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 _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F000	INITIAL COMMENTS Grand Traverse Pavilions was surveyed for a Recertification Survey on 9/19/2024. Intakes: MI00144951, MI00144850, MI00145004, MI00145621, MI00146192, MI00146856 and MI00146910. Census = 164	F000		
F623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) 483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. 483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F623	F 623 Notice Requirements Before Transfer / Discharge 1. Resident #56, 1, 621, 149 or representative were provided a copy of the transfer notification. The State Long-Term Care Ombudsman was also sent a copy of transfer notification. 2. The facility has determined that all residents who have been transferred or discharged have the potential to be affected. 3. An in-service education program was conducted by the Director of Nursing, or designee, with licensed nursing and social services staff addressing circumstances regarding required notices for residents upon transfer and discharge from the facility. 4. The Social Services designee, will conduct a random audit of five residents that have been discharged weekly for four consecutive weeks to ensure the record includes documentation showing the resident/representative was notified of the transfer, was sent a copy of the transfer/discharge notice, and the notice was sent to the Ombudsman. Random audits will then be completed monthly to ensure continued compliance. Audit	10/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/08/2024

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F623	Continued From page 1 be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. 483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F623	records will be reviewed by the QAPI committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. 5. Administrator is responsible for sustained compliance.	

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F623	Continued From page 2 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. 483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. 483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at 483.70(l). This REQUIREMENT is not met as evidenced by: . Based on interview and record review, the facility failed to notify the Resident and/or Resident Representative in writing, the reason for transfer of four Residents (R1, R56, R149, R621) of five residents reviewed for facility initiated transfers. Findings include: Resident #56 (R56)	F623		

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F623	Continued From page 3 During an interview on 9/16/24 at 12:20 PM, R56 stated he had been sent to the hospital during his stay at the facility. The Electronic Medical Record (EMR) for R56 revealed a transfer to the hospital on 6/24/24 with a readmission on 6/29/24. No evidence of written notification for the transfer provided to R56 or their representative could be located in the medical record. During an interview on 9/19/24 at 11:17 AM, the Director of Nursing (DON) stated she did not believe a system was in place to send written transfer notifications to the resident and resident representative. She said, "It looks like an opportunity for improvement." She further recommended checking with the social worker. During an interview on 9/19/24 at 11:25 AM, Social Worker (Staff "D") stated she was unaware of this process. Resident #1 (R1) The medical record documented R1 was transferred to the hospital on 6/26/24. R1 was readmitted to the facility on 6/29/24. There was no documentation in the EMR indicating R1 or the resident representative was provided with written notification of the transfer. During an interview on 9/18/24 at 12:27 p.m., Staff "D" said there was no written notification of transfer provided when R1 was transferred to the hospital. Resident #621 (R621)	F623		

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F623	Continued From page 4 Review of R621's EMR revealed the following physician communication on 7/11/24 at 4:22 PM: " ...Send to [acute care hospital] for evaluation ..." Review of the facility census report confirmed R621 was hospitalized on 7/11/24. On 9/19/24 at 11:17 AM, an interview was conducted with the DON who stated written transfer notifications were not completed by the facility. On 9/19/24 at 11:31 AM, an interview was conducted with Staff "D" who verified a written transfer notification was not issued to R621 upon transfer to the hospital on 7/11/24. Resident #149 (R149) Review of the EMR revealed R149 was hospitalized from 6/19/24 - 6/30/24. The EMR did not indicate a written notification of transfer was issued to R149. On 9/19/24 at 11:31 AM, an interview was conducted with Assistant Director of Nursing (ADON) "F" who verified a written transfer of notification was not given to R149 upon transfer to the hospital. Review of facility policy titled, "Discharge and Transfer Procedure," dated 6/20/22, read, in part: " ... [Facility Name] strives to provide a discharge plan that will assure a continuum of care and proper completion of medical records ..."	F623		

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F623	Continued From page 5 Review of facility policy titled, "Resident Care Policies," dated 3/20/24, read, in part: " ...Before the transfer or discharge, the Organization will ... Involve the resident and/or legal representative in discharge planning to the extent feasible including reasons for the move in writing and in a language and manner they understand ..."	F623		
F625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) 483.15(d) Notice of bed-hold policy and return- 483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. 483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F625	F 625 Notice of Bed Hold Policy Before / Upon Transfer 1. Residents #621 & 149 or representative were notified of the facility's bed hold policy upon admission and have returned from their hospital stay. 2. The facility has determined that all residents have the potential to be affected. 3. An in-service education program was conducted by the Director of Nursing Services, or designee, with licensed nursing staff and social services addressing the facilities notification of bed hold policy. 4. The Social Services designee will conduct a random audit of five residents that have been discharged weekly for four consecutive weeks. These residents charts will be audited to ensure proper notification of bed hold was provided to the resident and/or legal representative and documented as such. Random audits will then be completed monthly to ensure continued compliance. Audit records will be reviewed by the QAPI committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. 5. Administrator is responsible for sustained compliance.	10/10/24

