

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Grand Traverse Pavilions		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302</p> <p>This deficiency pertains to Intake MI00148163.</p> <p>Based on interview and record review, the facility failed to provide advanced written notice prior to a room change for one Resident (#2) of six residents reviewed for room changes.</p> <p>Findings include:</p> <p>Resident #2 (R2)</p> <p>Review of R2's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including Parkinson's Disease and neurocognitive disorder with Lewy bodies (a condition which impacts a person's ability to think, learn, and remember). Review of R2's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, indicative of severe cognitive impairment.</p> <p>An anonymous complaint submitted to the State Agency (SA) on 11/20/24 read, in part:</p> <p>[R2] was admitted [DATE] as a skilled, short term admit. In the evening, he wandered out of his room twice, he was confused. At the direction of [the Director of Nursing (DON)] he [R2] was moved to the locked Elm unit [secured memory care unit] . This was against his will .</p> <p>On 1/8/25 at 1:40 PM, a telephone interview was conducted with Registered Nurse (RN) F who verified he was working on the Dogwood unit on 11/15/24 when R2 was initially admitted to the facility around 3:30 PM. RN F confirmed he received direction from the DON to transfer R2 to a room on the secured memory care unit from the Dogwood unit shortly after 5:00 PM.</p> <p>On 1/8/25 at 12:40 PM, an interview was conducted with R2's spouse, Family Member H who stated she was displeased with R2's placement on the secured Elm unit. Family Member H stated she received a call from a nurse at the facility telling her R2 was moved to the secured unit. Family Member H stated, I had no idea what that meant. Family Member H then recalled visiting R2 on the secured Elm unit and stated, I was shocked . I didn't think [R2] was appropriate for that unit .</p> <p>(continued on next page)</p>

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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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 11:12 AM, an interview was conducted with the DON regarding R2's move to the secured Elm unit on the day of initial admission. The DON explained the typical process to move a resident to the secured unit is to obtain a consent prior to the move. The DON confirmed no written notification was provided to R2 or R2's resident representative prior to the room change.		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978</p> <p>This citation pertains to intakes MI00149104 and MI00149112.</p> <p>Based on interview and record review, the facility failed to protect the resident's right to be free from mental and verbal abuse by facility staff for one Resident (#1) of four residents reviewed for abuse, resulting in feelings of fear, humiliation, and the potential for psychosocial harm.</p> <p>Findings include:</p> <p>Resident #1 (R1)</p> <p>Review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed R1 was admitted to the facility on [DATE] and had a primary diagnosis of liver cell carcinoma. Review of the discharge MDS assessment, dated [DATE] revealed R1 was independent with bed mobility, sit to stand transfers, ambulation to 10 feet, and wheelchair use. Further review of R1's MDS assessments revealed the Resident was discharged to an acute care hospital on [DATE] and did not return. Review of R1's Clinical Admission progress note, dated [DATE], revealed R1 was his own decision-maker and was assessed as Alert & Oriented x 3 . able to understand and be understood . Alert (some forgetfulness).</p> <p>Review of a Facility Reported Incident (FRI), submitted [DATE] at 8:55 a.m., revealed the following:</p> <p>Incident Summary: Email received from unknown individual alleging that a staff member yelled at a patient [R1], pointed his finger in his face and told him 'You will not go outside until I say so.' Allegation states the patient [R1] said he was afraid and humiliated . The investigation substantiated the complaint. The current DON [Director of Nursing, name redacted] attempted to contact the former resident [R1] to discuss the incident, but she learned that he is now deceased . As a result of the complaint and the facility's investigation, the perpetrator [former Nursing Home Administrator (NHA) A] is no longer employed at the facility . It was noted in review of the investigation documents, no date or time of the alleged incident was provided.