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	10/16/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 This deficiency pertains to Intake MI00147235. Based on interview and record review, the facility failed to ensure a resident representative was informed about medication changes for one Resident (#1) of 3 residents reviewed for medication review. Findings include: Resident #1 (R1) Review of R1's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including dementia, type two diabetes with hyperglycemia (high blood glucose levels), and cognitive communication deficit. Review of R1's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9, indicative of moderate cognitive impairment. Review of Intake MI00147235 read, in part: .On or about July 1, 2024, the facility's doctor [Medical Director (MD) K] discontinued [R1]'s diabetes medication. [R1] had been taking diabetes medication(s) for at least the prior 15-[AGE] years. [Durable Power of Attorney (DPOA) M] of [R1] had durable power of attorney, was not informed of this change at the time it was made . On 10/16/24 at 11:00 AM, a telephone interview was conducted with Family Member A of R1 who confirmed the allegation details. Review of the Designation of Patient Advocate Form revealed DPOA M had authority to make medical treatment decisions for R1 beginning on 1/10/24. Review of a provider note dated 7/10/24 read, in part: .Diabetes mellitus without complication very well controlled. Will discontinue metformin [a medication used to treat diabetes] at this time due to weight loss. Continue to monitor A1c [a blood test used to monitor blood sugar management] as POA [power of attorney] desires . Unable to reach POA to discuss goals of care . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A hand-written note on the progress note read, Family needs updated . Review of a physician order dated 7/10/24 read, Metformin HCl [hydrochloride] Tablet Extended Release 24 Hour 500 MG . end date: 7/10/24. Review of R1's EMR did not revealed communication with DPOA M regarding the stoppage of Metformin. On 10/16/24 at 12:40 PM, an interview was conducted with the Director of Nursing (DON) who verified DPOA M was not notified prior to the stoppage of Metformin on 7/10/24. When asked her expectation regarding medication regimen communications with residents and/or their responsible parties, the DON stated, Typically, we would clarify with the DPOA prior to any medication change. Review of the facility policy titled, Resident Care Policies, dated 3/20/24, read, in part: .The Organization will immediately inform the resident, consult with the resident's physician and, if known, notify the resident's legal representative or family member at minimum when there is: . A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment or to commence a new form of treatment) . The resident has the right to: . Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being . Participate in planning care and treatment or changes in care and treatment .

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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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49302

This deficiency pertains to Intake MI00147134.

Based on interview and record review, the facility failed to provide timely notification to the physician for one Resident (#4) of three residents reviewed for a change in condition. This deficient practice resulted in a delay in medical treatment and subsequent death for Resident #4.

Findings include:

Resident #4 (R4):

Review of R4's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including stroke, anemia (a condition in which the blood doesn't have enough healthy red blood cells), and gastro-esophageal reflux disease (a condition in which the stomach contents move up into the esophagus). Review of R4's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicative of intact cognition.

Review of a progress note written by Licensed Practical Nurse (LPN) G on [DATE] at 4:01 AM read, in part:

CNA [certified nursing assistant] staff alerted this writer that resident [was] SOB [short of breath] this evening . Another alert by CNA staff stated that resident has had 4 med-large [medium-to-large] black tarry stools that have resulted in two bed changes this evening. This writer went into bathroom while resident was on toilet, and resident nodded off two times .Vitals at ,d+[DATE], 93% RA [oxygen saturation on room air], resp [respirations] from ,d+[DATE], HR [heart rate] 98 [beats per minute] .Resident stated she was dizzy while in [mechanical lift transfer aid] heading back to bed .Resident states that she has not had bowel movements like that before .

Review of R4's five blood pressure recordings prior to the event revealed the following:

1. [DATE] 13:45 [1:45 PM] - 144 / 69 mmHg [millimeters of mercury]

2. [DATE] 7:36 AM - 155 / 76 mmHg

3. [DATE] 8:37 AM - 145 / 72 mmHg

4. [DATE] 6:47 AM - 153 / 89 mmHg

5. [DATE] 18:16 [6:16 PM] - 168 / 70 mmHg

Review of R4's five pulse recordings prior to the event revealed the following:

1. [DATE] 13:45 [1:45 PM] - 59 bpm [beats per minute]

(continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	2. [DATE] 7:36 AM- 68 bpm 3. [DATE] 8:37 AM - 67 bpm 4. [DATE] 6:47 AM - 78 bpm 5. [DATE] 18:16 [6:16 PM] - 70 bpm On [DATE] at 12:03 PM, a phone interview was conducted with LPN G who verified she was the nurse who provided direct care to R4 on the midnight shift from [DATE] - [DATE]. LPN G recalled visiting R4's room several times during her shift due to CNA reports of shortness of breath and abnormal stools. When LPN G was asked about her assessments/conclusions, she replied, I asked for help because I was unsure what to do . I am a newer nurse. I had my manager in the room with me that night, [Registered Nurse (RN) H], who told me to write in the provider book that she [R4] should be seen . LPN G verified she wrote her concerns in the provider book to be reviewed at the next provider round and did not contact the on-call physician. LPN G recollected R4's vitals were, normal but could not remember if her vital assessments were compared relative to R4's baseline vital sets. LPN G acknowledged R4's respiration rate was, above normal. On [DATE] at 3:51 PM, a phone interview was conducted with RN H who verified he was Campus Coordinator on the midnight shift from [DATE] - [DATE]. RN H recalled receiving a phone call from LPN G during his shift who relayed R4 was unable to catch her breath. RN H stated, During the course of the phone call, I was never told she [R4] had black tarry stools . Had I had more information, I would have sought immediate medical evaluation by the provider . The provider book is helpful for non-immediate needs, but it sounds like for this patient there was immediate need to call the provider. Review of a progress note written by RN F on [DATE] at 4:27 PM read, in part: This nurse was doing rounds and observed this resident [R4] with head slumped forward and unresponsive. I was unable to arouse her and she had no pulse and no breathing observed at 3:26 PM a code nurse [was] called and CPR [cardiopulmonary resuscitation] started immediately and 911 called for EMS [Emergency Medical Services] and they arrived at 3:42 [PM] .The EMS team took over at 3:42 [PM] providing CPR with a machine, iv [intravenous] fluids and 2 rounds of epi [epinephrine] was given. EMS stopped CPR at 3:58 [PM] pronouncing her death . On [DATE] at 11:39 AM, an interview was conducted with RN F who confirmed she found R4 unresponsive on [DATE]. RN F stated she was notified during shift change that R4 experienced, a lot of bowel movements in the middle of the night but was unaware of any other symptoms. After review of the progress note written by LPN G on [DATE] at 4:01 AM, RN F stated, I would have called the provider right away. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:21 AM, an interview was conducted with Medical Director (MD) K regarding her clinical expectations for a resident who experienced multiple instances of black tarry stools. MD K stated black tarry stools combined with hemodynamic symptoms (symptoms that indicate an issue with blood flow in the body) would be indicative of an emergent situation. When asked for examples of hemodynamic symptoms, MD K stated, Things like hypotension [low blood pressure], tachycardia [accelerated heart rate], shortness of breath, abdominal discomfort, and/or dizziness. After record review of R4's symptoms which accompanied abnormal stools, MD K stated, A phone call to the on-call provider was warranted. Review of R4's death certificate read, in part: Cause of death: Acute End Organ Failure . GI [gastrointestinal] bleed . Approximate interval between onset and death: hours . Review of the facility policy titled, Change in Condition dated [DATE], read, in part: PURPOSE: To assist facility staff with identifying individuals at risk for acute changes in condition .describing and documenting symptoms and /or condition changes, and establishing a process of reporting findings . PROCEDURE: Assess the resident's symptoms, mental status and physical function .Use SBAR [A communication technique meaning Situation, Background, Assessment, Recommendation] to notify the physician and proceed as instructed . Vital Signs: Blood pressure 20 mm Hg lower or higher than normal . Respirations fewer than 12 or greater than 20 breaths per minute .Acute changes in any of the following: . Shortness of breath and/or change in breath sounds .Dizziness .

