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	07/07/2022

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. This citation pertains to intake Numbers MI 697 and MI 366 Based on observation, interview, and record review, the facility failed to maintain two Resident (#1 & #9) wheelchairs and rooms in a sanitary manner of three residents reviewed for homelike environment. This deficient practice resulted in unhygienic/unhomelike conditions. Findings include: Resident #1 On 7/6/22 at 12:25 p.m., Resident #1 was observed to have self-transferred himself from his chair to the bathroom. A wheelchair was located near the opposite wall of the bathroom. There was dust and thick film noted on the wheelchair below the arm rest and when wiped, left the debris on this Surveyors fingers. There was also a layer of dust located underneath his TV, near a ceramic figurine. On 7/7/22 at 10:10 a.m., Resident #1 was observed getting ready to leave his room to receive physical therapy treatment with Physical Therapist (PT) B. It was observed by this Surveyor that the wheelchair continued to have a thick film along the bars below the arm rests and the layer of dust continued to be below the TV. It was also observed that in his bathroom, there was a small yellow basin that was on the floor overturned, a tongue depressor wrapper behind the toilet on the floor, and a large yellow basin on the floor with splashes of dirt and dried liquid stains. An interview was conducted with Resident #1 on 7/7/22 at 12:00 p.m. Resident #1 stated that his room can get dirty at times, and it makes him upset. Resident #9 On 7/7/22 at 11:00 a.m., Resident #9 was observed resting in her bed after being helped with transferring to the toilet. Resident #9's wheelchair was noted to be near her bed, with a thick orange crust noted on the foot pedals which had been placed in her chair. Resident #9's wheelchair also had food debris and dried liquid stains near the arm rests of her wheelchair. An interview was conducted with the Director of Nursing (DON) and Chief Operating Officer (COO) A on 7/7/22 at 1:00 p.m. Both the DON and COO A confirmed that Certified Nurse Aides (CNA's) are to wipe down the wheelchairs and have a list of wheelchairs to complete each night. When asked if staff document that they have cleaned the wheelchairs as assigned, the DON stated that there was no documentation to verify that the wheelchairs were being cleaned.