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 9:16 a.m., Assistant Director of Nursing (ADON) D reported to be present during the reported incident. ADON D stated on [DATE] NHA A approached her and showed anger that, R1 was allowed to go outside in the courtyard, unattended. ADON D stated on [DATE], NHA A asked her and Registered Nurse (RN) E to accompany him as witnesses while he spoke with R1. When asked the details of the conversation, ADON D reported NHA A appeared angry as he pulled up a chair and sat down very closely in front of R1, who was also seated. ADON D stated NHA A proceeded to chastise R1 by pointing his finger in the Resident's face and saying, You will not go outside again until I say you can. ADON D stated NHA A told R1 he had to follow his (NHA A's) rules. When asked how the Resident responded, ADON D reported R1 appeared upset and did not speak, but in her follow-up with the Resident, R1 reported feeling embarrassed and fearful he would be evicted from the facility. ADON D reported R1 said he was afraid to leave his room. ADON D stated up until the incident, R1 was allowed to sign out of the building on a Leave of Absence form and go out into the courtyard where he was reported to enjoy the fresh air. ADON D reported she had no safety concerns related to R1 going out into the courtyard unattended.</p> <p>During a telephone interview on [DATE] at 10:06 a.m., RN E reported he was present during the reported incident in which NHA A told R1 he could no longer go outside. RN E stated he remembered NHA A appearing visibly upset as he told R1 he was no longer allowed to go out into the courtyard. RN E stated NHA A's demeanor could be interpreted as intimidating. RN E reported as NHA A spoke to R1, he (NHA A) made it clear he (NHA A) was in charge. RN E stated R1 appeared bummed out and deflated following the incident. RN E stated he had no concerns of R1 being unsafe to go into the courtyard unattended.</p> <p>Review of a witness statement, provided by NHA A and dated [DATE], revealed the following, in part:</p> <p>[NHA A's] Recollection of the Patient [R1] Incident in [DATE]: When I was on my rounds [RN O] asked me if I would speak to [R1] because he wouldn't listen to the nurses about staying inside for his own protection . In the moment, I went down and was forceful in my conversation with him [R1] . I didn't take a couple steps back.</p> <p>An attempt to reach NHA A by telephone was made on [DATE] at 3:40 p.m. NHA A phoned back on [DATE] at 3:48 p.m. and stated that he had no intention of causing fear during his conversation with R1, then added I'm sure I should've handled myself a little differently.</p> <p>Review of R1's Leave of Absence, form revealed R1 signed out of the building with a destination noted to be Courtyard on [DATE] at 3:11 p.m., [DATE] at 8:55 a.m. and [DATE] at 10:30 a.m. It was noted in review of the form, R1 did not sign out of the building again after the incident on [DATE] or thereafter, up until the Resident's discharge from the facility on [DATE].</p> <p>Review of the facility policy titled Abuse Prohibition and Prevention Program Policy, dated [DATE], revealed the following, in part:</p> <p>Willful Abuse is defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Verbal abuse is defined as any use of oral, written, or gestured language that willfully include disparaging and derogatory terms to residents . Mental abuse is defined as, but is not limited to, humiliation, harassment, threats of punishment, or withholding treatment or services .</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302</p> <p>This deficiency pertains to Intake MI00148163.</p> <p>Based on interview and record review, the facility failed to develop, implement, and operationalize policies and procedures to ensure the appropriate placement on a secured unit for one Resident (#2) of six residents reviewed for involuntary seclusion.</p> <p>Findings include:</p> <p>Resident #2 (R2)</p> <p>Review of R2's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including Parkinson's Disease and neurocognitive disorder with Lewy bodies (a condition which impacts a person's ability to think, learn, and remember). Review of R2's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, indicative of severe cognitive impairment. Further review of MDS Section E (Behaviors) revealed R2 did not display any physical or verbal behavioral symptoms directed toward others, did not reject care, and did not exhibit wandering behavior.