To provide nourishments at bedtime due to the length of time between evening meal and breakfast. To provide additional fluids other than at mealtime. Procedure: 1. Scheduled nourishments are delivered to the unit by Dietary department at 9:30 am. (mid-morning), 2:30 p.m. (mid-afternoon), and 7:00 p.m. (H.S. [at night] and bulk snacks). 2. After delivery, CNA staff will distribute scheduled nourishments to specified residents (by nourishment label). CNA staff will also offer nourishments to all residents such as juice, water, cookies, etc .