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	03/11/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 MI00150655 Based on interview and record review the facility failed to assess bowel function for one Resident (R1) of three residents reviewed for bowel care/complaints of constipation. This deficient practice resulted in the potential for missed signs and symptoms of constipation and resulted in hospitalization . Findings include: Review of the complaint intake revealed the following, .Complainant states the resident came from the hospital after having knee replacement for rehab on [DATE]. Complainant states the resident started complaining about his stomach hurting, it was extended and that he was having trouble going to the bathroom .On [DATE] the complainant states .the resident told them his stomach hurt .staff put a blanket over him and did come back later to check on him. Staff found that he was cold and clammy. The resident was transported to [Hospital Name] .he would pass away, which he did on [DATE]. The death certificate states the resident died from ischemic colitis, septic shock and organ failure . Review of R1's face sheet revealed admission to the facility on [DATE] with diagnoses including aftercare following joint replacement surgery, hemiplegia and hemiparesis, and nutritional deficiency. Review of R1's Physician Note dated [DATE] and written by Medical Director (MD) A read, in part, Patient is being admitted following planned hospital stay at [Hospital Name] from ,d+[DATE]-,d+[DATE] due to the above. Patient has a history of CVA (cerebrovascular accident) with right sided hemiplegia, failed conservative treatment and elected to undergo TKA (total knee arthroplasty). Procedure went as planned without immediate perioperative complications .States pain is about a 6, overall controlled. He has not had a bowel movement in a few days, having some abdominal fullness .Diagnosis, Assessment and Plan . Constipation; encouraged fluid intake, senna, miralax and other bowel meds per standing orders. Encouraged dietary changes including prunes, prune juice or raisins with meals . Review of R1's Physician Note dated [DATE] and written by Physician Assistant (PA) B read, in part, .He is reporting mild constipation, would like daily miralax .Diagnosis, Assessment and Plan .Constipation, encouraged fluid intake, continue senna-docusate BID (twice daily) will add miralax 17g once daily. Additional stool softeners available as needed per standing orders . (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: 235088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Bowel Documentation from [DATE] through [DATE] revealed the following: [DATE]: No bowel movement [DATE]: Continent large loose stool at 10:43 a.m. [DATE]: No bowel movement [DATE]: Incontinent large formed stool at 5:26 a.m.; continent large liquid stool at 6:26 a.m. [DATE]: No bowel movement [DATE]: Incontinent large liquid stool at 10:14 a.m. [DATE]: Incontinent large loose stool at 6:29 p.m.; hospitalized at 10:30 p.m. Review of R1's medical record revealed only two documented bowel assessments with one completed by MD A on [DATE] and Registered Nurse (RN) E on [DATE]. An interview was conducted with Registered Nurse/Unit Manager (RN/UM) C on [DATE] at 9:43 a.m. RN/UM C stated that she did not specifically recall R1's hospitalization and complaints of constipation. RN/UM C stated R1 would not have specifically triggered for the facility's bowel protocol but confirmed after R1's first initial concerns to MD A on [DATE], a bowel assessment should have been completed. An interview was conducted with RN D on [DATE] at 10:16 a.m. RN D stated that she could not recall R1's complaints of constipation. When asked when staff would complete a bowel or abdominal assessment, RN D stated if the resident was complaining of constipation or if either assessment triggered for completion in the computer system. An interview was conducted with RN E on [DATE] at 10:33 a.m. RN E stated he could recall R1's complaints of constipation but stated he felt it was more onset that night than a chronic complaint. RN E stated he wrote a late progress note for the day of [DATE] but could not recall why it was over six days later when he wrote it. RN E stated that he would begin a bowel or abdomen assessment if it was triggered in the computer. An interview was conducted with the Director of Nursing (DON) on [DATE] at 1:19 p.m. The DON stated that there is no specific policy for skilled nurse charting which includes a bowel or abdomen assessment, but staff should chart based on the residents' statements. The DON confirmed that a thorough nursing assessment should have been completed for R1 when he started to complain of constipation on [DATE], especially since R1 was on opioid medication for his recent surgery. A review of the facility policy Bowel Program dated [DATE] revealed the following: PURPOSE To promote normal bowel function for residents and prevent constipation and/or fecal impaction. (continued on next page)