</p> <p>An anonymous complaint submitted to the State Agency (SA) on 11/20/24 read, in part:</p> <p>[R2] was admitted [DATE] as a skilled, short term admit. In the evening, he wandered out of his room twice, he was confused. At the direction of [the Director of Nursing (DON)] he [R2] was moved to the locked Elm unit [secured memory care unit] . This was against his will .</p> <p>Review of R2's EMR revealed the following progress notes written by Registered Nurse (RN) F:</p> <ol style="list-style-type: none"> 11/15/24 at 16:43 [4:43 PM]: Resident noted to not be in his room. Wheelchair in resident's room and resident's walker gone. Staff observed resident in main hallway by Cherry Unit confused and disoriented . Resident redirected and brought back to his room and placed in chair in room . 11/15/24 at 17:25 [5:25 PM]: Resident noted to not be in his room again. [NAME] and wheelchair remained in resident's room. Resident was then observed in another resident's [room] sitting in his bed. DON updated and DON stated to transfer resident to room [ROOM NUMBER] [secured memory care unit] . <p>On 1/8/25 at 1:40 PM, a telephone interview was conducted with RN F who verified he was working on the Dogwood unit on 11/15/24 when R2 was initially admitted to the facility around 3:30 PM. RN F confirmed he received direction from the DON to transfer R2 to the secured memory care unit from the Dogwood unit shortly after 5:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/8/25 at 2:40 PM, an interview was conducted with the Assistant Director of Nursing (ADON) I who verified she oversaw the Elm secured unit on 11/15/24. ADON I confirmed R2 was initially admitted to the Dogwood unit and was transferred to the Elm secured unit approximately 2 hours later under the direction of the DON. When asked if moving a resident to the secured Elm unit within hours of their initial admission was common, ADON I stated, it's atypical. ADON I was asked if there were specific criteria a resident must meet to be considered an appropriate candidate for the Elm secured unit to which she responded, Besides meeting the clinical criteria, it's usually for a safety concern, like if a resident is trying to exit the building. When asked if R2 was exhibiting unsafe behavior, ADON I stated it was more likely that R2 had not yet acclimated to the large building. ADON I stated R2 likely mistakenly entered another resident's room because it was across the hall from R2's room.</p> <p>Review of an assessment titled Elopement Evaluation, dated 11/15/24, revealed a score of 0, indicating R2 was not at risk for elopement.</p> <p>On 1/8/25 at 12:40 PM, an interview was conducted with R2's spouse, Family Member H who stated she was displeased with R2's placement on the secured Elm unit. Family Member H recollected she received a call from a nurse at the facility telling her R2 was moved to the secured unit. Family Member H stated, I had no idea what that meant. Family Member H recalled visiting R2 on the secured Elm unit and stated, I was shocked . I didn't think [R2] was appropriate for that unit .</p> <p>Review of R2's EMR revealed the following progress note on 11/17/24 at 15:50 [3:50 PM]:</p> <p>This nurse had a long conversation with the resident's wife . [Family Member H] came to the front desk and had several concerns about the care here and the resident's [R2's] precipitate move to Elm . [Family Member H] was upset and didn't feel the resident [R2] was appropriate for that setting. She said she was told the resident was coming here for rehab which she thought would take place on the rehab unit .</p> <p>On 1/9/25 at 11:12 AM, an interview was conducted with the DON regarding R2's move to the secured Elm unit on the day of initial admission. The DON explained the typical process to move a resident to the secured unit is to obtain a consent prior to the move unless there was, an emergent need. When asked if the two instances of redirection R2 required was considered an emergent need and subsequently justified a move to the secured unit, the DON stated R2 was admitted on a Friday afternoon going into the weekend. The DON explained the relocation provided additional security, as there was less managerial support on the weekends. The DON confirmed there was no defined criteria for admission to the secured unit.</p> <p>Review of the facility policy, Resident Care Policies, dated 3/15/22, read, in part:</p> <p>.the resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion .</p> <p>Review of R2's EMR did not include clinical criteria for placement in the secured area, whether placement in the secured/locked area was the least restrictive approach, nor were there ongoing assessments to determine R2's need to reside on the secured unit.