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F625	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide written notification of the facility bed hold policy for two Residents and/or Resident Representatives (#621 and #149) of five residents reviewed for notice of bed hold policy. Findings include: Resident #621 (R621) Review of the R621's Electronic Medical Record (EMR) revealed the following physician communication on 7/11/24 at 4:22 PM: " ...Send to [acute care hospital] for evaluation ..." Review of the facility census report confirmed R621 was hospitalized on 7/11/24. On 9/19/24 at 11:17 AM, an interview was conducted with the Director of Nursing (DON) who stated she was unaware if a bed hold policy was issued to R621 upon transfer. On 9/19/24 at 11:31 AM, an interview was conducted with Social Worker (Staff "D") who verified a R621 was not issued a bed hold policy. Resident #149 (R149) Review of the EMR revealed R149 was hospitalized from 6/19/24 - 6/30/24. The EMR did not indicate a bed hold policy was issued to R149.	F625		

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F625	Continued From page 7 On 9/19/24 at 11:31 AM, an interview was conducted with Assistant Director of Nursing (ADON) "F" who verified a bed hold policy was not given to R149 upon transfer to the hospital. Review of facility policy titled, "Discharge and Transfer Procedure," dated 6/20/22, read, in part: " ...upon actual transfer with admission to another Health Care institution, contact will be made with the responsible party to inform them of the right to hold a bed ... if the resident/responsible party holds the bed or declines to hold the bed, Bed Hold Form will be activated by the person making the contact and forwarded to the Financial office ...for completion ..."	F625		
F656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) 483.21(b) Comprehensive Care Plans 483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at 483.10(c)(2) and 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.24, 483.25 or 483.40; and (ii) Any services that would otherwise be required under 483.24, 483.25 or 483.40 but are not provided due to the resident's	F656	F656 Develop / Implement Comprehensive Care Plan 1. Care plans of R136 were reviewed and updated as indicated. 2. The facility has determined that all residents have the potential to be affected. 3. Interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility's policy and procedures for developing comprehensive care plans specific to psychoactive medication use. 4. Random weekly audits of five care plans will be completed for four consecutive weeks to ensure they are comprehensive, and resident centered. Random audits will then be completed monthly to ensure continued compliance. Audit records will be reviewed by the QAPI committee monthly until such time consistent substantial compliance has been achieved as determined by the	10/10/24

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F656	Continued From page 8 exercise of rights under 483.10, including the right to refuse treatment under 483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. 483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for the use of psychotropic medications for one Resident (#136) of five residents reviewed for unnecessary medications, resulting in the potential for unnecessary use of mood-altering drugs and decreased quality of life. Findings include:	F656	committee. 5. Director of Nursing is responsible for sustained compliance.	

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F656	Continued From page 9 Resident #136 (R136) Review of R136's Minimum Data Set (MDS) assessment, dated 7/23/2024, revealed admission to the facility on 4/23/2024 with diagnoses including dementia with psychotic disturbance, depression and anxiety disorder. R136 was rated as having severely impaired cognition. Review of R136's electronic medical record (EMR) revealed the following orders: "Lorazepam (a controlled substance anti-anxiety medication) Oral Tablet 0.5 MG (milligram). Give 0.5 mg by mouth every 6 hours as needed for anxiety..." Review of R136's care plan revealed the following: "Focus: The resident uses psychotropic medications [related to] end of life, comfort measures ... Date initiated: 4/25/2024. Goal: The resident will be/remain free of psychotropic drug related complications ... Date Initiated: 4/25/2024. Interventions: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness ... Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Date Initiated: 4/25/2024." It was noted the care plan did not include specific targeted behaviors, indication of use (diagnosis), or person-centered, non-pharmacological interventions to be used prior to administration of the medication. During an interview on 9/19/2024 at 8:31 a.m., Assistant Director of Nursing (ADON) "G" reported targeted behaviors and/or indications of use should be documented for each	F656		