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

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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 pertains to intake MI 150 Based on interview and record review, the facility failed to prevent non-consensual sexual contact between two Residents (#8, #9) of six residents reviewed for abuse. This deficient practice resulted in inappropriate sexual contact, with the potential for emotional distress and feelings of helplessness based on a reasonable person standard. Findings include: A Facility Report Incident (FRI) investigation reported non-consensual sexual contact by Resident #8 when he lifted Resident #9's leg over top of his lap and placed his hand in her groin area on 4/16/22 at approximately 1:05 p.m. Facility Reported Incident (FRI) # 0 read, in part, .Witness statement by Certified Nurse Aide (CNA C) 4/16/22. (CNA C) stated she went into main dining room to drop off a meal tray around 1:05 p.m. (CNA C) noticed that (Resident #8) was sitting close to (Resident #9) and walked over. (CNA C) noted (Resident #9's) right leg to be on top of (Resident #8's) lap and saw his hand on the outside of (Resident #9's) clothing. Hand on peri-area and appeared to be pushing in .Review of video footage. (Resident #9) is observed sitting at table in the main dining room when (Resident #8) is brought in and placed on (Resident #9's) left side .At 1:05 p.m. (Resident #8) can be observed turning (Resident #9's) wheelchair to face him a bit more. At 1:07 p.m. (Resident #8) lifts (Resident #9's) left leg onto his lap . (Resident #9) admitted on [DATE] .BIMS 3/15 (severely cognitively impaired) .Resident #8 admitted on [DATE] .BIMS 3/15 . Resident #8's face sheet dated 4/22/22 revealed diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] Resident #9's face sheet dated 4/22/22 revealed diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . An attempted telephone interview was made with CNA C on 7/7/22 at 11:30 a.m. and 12:12 p.m. A witness statement from CNA C was provided from the facility and read, in part, 4/16/22 .notice that (Resident #8) was sitting very close to (Resident #9) walked over to them and saw (Resident #9's) rt. (right) leg on (Resident #8's) lap and I looked at her and saw (Resident #8's) hand on the outside of her pants, down deep pushing in .Put (Resident #9's) leg down and moved (Resident #8) to his table. Reported it to the RN (Registered Nurse) . This witness statement was signed by CNA C. Review of Resident #8's care plan with effective date 5/18/18 read, in part, I have a history of sexually inappropriate language and behaviors .If you see me approaching a female resident or a female resident approaching me, please provide me with increased supervision, go with me, redirect me to an area without women, redirect me to an activity, offer me a snack, offer me TV or music . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 7/7/22 at 11:30 a.m., RN D confirmed Resident #8 had a history of [MEDICAL RECORD OR PHYSICIAN ORDER] . RN D confirmed that Resident #8 was to have increased supervision or redirection away from female residents prior to the incident on 4/16/22. RN D stated that CNA C was new to the facility, and was under orientation at the time, and was not instructed to keep Resident #8 away from female residents, and placed Resident #8 at the same table as Resident #9. RN D was unable to provide the staff name of who was orientating CNA C on 4/16/22. RN D confirmed that CNA C did not read Resident #8's care card in its entirety. An interview was conducted on 7/7/22 at 1:00 p.m. with the Director of Nursing (DON) and Chief Operating Officer (COO) A. The DON and COO A expressed understanding of the concern involving Resident #8 and Resident #9. Review of the facility's Abuse Prohibition and Prevention Program dated 7/10/20 read, in part, .Our organization is committed to protecting our residents from abuse by anyone including, but not necessarily limited to .other residents .sexual abuse is defined as non-consensual sexual contact of any type with a resident .resident-to-resident altercations: facility staff will monitor residents for aggressive/inappropriate behavior towards other residents .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertain to intake MI 697 Based on observation, interview and record review, the facility failed to revise and implement new interventions for one Resident (#1) of nine residents reviewed for care plans.This deficient practice resulted in the use of ineffective repetitive interventions and interventions which lacked the ability to evaluate effectiveness in preventing further fall incidents. Findings include: Review of Resident #1's face sheet revealed an admission to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of his 5/12/2022 Minimum Data Set (MDS) assessment showed he required extensive one-person physical assist for bed mobility and transfers, had functional impairment in both upper and lower extremities, and had a history of [MEDICAL RECORD OR PHYSICIAN ORDER] On 7/6/22 at 12:25 p.m. an observation and brief interview was conducted with Resident #1. Resident #1 was noted to have self-transferred himself from his recliner to the bathroom. Resident #1 did not use his call light to notify staff that he needed to use the restroom because He didn't want to wait. This Surveyor left his room and found an unidentified staff member to inform her Resident #1 had just self-transferred without their knowledge. Review of Resident #1's fall care plan, undated, read, I am at risk for falls/alteration in safety behavior AEB (as evidence by) history of falls, poor safety awareness .remind me as needed to use my call light .please complete frequent safety checks and try to anticipate my needs .educate and remind me to call for assistance .please remind me and educate me on the importance of asking for assistance with all transfers and ambulation, provide me with call light education as needed to ensure I am pressing and holding button on wrist pendant to activate call light . Review of Resident #1's 'Fall/Incident' report dated 5/1/22 read, in part, staff witnessed resident lying on the floor, face down, in his bedroom. Resident stated he was getting up from his recliner to walk to his bed, tripped and fell to the ground .Encourage resident to wait for staff to assist him if he is not feeling well . Review of Resident #1's 'Fall/Incident' reported dated 6/21/22 read, in part, CNA (Certified Nurse Aide) notified this nurse that res (resident) was on the floor. Another resident had notified staff that res was calling out from his room. Res did not have his call light on . An interview was conducted with Physical Therapist (PT) B on 7/7/22 at 10:50 a.m. PT B stated that Resident #1's intervention of educating to use his call light is not a useful intervention as his cognition is starting to decline and he can no longer consistently remember to use his call light. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with RN E on 7/7/22 at 11:45 a.m. RN E stated that Resident #1 does have the physically ability to use his call light, and he is able to press it down. However, he has had a slow decline in cognition. He can go both ways, some days he is aware and can use the call light appropriately, some days he is not aware and does not use the call light at all, some days he even thinks he pressed it when he didn't. RN E stated that there is ongoing education for Resident #1 to use his call light. When asked of the care plan intervention of more frequent checks from staff, RN B stated that there is no documentation completed from staff members as to how often. RN E also stated that there is no time frame for frequent checks. An interview was conducted on 7/7/22 at 1:00 p.m. with the Director of Nursing (DON) and Chief Operating Officer (COO) A. The DON stated that Resident #1 is capable of physically using his call light. When asked on the intervention of frequent checks, the DON stated, We use that because we have exhausted all our resources, we've got nothing left. Review of the facility's Care Planning policy dated 3/01/20 read, in part, The organization will develop a comprehensive care plan for each resident that includes measurable objectives to meet a resident's clinical and psychosocial needs to maintain the resident's highest practicable, physical, mental, and psychosocial well-being .