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41978</p> <p>This citation pertains to intakes MI00149113, MI00149014 and MI00148163.</p> <p>Based on interview and record review, the facility failed to report allegations of abuse to the State Agency (SA) within the appropriate time frame for one Resident (#1) of four residents reviewed for abuse, resulting in the potential for continued abuse.</p> <p>Findings include:</p> <p>Review of a Facility Reported Incident (FRI), submitted 12/13/2024 at 8:55 a.m., revealed the following:</p> <p>Incident Summary: Email received from unknown individual alleging that a staff member yelled at a patient [R1], pointed his finger in his face and told him 'You will not go outside until I say so.' Allegation states the patient [R1] said he was afraid and humiliated . The investigation substantiated the complaint . As a result of the complaint and the facility's investigation, the perpetrator [former Nursing Home Administrator (NHA) A] is no longer employed at the facility . It was noted in review of the investigation documents, no date or time of the alleged incident was provided.</p> <p>During an interview on 1/9/2025 at 9:16 a.m., Assistant Director of Nursing (ADON) D stated she was a witness to the reported incident. ADON D stated on 5/7/2024, NHA A asked her and Registered Nurse (RN) E to accompany him as witnesses while he spoke with R1. When asked the details of the conversation, ADON D reported NHA A appeared angry as he pulled up a chair and sat down very closely in front of R1, who was also seated. ADON D stated NHA A proceeded to chastise R1 by pointing his finger in the Resident's face and saying, You will not go outside again until I say you can. ADON D stated NHA A told R1 he had to follow his (NHA A's) rules. When asked how the Resident responded, ADON D reported R1 appeared upset and did not speak, but in her follow-up with the Resident, R1 reported feeling embarrassed and fearful he would be evicted from the facility. ADON D reported R1 said he was afraid to leave his room. ADON D stated she viewed NHA A's interaction to be verbally and mentally abusive toward R1 and she reported the incident to the Director of Nursing (DON). ADON D reported she informed the DON of her concerns during rounds on 5/7/2024 and provided a written statement at that time.</p> <p>During an interview on 1/9/2025 at 10:36 a.m., the DON reported she remembered ADON D informing her of the incident. The DON stated she did not remember ADON D voicing concerns about the way NHA A spoke with R1, only that ADON D was concerned NHA A was infringing on R1's rights by not allowing the Resident to go outside unattended. The DON reported she did not report the incident to the SA because she did not identify the situation as potentially abusive but a violation of the Resident's rights. The DON stated she did not remember receiving a written statement from ADON D alleging NHA A was verbally and mentally abused R1. The DON reported being unaware of the situation until a complaint was filed with the facility Human Resources Department on 12/12/2024.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the SA database revealed no FRI or complaint was received prior to 12/15/2024 at 8:55 a.m. related to the incident that occurred on 5/7/2024 alleging NHA A verbally and mentally abused a resident and naming R1 as the victim.</p> <p>Review of the facility policy titled, Abuse Prohibition and Prevention Program Policy, dated 7/03/2024, revealed the following, in part:</p> <p>Any person(s) witnessing or having knowledge of potential or actual abuse must immediately report the incident to the Administrator and the Director of Nursing . The person reporting the abuse must complete a statement . The report is to be given immediately to the Administrator or designated representative for further investigation . The results of the investigation of alleged violations will be reported to the Administrator or designated representative and to other officials, include the state survey and certification agency, in accordance with state law within five working days of the incident .</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978</p> <p>This citation pertains to intake MI00149014.</p> <p>Based on interview and record review, the facility failed to ensure a thorough investigation of an allegation of verbal abuse for one Resident (#6) of four residents reviewed for abuse, resulting in the potential for unidentified and continued abuse.