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F656	Continued From page 10 administration of as needed psychotropic medications, including lorazepam, to ensure appropriate use of the medications. During review of R136's care plan at the time of the interview, ADON "G" confirmed no focus area to include triggers for behavior or non-pharmacological interventions were listed related to the use of as needed anti-anxiety medication. Review of the facility policy titled, "Care Planning," dated 10/09/2023, revealed the following, in part: "The organization will develop a comprehensive care plan for each resident to meet a resident' clinical and psychosocial needs and to maintain the resident's highest practicable physical, mental, and psychosocial well-being .... The written plan of care shall be available to all individuals involved in the care of the resident and shall document all of the following: The resident's problems and needs. Goals and objectives of care. Interventions."	F656		
F684 SS=G	Quality of Care CFR(s): 483.25 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00145621.	F684	F684 Quality of Care: Timely Follow-up and Implementation of Orders Re: Timely F/U & Timely Implementation of provider orders 1. Root cause analysis was completed for R173 and R621. 2. The facility determined that all residents have the potential to be affected. 3. Licensed nursing staff members will be re-educated on the facility's policies and procedures regarding acute change of condition. 4. Acute change of conditions (ACOC) will be reviewed and discussed at daily IDT meetings. Audits will be competed of ACOCs x 4 weeks to ensure that appropriate, timely assessments and physician/provider notification for a change	10/10/24

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F684	Continued From page 11 This citation has two parts: A and B. A. Based on interview and record review, the facility failed to ensure appropriate, timely assessments and physician/provider notification for a change in condition for one Resident (#173) of three residents reviewed for death, resulting in actual harm when R173 became unresponsive and ultimately expiring in the facility. Findings include: Resident #173 (R173) R173 was admitted on 7/12/2024 with diagnoses including congestive heart failure (CHF), atrial fibrillation (abnormal heart rhythm), coronary artery disease (CAD) S/P (status-post) heart catheterization, transient ischemic attack (ministroke) and acute kidney injury. Review of R173's Minimum Data Set (MDS) assessment, dated 7/13/2024, revealed R173 expired in the facility on 7/13/2024. Review of R173's "Medical Certificate of Death," revealed the Resident expired on 7/13/2024 at 1:59 p.m., cause of death was heart failure. Review of R173's electronic medical record (EMR) revealed on 7/13/2024 the resident was hypotensive (blood pressure below 90/60 mmHg (millimeters of Mercury, a unit of pressure) became unresponsive and expired in the facility. Further review revealed the following: "7/13/2024 at 12:35 [p.m.], [signed by Registered Nurse (RN) "V"] Behavior Note: low BP [blood pressure] with a manual this morning, asymptomatic. Noted to run low following hospital discharge and among admission yesterday, [R173] had a shower and was ambulating with no complaints following lunch.	F684	in condition are completed and recommendations/orders from provider are implemented timely. Random audits will then be completed monthly to ensure continued compliance. Audit records will be reviewed by the QAPI committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. 5. Director of Nursing is responsible for sustained compliance.	

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	235088	A. BUILDING _____ B. WING _____	C 09/19/2024

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F684	Continued From page 12 Upon laying down this nurse was planning to obtain another set of vitals and other care. Wife requested for blood sugar to be checked before lunch ... and requested he get short acting insulin; provider notified and ordered a sliding scale..." "7/13/2024, 15:45 [3:45 p.m.], Alert Note: Wife informed CNA [Certified Nurse Assistant] that [R173] became unresponsive. CNA alerted nursing staff ... immediately responded and noted [R173] to have irregular, apneic breathing with a weak thready pulse... still assessing patient, pulse stopped and CPR [Cardiopulmonary Resuscitation] was immediately initiated. Fire arrived at 1336 [1:36 p.m.], EMS [Emergency Medical Services] arrived at 1341 [1:41 p.m.]. CPR lasted 1325-1359 [1:25 p.m. - 1:59 p.m.]. At that time EMS called time of death [1:59 p.m.] ..." Further review of R173's EMR revealed the following blood pressure readings: 7/12/2024 at 5:57 p.m. - 92/66 mmHg (manual, right) 7/12/2024 at 10:19 p.m. - 110/72 mmHg (machine) 7/13/2024 at 7:24 a.m. - 80/51 mmHg (machine) [normal blood pressure range is below 120/80 mmHg and above 90/60 mmHg] 7/13/2024 at 8:48 a.m. - 80/50 mmHg (manual, right) 7/13/2024 at 8:49 a.m. - 90/50 mmHg (manual, left) The following was noted in review of R173's blood pressure readings, the documented reading on 7/13/2024 at 7:24 p.m. was 30 points lower systolic and 21 points lower diastolic than the previous reading on 7/12/2024 at 10:19 p.m.	F684		