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Centers for Medicare & Medicaid Services

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

PROCEDURE

1. Daily bowel function is documented on the touchscreen by the CNAs (Certified Nurse Aide's).

2. Nurse reviews ADL (Activity of Daily Living) caregiver documentation daily to determine need for intervention. Nurse is responsible for running report at approximately 0600 and 1800 (6 p.m.)

3 If no bowel movement in 48 hours (,d+[DATE]'s) implement Bowel Management order set, which includes the following:

a) If no bowel movement in 48 hours (,d+[DATE]'s), administer 30 cc MOM at Rise/0800 medication pass

b) If no bowel movement in 60 hours (,d+[DATE]'s), administer Dulcolax suppository at Bed/2000 medication pass.

c) If no bowel movement in 72 hours (,d+[DATE]'s), administer enema at next day Rise/0800 medication pass.

d) If no bowel movement in 84 hours (,d+[DATE]'s), Update provider. Ensure provider has addressed update of no BM in 84 hours in log book or call provider to address.

4. Document any resident refusal in MAR< if consecutively or frequently refusing bowel protocol medications complete clinical note. Review bowel medication. Obtain order for regularly scheduled medication if indicated.

5. As you complete each step, put your initials in the appropriate box indicating completion.

6. If resident has documented loose stools hold scheduled laxative.

A review of an article related to standards of practice for assessment of constipation accessed on [DATE] and located at: https://wtcs.pressbooks.pub/nursingfundamentals/chapter/, d+[DATE]-constipation/#:~:text=Bowel%20sounds%20must%20be%20assessed, Open%20RN%20Nursing%20Skills%2C%202e.

revealed the following:

16.6 Constipation

. Constipation can be caused by slowed peristalsis due to decreased activity, dehydration, lack of fiber, medications such as opioids, depression, or surgical procedures in the abdominal area. As the stool moves slowly through the large intestine, additional water is reabsorbed, resulting in the stool becoming hard, dry, and difficult to move through the lower intestines . The client may experience associated symptoms such as rectal pressure, abdominal cramps, bloating, distension, and straining. Fecal impaction can occur when stool accumulates in the rectum, usually due to the client not feeling the presence of stool or not using the toilet when the urge is felt. Fecal impact has hallmark signs of seepage of liquid stool from the anus. It is important to not confuse this seepage with diarrhea .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intestinal Obstruction or Paralytic Ileus Intestinal obstruction is a partial or complete blockage of the intestines so that contents of the intestine cannot pass through it. It can be caused by paralytic ileus, a condition where peristalsis is not propelling the contents through the intestines, or by a mechanical cause, such as fecal impaction. Clients who have undergone abdominal surgery or received general anesthesia are at increased risk for paralytic ileus. Other risk factors include the chronic use of opioids, electrolyte imbalances, bacterial or viral infections of the intestines, decreased blood flow to the intestines, or kidney or liver disease. If an obstruction blocks the blood supply to the intestine, it can cause infection and tissue death (gangrene).[3] Symptoms of an intestinal obstruction or paralytic ileus include abdominal distention or a feeling of fullness, abdominal pain or cramping, inability to pass gas, vomiting, constipation, or diarrhea. Bowel sounds must be assessed for abnormal findings. It can be difficult to accurately interpret changes in bowel sounds, so any change in bowel sounds accompanied with other symptoms should be reported to the health care provider. Early intestinal obstruction can present with high-pitched tinkling sounds. Hypoactive bowel sounds can indicate constipation and may occur after abdominal surgery, anesthesia, or with use of opioid medications. Absent bowel sounds can indicate an ileus or mechanical bowel obstruction.[4] Because of the common occurrence of paralytic ileus in postoperative clients, nurses routinely monitor for these symptoms .