| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235088 | A. Building<br>B. Wing | 10/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grand Traverse Pavilions | 1000 Pavilions Circle<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(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 |
|---|---|---|
| | | |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficient practice pertains to Intake 2641153.Based on interview and record review, the facility failed to effectively monitor, report, and respond to a change in condition for one Resident (#1) of three residents reviewed for quality of care. This deficient practice resulted in Resident #1 receiving delayed medical treatment leading to hospitalization and subsequent death.Findings include:Resident #1 (R1)Review of R1's Hospital Transfer Form, dated 10/10/25 at 7:16 PM, read, in part: .Reason(s) for transfer: hypoxic. BP [blood pressure] 158/88. HR [heart rate] 121. RR [Respiratory Rate]: 31. O2 Sat [Oxygen Saturation] 85% .Review of the Emergency Medical Service (EMS) Transfer form, dated 10/10/25 at 10:01 AM, read, in part: .Upon arrival.[R1] has visible labored breathing.and tachypnea. Upon auscultation, inspiratory and expiratory wheezing was present in all fields, as well as crackles.Review of Discharge Documents from an acute care hospital dated 10/13/25 at 6:11 PM, read, in part: [R1].presents to [acute care hospital] ED from the [facility name] for [NAME] [difficulty in breathing] & hypoxia. admitted .under pulmonary critical care. [R1] had made it clear she did not want to be on any life support. With her increased pain and confusion daughters did decide to pursue comfort measures only. [R1] passed peacefully with her daughters at bedside on 10/11/2025.Review of R1's Electronic Medical Record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), disorders of the diaphragm (a major muscle used in respiration), and history of a malignant neoplasm (cancerous tumor) of the lung. Review of R1's St. Louis University Mental Status (SLUMS) Examination, dated 10/8/25, revealed a score of 19, indicative of dementia.Review of R1's Plan of Care revealed the following Focus, undated: My name is [R1] and I am staying on the Rehab Pavilion to complete therapies.Review of R1's EMR revealed the following physician's order, initiated 10/9/25: Continuous oxygen @ [at] 6-8 L/min [liters/minute] via NC [nasal cannula].R1's EMR revealed the following Health Status Note written on 10/10/25 at 3:25 AM by Registered Nurse (RN) C: CNA [Certified Nursing Assistant] called out to RN's [sic] for assistance, Patient on toilet with SpO2 [oxygen saturation] reading 53%, very SOB [short of breath], stating I can't breath [sic]. Patient assisted back into bed via [mechanical lift aide], this RN then observed that the adapter tubing that leads from the oxygen concentrator and onto the water humidifier had become disconnected. Connections fixed and SpO2 quickly improved upwards and dyspnea [difficulty breathing] improved quickly as well. O2 [oxygen] increased from 6 L to 8 L, SpO2 now ranging 87-89% . Albuterol inhaler provided.On 10/14/25 at 5:57 PM, a telephone interview was conducted with CNA J who confirmed she assisted R1 to the toilet in the early morning hours of 10/10/25. CNA J stated she checked on R1, who was lying in bed, around 3:30 AM when R1 requested to use the restroom. CNA J verified she independently transferred R1 to the bathroom using a mechanical lift when R1 soon became short of breath after sitting on the toilet. CNA J recalled, She [R1] was struggling. CNA J reported she notified RN C and RN H who took R1's vitals and assisted R1 back to bed via the mechanical lift. CNA J stated she was unaware of R1 vitals at the time of the incident and was not informed R1's oxygen tubing had become disconnected from the concentrator. When asked if she should have independently transferred R1 to the toilet using a mechanical lift, CNA J replied, Yes, she's [R1] a one person assist.Review of R1's Plan of Care reviewed the following undated interventions:TOILET USE: The resident is (Dependent) by (2) staff for toileting. TRANSFER: The resident is totally dependent on (2) staff for transferring.On 10/14/25 at 4:53 PM, a phone interview was conducted with RN H who confirmed she was the first one to assess R1 in the restroom in the early morning hours of 10/10/25. RN H recalled increasing the oxygen flow rate from 6L to 8L, but R1's oxygen saturation remained around 54%. RN H stated RN C then arrived on scene who turned the flow rate to 10L and helped transfer the resident back to bed, at which point they noticed the oxygen tubing had become disconnected from the concentrator.Review of R1's EMR revealed the following Health Status Notes written by Registered Nurse (RN) C:10/10/25 at 4:10 AM: This RN contacted Patient's daughter, [Family Member (FM) A] regarding the change in condition and incident that lead to her [R1's] SpO2 dropping. This RN is still waiting for on-call provider to respond. O2 now reading around 78%, Patient would like to avoid rehospitalization. [FM A] is in agreeance with keeping [R1] here and seeking more comfort medications for her. 10/10/25 at 4:35 AM: Still no call from Telehealth provider after 53 minutes. On-call [physician's group] number utilized and provider contacted regarding situation. Approval given to give another dose of her PRN [as