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F684	Continued From page 13 It was also noted there were no blood pressure readings recorded from 7/13/2024 at 7:24 a.m. until 7/13/2024 at 8:48 a.m., a timeframe of one hour and 24 minutes after R173's blood pressure was noted to be low. It was noted in review of R173's EMR, there were no physical assessments documented prior to or in response to the Resident's low blood pressure readings on 7/13/2024. It was also noted there was no documentation of assessments of R173's heart rate, oxygen saturation, or respiratory rate to accompany the low blood pressure readings at 8:48 a.m. or 8:49 a.m. Review of R173's Medication Administration Record (MAR) revealed RN "V" withheld administration of the following scheduled morning (8:00 a.m.) medications: "Bumex [medication used to remove excess fluid in the body] Oral Tablet 1 MG (milligram). Give 1 tablet by mouth two times a day for CHF." "Metoprolol Tartrate [medication used to lower blood pressure and heart rate] Oral Tablet 25 MG. Give 1 tablet by mouth two times a day for HTN [hypertension]." Further review of R173's MAR revealed RN "V" documented the reason for withholding the medications as "Vital outside of parameters for administration." It was noted, the orders for the medications included no vital sign parameters for administering or withholding the medications. Further review of R173's EMR revealed no documentation of physician/provider notification of R173's low blood pressure readings on 7/13/2024 or of RN "V" withholding	F684		

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F684	Continued From page 14 administration of the scheduled doses of Bumex 1mg and metoprolol tartrate 25mg. Review of physician/provider notification documentation binder for July 2024, provided by Assistant Director of Nursing (ADON) "F", revealed no entry or documentation to alert the physician or advanced practice providers of R173's low blood pressures on 7/13/2024 or of the need to withhold administration of the Resident's scheduled Bumex 1 mg or metoprolol tartrate 25mg. During an interview on 9/18/2024 at 1:50 p.m., RN "V" confirmed she was assigned to R173's care on 7/13/2024. RN "V" reported she was aware of the Resident's low blood pressure readings and verified the blood pressure readings on 7/13/2024 were out of normal range. RN "V" stated she was not concerned about R173's low blood pressure readings because the Resident was not having any symptoms of hypotension, but the Resident's blood pressure was difficult to measure due to being "hard to hear" when taken manually. When asked what symptoms she would expect to see a change in condition, RN "V" stated R173 was not having symptoms because the Resident took a shower and ate lunch without reporting any increased fatigue. RN "V" did not remember conducting a physical assessment of R173, including listening to R173's lung sounds in response to the low blood pressure. RN "V" was asked if R173 was having any difficulty with breathing or cough to which she replied "he must have at some point, he was wearing oxygen." A query was made regarding withholding administration of R173's scheduled Bumex 1mg and metoprolol tartrate 25mg on the morning of 7/13/2024. RN "V" reported she held administration of the medications because she	F684		

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F684	Continued From page 15 was worried the medications would lower R173's blood pressure further. RN "V" reported she did not notify the physician of the need to withhold administration of the medications or of R173's low blood pressure readings. When asked why her concern over R173's blood pressure dropping further did not warrant physician notification, RN "V" stated she did not feel a call was necessary because the resident was "asymptomatic" and had been running low prior to admission. Review of R173's "Hospital Summary," dated 7/12/2024 at 3:04 p.m., revealed a blood pressure reading of 108/56 mmHg at discharge. During an interview on 9/18/2024 at 4:50 p.m., the Director of Nursing (DON) confirmed R173's low blood pressure readings and RN "V" withholding scheduled medications on 7/13/2024 warranted physician/provider notification and should have been considered a change in condition. The DON agreed withholding medications for complicated cardiac conditions and heart failure is not always the best option. The DON confirmed transfer to a higher level of care is at times needed for continuous monitoring while providing the necessary medications. During a telephone interview on 9/19/2024 at 10:47 a.m., Physician Assistant (PA) "W" reported being the provider on-call on 7/13/2024. PA "W" reported she was not notified of R173's low blood pressure readings or the withholding of the Resident's scheduled Bumex 1mg or metoprolol tartrate 25mg on 7/13/2024 until after the Resident expired. PA "W" stated she did remember being called by RN "V" for R173's insulin order on 7/13/2024 but no mention of the Resident being hypotensive or	F684		