</p> <p>Findings include:</p> <p>Resident #6 (R6)</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 12/27/2024, revealed R6 was admitted on [DATE] with diagnoses including depression and bipolar disease. Further review of the MDS assessment revealed R6 scored 15 out of 15 on the Brief Interview for Mental Status, indicating the Resident was cognitively intact.</p> <p>During a confidential interview on 1/9/2025 at 8:52 a.m., Staff U reported a concern that an allegation of staff verbal abuse of a resident was never investigated. Staff U described an incident when R6 was called a derogatory name by a member of the housekeeping staff. Staff U stated on May 17, 2024, Staff T called R6 a butt head in a manner that was reported as demeaning. Staff U stated the incident was reported to the Director of Nursing (DON), but they were concerned the matter was not appropriately followed up on or investigated.</p> <p>During an interview on 1/9/2025 at 10:20 a.m., R6 recalled being called a butt head by Staff T. R6 reported she could not remember the exact day of the event, then stated she was unsure why Staff T would speak to her in a derogatory manner. R6 said, I wasn't even doing anything. R6 reported Staff T's comment made her feel less-than and not good enough. R6 stated at the time of the incident she was angry and added, I pay to be here like everyone else.</p> <p>During an interview on 1/9/2025 at 10:36 a.m., the DON reported she was aware of the incident that occurred on 5/17/2024 of which Staff T called R6 a derogatory name. The DON provided witness statements from CNAs V and W, both dated 5/17/2024, verifying the event. When asked if there was a witness statement from R6, the DON reported she is unsure if R6 was formally interviewed regarding the incident, but that ADON I informed her on 5/17/2024 that R6 was going about her day as usual following the incident, therefore it was assumed R6 did not remember the event or was not bothered by it. The DON reported Staff T was given a written warning and retraining on professionalism and speaking to residents in a respectful manner. The DON stated no other residents were interviewed to determine if other residents had concerns with verbal abuse by staff. The DON was unable to provide any other documentation of an investigation into the incident. A query was made at that time as to how verbal abuse could be ruled out if a complete investigation was not conducted to which the DON replied she did not feel it was warranted at the time, but the incident was reported to the State Agency (SA) on 1/09/2025 as an allegation of verbal abuse.</p> <p>Review of CNA W's Incident Witness Statement, signed and dated 5/17/2024, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Time of Incident: Approx. (approximately) 1:45 p.m. Resident was upset about having lunch plans with family canceled. Wife of another resident overheard [R6] visibly upset and approached [R6] to compliment her on her dress. [R6] responded what am I supposed to dance different? [Staff T] interjected I complimented her on her dress earlier then said [R6] are you being a butt head? to which [R6] replied oh so now I'm a butt head? then stormed down the hallway. Nurse notified.</p> <p>Review of CNA V's Incident Witness Statement, signed and dated 5/17/2024, revealed the following:</p> <p>Time of Incident: 1:45 p.m. [Staff T] walked by and said on the quieter side to either me or resident Oooh, you're being a butt head followed with giggles.</p> <p>A review of R6's electronic medical record for the period of 5/01/2024 through 1/08/2025 at 2:26 p.m., revealed no documentation of the incident that occurred on 5/17/2024, including no description of the event and no post-incident evaluation of R6 to determine her response to being called a derogatory name by Staff T.</p> <p>Review of the facility policy titled, Abuse Prohibition and Prevention Program, dated 7/03/2024, revealed the following, in part:</p> <p>The individual conducting the investigation will, as applicable: review the resident's medical record to determine events leading up to the incident; interview the person(s) reporting the incident; interview any witnesses to the incident; Interview the resident (as medically appropriate); interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; interview the resident's roommate, family members, and visitors; interview other resident's to whom the accused employee provides care or services; and review all events leading up to the alleged incident; and review employee records as appropriate . The results of the investigation will be recorded in a written report .</p>		