needed] Ativan early, provider to follow-up later today. Okay given to keep Patient at 10 L of O2. [R1] is agreeable to utilizing the PRN Ativan again and seeking comfort rather |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficient practice pertains to Intake 2641153.Based on interview and record review, the facility failed to provide the necessary oxygen therapy as prescribed by a physician for one Resident (#1) of three Residents reviewed for respiratory services.Findings include:Resident #1 (R1)Review of R1's Electronic Medical Record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), disorders of the diaphragm (a major muscle used in respiration), and history of a malignant neoplasm (cancerous tumor) of the lung. Review of R1's St. Louis University Mental Status (SLUMS) Examination, dated 10/8/25, revealed a score of 19, indicative of dementia.Review of Intake 2641153 submitted to the State Agency (SA) on 10/13/25 read, in part: .On 10/7/25, [facility] staff transported [R1] to her orthopedic doctor's appointment. [R1's] daughter, [Family Member (FM) B], accompanied [R1]. [The facility] provided one oxygen tank .During the appointment, [R1] ran out of oxygen.On 10/14/25 at 12:19 PM, a telephone interview was conducted with FM B who confirmed she was present at the time of R1's appointment on 10/7/25. FM B stated the facility transported R1 to her appointment in the facility bus with one portable oxygen E-cylinder. FM B recalled toward the end of the appointment, R1 was running low on oxygen and eventually ran out while waiting in the lobby for transport back to the facility. FM B stated the transport driver [Transport Driver (TD) R] said there were no back-up oxygen cylinders on the bus, and he would have to make a trip back to the facility to retrieve another tank. FM B recalled staff at the orthopedic clinic were assisting as best as they could as R1's oxygen saturation dropped to around 70% while waiting for supplemental oxygen.Review of an Incident Witness Statement written by TD R on 10/14/25 read, in part: Arrived at [orthopedic facility] to pick up [R1] and [FM B].Once I arrived, [FM B] came out in a slight panic, asking if I had an extra O2 (oxygen) tank. I said no and she told me her mother did not have any more in her tank. I imedietly [sic] drove back and grabbed a new tank.Review of R1's plan of care revealed the following Focus: The resident has oxygen therapy r/t (related to) COPD and chronic hypoxic respiratory failure. An undated intervention read, OXYGEN SETTINGS: O2 via (nasal prongs) @ [at] (6-8) L [liters] (continuous). Humidified.On 10/14/25 at 2:05 PM, a telephone interview was conducted with Medical Assistant (MA) G of the orthopedic facility who stated he assisted R1 when she ran out of oxygen at her appointment. MA G recalled, [R1's] oxygen dropped as low as 70% . she was extremely anxious. we waited longer than 10 minutes for extra oxygen. MA G noted R1's oxygen canister was set at 8L and noticed R1 was wearing a normal nasal cannula. MA G stated, At that point, the oxygen delivery isn't effective. [R1] should have had a high flow cannula or a mask.On 10/14/25 at 1:14 PM, an interview was conducted with Registered Nurse (RN) E who stated she was on duty at the time of R1's orthopedic appointment on 10/6/25. When asked who was primarily responsible for getting R1 oriented and ready for her appointment, RN E responded, I don't think I ever saw her [R1] go. The CNAs [certified nursing assistants] are usually the ones responsible for getting residents ready for appointments, including making sure oxygen tanks are full. RN E stated she thought R1's prescribed oxygen flow rate was 6L. When asked if R1 was sent to her appointment with more than one tank, she replied, I didn't think she [R1] would need a backup tank. Oxygen will go fairly quickly with 6L, but not that quickly. maybe a couple hours. RN E recollected when R1 returned to the facility she vocalized that the experience of running out of oxygen was, really scary.On 10/14/25 at 1:35 PM, an interview was conducted with CNA F who verified she assisted R1 in getting ready for her appointment on 10/7/25. CNA F acknowledged a 6L flow rate would run out pretty quickly but did not believe backup tanks were allowed to be sent out with residents per facility policy.On 10/15/25 at 12:15 PM, an interview was conducted with Environmental Services Director (EVD) I regarding portable oxygen cylinders who confirmed the transport vehicles are not equipped with stationary racks, but back-up tanks could be transported in cylinder cart carriers. Review of a document titled Oxygen duration with Tanks from the facility's portable oxygen vendor revealed the E-tank duration for a 6 LPM [liter per minute] flow rate equaled 75 minutes. No data was available for an 8 LPM flow rate.On 10/15/25 at 1:42 PM, an interview was conducted with the Director of Nursing (DON) who understood the concerns related to accessibility of respiratory equipment and services at all times for oxygen dependent residents. The DON verified a flow rate of 6 LPM or above would necessitate a high flow nasal cannula. Review of guidance from a cardiovascular specialty hospital titled, Blood Oxygen Levels: Everything you Need to Know, dated 5/19/2022, read, in part: .Blood oxygen levels:. Below 91%: low blood oxygen level. Below 85%: Very low oxygen levels (Hypoxemia) Below 80%: Severe |