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F684	Continued From page 16 supplemental oxygen was made. PA "W" confirmed physician notification should be made for a change in condition to allow for changes in the plan of care or transfer to a higher care setting. Review of the facility policy titled, "Change in Condition," dated 8/21/2023, revealed the following, in part: "To assist facility staff with identifying individuals at risk for acute changes in condition ... Procedure: Assess the resident's symptoms, mental status and physical function ... Use SBAR to notify the physician and proceed as instructed, complete clinical note ... Vital Signs ... Blood pressure 20 mmHg lower or higher than normal." B. Based on observation, interview, and record review, the facility failed to adhere to physician treatment orders for rehabilitation services and fluid administration for one Resident (#621) out of 32 residents reviewed for quality of care. This deficient practice resulted in delayed treatment for respiratory illness, hospitalization, sepsis, and death. Findings include: Resident #621 (R621) Review of R621's electronic medical record (EMR) revealed admission to the facility on 1/19/24 with diagnoses including dementia and fracture of the left femur (leg). Review of R621's MDS, dated 4/12/24, revealed a score of 3 on the Brief Interview for Mental Status (BIMS) assessment, indicative of severe cognitive impairment. Review of R621's EMR revealed the following	F684		

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F684	Continued From page 17 progress notes: 1. 7/8/24 at 17:22 (5:22 PM): "Res [resident] continues to be lethargic and refuse[s] to get out of bed or eat meals. Oral intake is poor. output is minimal. Low grade temp [temperature] continues at 99.7 [degrees Fahrenheit]." 2. 7/10/24 at 12:31 PM: "Pt [patient] heard with barky, productive cough. Thick clear mucus noted on tissue. Pt also has thick, clear mucus noted from nose. Lungs clear in upper lobes, clear in right lower, slight crackles heard in left lower lobe ..." 3. 7/10/24 at 15:55 (3:55 PM): "Writer contacted on-call provider ... New orders: Peripheral IV [intravenous] placement; 500 cc [cubic centimeters] NS [normal saline] IV fluid bolos [sic] followed by 100 cc/hr [cubic centimeters per hour] x 10 hours ..." 4. 7/10/24 at 22:50 (10:50 PM): "At approximately 2130 [9:30 PM] resident noted to be in bed shivering. Temperature 100.5 [degrees Fahrenheit] ... Resident lethargic, responding minimally ...This nurse sat with resident and provided emotional support and comfort for approximately one hour. Temp is now 101.5 [degrees Fahrenheit] ... 5. 7/11/24 at 16:22 (4:22 PM): "Positive sepsis screen ... send to [acute care hospital] for evaluation ..." 6. 7/15/24 at 9:55 AM: "Per [acute care documentation], resident passed away 7/13/24." On 9/18/24 at 2:49 PM, an interview was conducted with Licensed Practical Nurse (LPN) "O" who verified she was the nurse on duty who received orders on 7/10/24 for IV fluid. LPN "O" stated she gathered the necessary supplies to hang the prescribed IV fluids and asked Registered Nurse (RN)/Staff Educator "P" for assistance hanging fluids as it was outside her scope of practice. LPN "O" stated, "She didn't	F684		

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F684	Continued From page 18 help me ... she told me to start the fluids at 8:00 PM so the next shift could deal with it ...I think we received orders [from the physician] between 12:00 PM and 4:00 PM." On 9/18/24 at 3:29 PM, an interview was conducted with LPN "Q" who verified she worked the night of 7/10/24 alongside LPN "O." LPN "Q" verified RN/Staff Educator "P" said to delay hanging the IV fluids until the night shift arrived after LPN "O" asked for assistance. On 9/18/24 at 2:19 PM, an interview was conducted with Assistant Director of Nursing (ADON) "I" who verified she was aware R621 was being monitored for a possible infection. ADON "I" stated, "When I came into work that night, I poked my head in to check on her [R621]. I noticed the fluids weren't hung, so I personally hung them around 11:00 PM." ADON "I" verified the orders for IV fluids were given around 4:00 PM on 7/10/24. When asked the acceptable timeframe between physician orders and administration, ADON "I" stated, "My expectation is it should be done right away." ADON "I" replied, "Yes" when asked if this would be considered a delay in treatment. On 9/18/24 at 3:36 PM, an interview was conducted with the DON regarding the lapse in time between physician orders and administration of IV fluids to R621. The DON stated, "That is not an acceptable timeframe and does not meet my expectation." Review of "2023 Update on Sepsis and Septic Shock in Adult Patients," published by the Journal of Clinical Medicine in April 2023 (https://doi.org/10.3390/ jcm12093188), read, in part:	F684		