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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 0770 Level of Harm - Actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 This deficiency pertains to Intake MI00147235. Based on interview and record review, the facility failed to ensure timely laboratory services were provided per physician's orders for one Resident #1 (R1) of 3 residents reviewed for laboratory services. This deficient practice resulted in extreme elevation of blood glucose levels requiring R1 to be hospitalized . Findings include: Resident #1 (R1) Review of R1's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including dementia, type two diabetes with hyperglycemia (high blood glucose levels), and cognitive communication deficit. Review of R1's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9, indicative of moderate cognitive impairment. Review of Intake MI00147235 read, in part: .On or about [DATE], the facility's doctor [Medical Director (MD) K] discontinued [R1]'s diabetes medication. [R1] had been taking diabetes medication(s) for at least the prior ,d+[DATE] years. [Durable Power of Attorney (DPOA) M] of [R1] had durable power of attorney, was not informed of this change at the time it was made . [DPOA M] was given a few reasons why they might have done . [DPOA M] was told that [R1]'s A1c [a blood test which measures blood sugar levels as a means to diagnose of manage diabetes], which was supposedly checked every 3 months, had gone down .However, [acute care hospital] records showed her [R1] last A1c had been about 7.5 [%] in [DATE], and it hadn't been taken since . On [DATE] at 11:00 AM, a telephone interview was conducted with Family Member A of R1 who confirmed R1 was supposed to have an A1c test every 3 months to assist in diabetic management. Review of R1's laboratory records in the facility EMR revealed the most recent A1c lab test occurred on [DATE]. Review of a physician order dated [DATE] read, HgbA1c [hemoglobin A1c] one time a day every 90 day(s) for diabetes. On [DATE] at 12:14 PM, an interview was conducted with Director of Nursing (DON) who verified R1 had physician orders for an A1c laboratory test every 3 months. The DON confirmed R1's last A1c result was on [DATE]. The DON did not know why an A1c test was not conducted in June per physician orders. Review of R1's EMR revealed the following progress notes by Registered Nurse (RN) B: (continued on next page)

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F 0770 Level of Harm - Actual harm Residents Affected - Few	1. [DATE] at 5:14 PM: Resident lethargic this shift, unable to communicate at her baseline, unable to complete a sentence. Resident refusing food & drink . 2. [DATE] at 10:50 AM: Resident lethargic this AM [morning] attended breakfast but would only drink sips of fluid, refused to eat making gestures as if she was going to throw-up, unable to communicate. Blood sugar tested reading of HI obtained at 09:00 [AM]. Blood sugar re-checked at 09:45 [AM] reading of HI obtained again. On-call provider notified . ordered resident to be sent to ER for treatment due to extreme hyperglycemia [an excess of glucose in the bloodstream] . On [DATE] at 1:07 PM, a telephone interview was conducted with RN B who verified she checked R1's blood glucose level on [DATE] due to confusion, nausea, and changes in ability to communicate. RN B confirmed the glucometer read HI both times she tested R1's blood sugar, meaning the level was over 600 [milligrams per deciliter (mg/dL)] per glucose meter manufacturer's guide. RN B stated she notified the physician who gave orders to send R1 due to severe hyperglycemia. Review of R1's Emergency Department summary, dated [DATE], read, in part: Chief complaint: .Recently taken off diabetic meds per [DPOA M] unbenknowst [sic] to her. x2 weeks of mental status changes, lethargy, and nausea without vomiting . Based on patient's [R1]'s history and physical examination there is concern for hyperglycemia, DKA [diabetic ketoacidosis], electrolyte abnormality, dehydration . Review of R1's Hospital summary, dated [DATE], read, in part: [R1] is a .female with untreated DM2 [type II diabetes mellitus] . who presented to the ED [emergency department] . for altered mental status . Her [DPOA] states that she has been concerned about elevated blood glucose for a while, as her diabetic regimen was discontinued . Per review of records, her last A1c was checked ,d+[DATE] and came back at 7.6%, compared to 10.9% today . Laboratory studies demonstrated a hyperglycemia at 834 [mg/dL] . (Reference fasting range: ,d+[DATE] mg/dL). On [DATE] at 11:00 AM, a telephone interview was conducted with Family Member A of R1 who confirmed R1 was hospitalized from [DATE] - [DATE] as a result of the hyperglycemic episode. Family Member A stated R1 discharged to the facility on [DATE] and expired on [DATE] on hospice services. Review of a Health Status Note on [DATE] read, in part: .Upon revisit to administer comfort medications at 8:15 [AM] resident was noted to be no longer breathing. Upon auscultation residents' death was confirmed by 2 RN's. Time of death 8:18 [AM] . Review of the facility policy titled, Resident Care Policies, dated [DATE], read, in part: In order to meet the physical and psychological needs of the resident, diagnostic services are provided to enhance identification of these needs, and facilitate diagnoses . A diagnostic test or service shall only be provided per written order of the physician .