

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 02/20/2025
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 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** 49302</p> <p>This citation pertains to Intake MI00150291.</p> <p>Based on interview and record review, the facility failed to protect the residents' right to be free from verbal abuse and neglect by facility staff for three Residents (#1, #2, #3) of five residents reviewed for abuse, neglect, and exploitation.</p> <p>Findings include:</p> <p>Resident #1 (R1):</p> <p>Review of R1's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including prosthetic joint infection and sepsis with septic shock. Review of R1's most recent Minimum Data Set (MDS) assessment, dated 1/23/25, revealed a Brief Interview for Mental Status (BIMS) score of 7/15, indicative of severe cognitive impairment. Review of MDS Section GG (Functional Abilities and Goals) revealed R1 was dependent for both toileting hygiene and lower body dressing.</p> <p>Resident #2 (R2):</p> <p>Review of R2's EMR revealed initial admission to the facility on [DATE] with diagnoses including post-hemorrhagic anemia. Review of R2's MDS assessment, dated 2/6/25, revealed a BIMS score of 12/15, indicative of moderate cognitive impairment. Review of MDS Section GG revealed R2 required moderate assistance for toileting hygiene.</p> <p>Resident #3 (R3):</p> <p>Review of R3's EMR revealed initial admission to the facility on [DATE] with diagnoses including an open wound of the buttock and bacteremia. Review of R3's most recent MDS assessment, dated 12/19/24, revealed a BIMS score of 14/15, indicative of intact cognition. Review of MDS Section GG revealed R3 was dependent for both upper and lower body dressing.</p> <p>A Facility Reported Incident (FRI) submitted to the State Agency (SA) on 2/13/25, read, in part:</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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[R1, R2, and R3] informed staff that they were not happy with the care provided by [Certified Nursing Assistant (CNA) A] in the early morning of 2/4/25 . [R1] stated, 'I asked [CNA A] to get me a brief and show me how to get it on and he threw it on the bed and left the room.' When asked if [CNA A] ended up coming back to assist, resident denied that [CNA A] assisted him. [R1] mentioned several times, 'I do not like his attitude, and he is rude.' . [R3] reported that she was having some issues with leaking from her [intravenous] pump through the eve. During the night, her bedding was saturated from the pump leaking and she was in need of getting up to the restroom to have a bowel movement. [R3] rang for assistance . [R3] reported that [CNA A], 'swatted my hand and ripped the cord out my hands slightly roughly' . [R3] continued, '[CNA A] is very rude and condescending .' [R3] reports that [CNA A] kept telling her over and over to 'be quiet, you are waking others up.' [R3] stated that '[CNA A] was, 'hollering at me to be quiet .' [R2] stated that her call light fell off of her during the night, she was unable to call for help and resorted to banging on her bedside table for assistance. '[CNA A] came to assist her to the restroom . [R2] stated, 'I asked '[CNA A] to clean me up further because I felt like I still had things on my bottom and poop stuck and he rudely told me to talk to my nurse about it in the morning and he left the room .'</p> <p>On 2/20/25 at 11:41 AM, an interview was conducted with R2 regarding the care received on the night of 2/4/25 and into the morning hours of 2/5/25. R2 stated she required the restroom overnight to have a bowel movement. R2 stated CNA A assisted her to the toilet and provided peri-care that was not thorough. R2 stated when she asked CNA A for additional wipes, he declined and told her to notify the floor nurse in the morning.</p> <p>On 2/20/25 at 11:55 AM, an interview was conducted with CNA G who confirmed she worked the morning shift on 2/5/25 and received some resident complaints regarding care the previous night. CNA G stated, When I came on morning shift [R1] was already upset and in a bad mood which is not normal for him . [R1] stated he didn't ever want [CNA A] again [as a care assistant]. CNA G reported R1 indicated CNA A refused to help him during the night hours. R1 stated after he asked CNA A to assist with a brief change, 'He tossed a brief on my bed, walked out, and dismissed me without helping.' CNA G stated, [R1] couldn't put briefs on himself, he always received assistance. CNA G explained she assisted R2 to the bathroom on the morning of 2/5/25 to urinate and noticed an excessive amount of dried stools on her buttock. CNA G stated she asked R2 if she had been incontinent overnight and R2 responded, No, but I told [CNA A] I didn't feel clean enough and he didn't clean me. He just told me, 'You'll have to tell your nurse about it.' CNA G stated she helped R2 get fully clean and applied some soothing cream to the area because it seemed red and irritated. CNA G stated when she assisted R3 with her morning cares, R3 reported feeling cold because had been laying in a wet gown and wet linens. CNA G explained R3 had several medical lines that would sometimes become dislodged and continue pumping. CNA G recalled R3 reported asking [CNA A] for assistance with dry bedding throughout the night. CNA G reported R3 stated, [CNA A] swatted my hands away and told me to quite tugging on the lines.</p> <p>On 2/20/25 at 12:17 PM, an interview was conducted with CNA H who confirmed she also worked the morning shift on 2/5/25. CNA H stated when she entered R1's room that morning, he seemed upset. CNA H stated when she inquired what was bothering R1, he stated, [CNA A] threw the brief right at me and told me to get dressed myself.</p> <p>Review of an email correspondence sent by Registered Nurse (RN)/Rehab Case Manager K to the Director of Nursing (DON) on 2/5/25 at 7:44 AM read, in part:</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>. [R1] reported [CNA A] threw a brief at him and told him to change himself . [R3] reported [CNA A] slapped her hand when she was trying to show him her wet bed . [R2] stated she asked for [CNA A] to wipe as she still had stool on her following a bowel movement and he said you will have to talk to your nurse about it and walked out .</p> <p>Review of the FRI investigation summary submitted to SA on 2/13/25, read, in part:</p> <p>. In this case based on the interviews and follow-up interviews with residents and staff, abuse has been substantiated and [CNA A] has been terminated from this Organization .</p> <p>On 2/20/25 at 2:48 PM, an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) who confirmed CNA A had been terminated following the abuse investigation.</p> <p>Review of the facility policy titled, Abuse Prohibition and Prevention Program, dated 7/3/24, read, in part:</p> <p>. Our Organization will not condone any form of resident abuse and will continually monitor our policies, procedures, training programs, systems, etc., to assist in preventing resident abuse .</p> <p>Review of the facility policy titled, Resident Care Policies, dated 3/15/22, read, in part:</p> <p>. The resident has the right to a dignified existence, self-determination and communication . the resident has the right to be free from verbal, sexual, physical, and mental abuse . the Organization will care for our residents in a manner and in an environment that promote maintenance or enhancement of each resident's quality of life . the Organization will promote care for the residents in a manner in an environment that maintains or enhances each resident's dignity and respect . Each resident will receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psych-social well-being . Personal care: A resident shall be provided the opportunity for, and, as necessary assisted with personal care, including toileting . a resident's clothing or bedding shall be changed promptly when wet or soiled .</p>		