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F684	Continued From page 19 dependent condition that is still accompanied by an overall poor prognosis ... Nonetheless, a well-orchestrated treatment based on selected antimicrobics, fluids, oxygen, and, if necessary, vasoactive agents can improve patients' outcomes ..."	F684		
F688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) 483.25(c) Mobility. 483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and 483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to apply orthopedic braces per physician orders for two Residents (#104 and #155) out of five Residents reviewed for range of motion, positioning, and mobility. This deficient practice resulted in the potential for a reduction in range of motion and/or complications following cervical [neck] surgery.	F688	F688 Increase / Prevent Decrease in ROM / Mobility 1. Care plans and orders r/t bracing were reviewed R104 and R155 and updated as indicated. Education provided to direct care staff r/t following Kardex and orders. 2. The facility determined that all residents have the potential to be affected. 3. Nursing staff and therapy staff will be educated on the facilities policies and procedures r/t bracing, following the Kardex and notifying licensed staff of any refusals or concerns. 4. Care will be reviewed for a random sample of 5 residents requiring splints/bracing per week for 4 weeks to assure the proper and consistent use of recommended splints. Random audits will then be completed monthly to ensure continued compliance. Audit records will be reviewed by the QAPI committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. 5. Director of Rehabilitation is responsible for sustained compliance.	10/10/24

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F688	Continued From page 20 Findings include: Resident #155 (R155) Review of R155's electronic medical record (EMR) revealed initial admission to the facility on 8/13/24 with diagnoses including surgical aftercare following surgery on the nervous system, inflammatory reaction due to internal fixation device of the spine, and quadriplegia (paralysis of all four limbs due to spinal cord damage). Review of R155's Minimum Data Set (MDS), dated 8/19/24, revealed a score of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicative of intact cognition. Review of a Neurosurgery Progress Note, dated 9/4/24, read, in part: " ...Cervical collar to be worn at all times ..." Review of R155's EMR revealed an order, initiated 9/5/24, which read, "Wear cervical collar at all times." Review of R155's Plan of Care read, "C-Collar to be worn at ALL times." On 9/16/24 at 3:44 PM, R155 was observed lying in bed without a cervical collar. The neck brace was observed resting on top of a chair across the room, out of reach of R155. On 9/17/24 at 8:23 AM, R155 was again observed lying in bed without the prescribed cervical collar. On 9/17/24 at 1:35 PM, an interview was conducted with Certified Nursing Assistant (CNA) "K" regarding expectations surrounding	F688		

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F688	Continued From page 21 R155's cervical brace. CNA "K" stated, "I believe he's [R155] able to have it off in bed. But if he's up and moving around, he should have it on." When asked if R155 could apply and remove the cervical collar independently, CNA "K" replied, "I don't think so." On 9/17/24 at 1:39 PM, CNA "L" was observed exiting R155's private room after providing care. R155 was observed sitting upright in his wheelchair without a cervical collar. When CNA "L" was asked if R155 had a physician order for an orthotic, she responded, "I don't know, I'm usually not down here [on the unit]. I'm just covering for the day." On 9/17/24 at 1:41 PM, an interview was conducted with Occupational Therapist (OT) "M" who verified R155 had orders to always wear a cervical collar. OT "M" stated R155 had never refused to wear the prescribed orthotic during her treatment sessions. On 9/18/24 at 3:12 PM, R155 was observed lying in bed without a cervical collar. When asked if he could apply and remove the collar himself, R155 replied, "No, I need help." On 9/18/24 at 3:13 PM, an interview was conducted with Assistant Director of Nursing (ADON) "F" who stated R155 had surgery on his neck prior to admitting to the facility. ADON "F" stated, "As far as I'm aware, he's [R155] supposed to be wearing it [cervical collar] at all times ...He can't put it on himself..." ADON "F" stated direct-care staff had access to R155's care plan which stated to ensure the cervical collar was always applied. ADON "F" stated R155 was prescribed a cervical collar to protect recent surgery on his spine and verbalized the importance of following orders to avoid	F688		

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F688	Continued From page 22 compromise of the surgical site. Resident #104 (R104) On 9/18/24 at 2:05 PM, R104 was observed in the Birch Dining Room and was not wearing ordered lamb's wool palm shield/protectors. R104's hands were noted to be contracted with overlapping fingers. CNA "R" was assisting R104 and stated, "I don't have him, but some splints are 2 hours on 2 off." CNA "R" was unsure of when R104 should have these orthotic devices on. During an interview on 9/18/24 at 2:20 PM, LPN "T" stated the plan was for R104 to wear his palm shield/protectors alternating one protector on during the day and one on the other hand during the night. LPN "T" observed with this Surveyor, R104 was in his room and confirmed he was not wearing any palm shield/protectors. On 9/18/24 at 2:24 PM, CNA "S" was with R104 in their room. When asked why R104 was not wearing palm shield/protectors, CNA "S" replied, "He wears them at night. I take it off in the morning. I was unaware he was to have them on during the day." On 9/18/24 at 2:44 PM, R104 was transferred into bed by CNA "S" and was observed not wearing palm protectors. On 9/18/24 at 5:02 PM, R104 was observed in bed and was not wearing palm protectors. During an interview on 9/19/24 at 9:56 AM, RN "U" discussed the absence of the care planned palm protectors. RN "U" stated the staff "needed re-education on this issue".	F688		

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F688	Continued From page 23 The EMR for R104 revealed no physician order for palm shield/protectors. During an interview on 9/18/24 at 4:50 PM, Physical Therapist (PT) "N" stated they did not always get an order for orthotics such as palm protectors. The EMR for R104 contained a progress note dated 6/18/2024 at 14:18 (2:18 PM) titled: "Therapy Communication to Nursing" which read in part: "Note Text: Please discontinue palm shield/protector with finger separators for L hand. Update: (R104) has been issued BUE (Bilateral Upper Extremity) (name brand) palm protectors for contracture management. Recommend RUE (Right Upper Extremity) palm protector be worn during sleeping hours; LUE (Left Upper Extremity) palm protector to be worn during waking hours, as tolerates ... caution with opening hand due to h/o (history of) joint pain; may need to provide gentle ROM (Range of Motion) to hand prior to donning. A second set of palm protectors will be ordered and delivered upon arrival. (Pair to wear while the other is being washed). Notify OT of any questions or concerns." The EMR for R104 contained a care plan which read in part: "(R104) has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) Disease Process (progressive decline in mobility); increased weakness." The interventions for this care plan included: "I am issued BUE (name brand) palm protectors for contracture management. Recommend RUE palm protector be worn during sleeping hours; LUE palm protector to be worn during waking hours, as tolerates. Recommend warm towel or blanket wrap to hand prior to application; caution	F688		

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	235088	A. BUILDING _____ B. WING _____	C 09/19/2024

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F688	Continued From page 24 with opening hand due to h/o joint pain; may need to provide gentle ROM to hand prior to donning." On 9/18/24 at 11:15 AM, an undated facility document titled "Resident brace, orthotic, and assistive device policy" was received and read in part: "Each resident will have an individualized care plan documented to reflect any and all applicable devices being used for positioning, bracing, or ambulation. 1. Braces and/or splints will have written orders for type and wearing frequency. 2. Braces and/or splints will have care plan documented for wearing frequency as applicable. 3. Refusals to wear said device will be documented in daily notes. 4. Poor fitting braces, splits, prosthetics, orthotics will be documented and referred to appropriate skilled therapy services and/or prosthetics/orthotics company for re-assessment of fit and modification. 5. Each resident will have their own assistive device as deemed necessary and appropriate for their condition for safe ambulation and transfers. 6. Each resident will have their mobility and ambulation status and programs as appropriate, documented in care plan. Refusals of ambulation programs will be documented weekly." On 9/18/24 at 8:37 AM the Resident Care Policies dated 3/20/24 were presented. The Quality of Care policy embedded in this set of policies read in part: "Based on the comprehensive assessment of the resident, the Organization will strive to ensure that: 1. A resident who is admitted without a	F688		

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F688	Continued From page 25 limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that reduction of range of motion was unavoidable. 2. A resident with a limited range of motion receives appropriate treatment to increase range of motion and/or to prevent further decrease in range of motion." .	F688		
F689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) 483.25(d) Accidents. The facility must ensure that - 483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and 483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement appropriate interventions to prevent unsafe wandering and elopement for three Residents (R132, R156, & R221) of three residents reviewed for elopement. This deficient practice resulted in continued unsafe supervision and an elopement from the locked memory care unit. Findings include: R132 Review of R132's Electronic Medical Record (EMR) revealed admission to the facility on 11/1/23 with diagnosis including dementia.	F689	F689 Free of Accident Hazards / Supervision / Devices 1. R132 has remained in the secured unit. Access to Elm's secured doors has been limited to direct care staff assigned to the Elm pavilion and all licensed nurses to ensure R132 is not let off the unit. R132 does not ambulate with an assistive device. R156 care plan has been updated with the intervention Direct me to common living areas if I am entering other's rooms. Document wandering behavior and attempted diversional interventions in behavior log. R221 care plan has been updated with the intervention Direct me to common living areas if I am entering other's rooms. Document wandering behavior and attempted diversional interventions in behavior log. I may require 1:1 supervision when unable to participate in diversional activities and if restless as I tend to be very active with walking. R221 has since consulted with psychiatric services through Behavioral Care Solutions and medication changes have been made. 2. All residents have the potential to be affected. 3. Nursing staff has completed education about potential elopements and documentations of elopements and/or	10/10/24

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F689	Continued From page 26 R132's Quarterly Minimum Data Set (MDS) assessment dated 7/5/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated severe cognitive impairment. R132 was also noted on the 11/3/23 Elopement Evaluation to be at risk for elopement due to wandering. On 9/15/24 at 11:55 a.m., R132 was observed participating in an activity prior to lunch. R132 was observed in a seated position with no walker or wheelchair present near him. R132 ambulated to the lunchroom after the activity had concluded. Review of 132's Progress Note dated 8/13/24 read, in part, "CNA (Certified Nurse Aide) staff reported to this nurse that Resident had eloped off the unit without triggering the alarm system. Resident was off the floor for only minutes before CNA staff escorted resident back to the unit. Resident does not express any irritability or negative behaviors. This nurse asked resident where he was trying to go, resident stated "well I saw that guy going over there, so I thought that was the way to go. And then I got all turned around and now here I am ..." A phone interview was conducted with Registered Nurse (RN) "X" on 9/18/24 at 2:27 p.m. RN "X" stated that R132 had eloped off the locked memory care unit on 8/13/24 after being mistaken for a visitor by a dietary aide who let him off the unit. There was no further information or incident/accident report for R132's elopement on 8/13/24. Review of R132's Care Plans read, in part, "The resident is an elopement risk/wanderer r/t (relate	F689	potential elopements. Staff building wide have completed education regarding Elm access and safety measures when entering and exiting the Elm doors. 4. All unplanned resident leaves from secured unit will be reviewed and discussed at daily IDT meetings x 4 weeks to ensure none qualify as elopement from secured unit. Additionally, random audits five times a week will be conducted for no less than fifteen minutes each to ensure residents are not attempting to exit doors unattended or enter other residents rooms. Random audits will then be completed monthly to ensure continued compliance. Audit records will be reviewed by the QAPI committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. 5. Director of Nursing is responsible for sustained compliance.	

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F689	Continued From page 27 to) disoriented to place, resident wanders aimlessly ...Interventions: Monitor location frequently. Document wandering behavior and attempted diversional interventions in behavior log. Date initiated: 11/24/23" R156 Review of R156's EMR revealed admission to the facility on 7/25/24 with diagnosis including dementia. R156's Admission MDS assessment dated 7/31/24 revealed severe cognitive impairment. The 7/31/24 MDS indicated R156 had 1 to 3 days of wandering behavior. On 9/16/24 at 11:25 a.m. R156 was observed wandering on the locked memory care unit. During this time R156 was observed entering into another resident's room, pulled the curtain, and sat on the bed. R156 stayed in this room for approximately 25 minutes before an unidentified staff member began asking if anyone knew where R156 was last seen. Shortly after this, staff member began to check rooms in the other hallways before finding R156 on 9/16/24 at 11:49 a.m. On 9/16/24 at 11:53 a.m., R156 was observed wandering into other resident rooms that were occupied. R156 then walked down to the dining room and attempted to elope out the fire exit door sounding the alarm. Staff were observed responding to the alarms, but no staff were present with R156 at the time. On 9/17/24 at 9:15 a.m., R156 was observed in the dining room for her breakfast meal. R156 would continue to leave the dining room and wander into other residents' rooms down the hall before coming back to take a small bite of food. Staff were unable to redirect R156 to stay for her breakfast.	F689		

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F689	Continued From page 28 On 9/18/24 at approximately 11:30 a.m., R156 was observed sitting on the bed of a male resident while the male resident was sitting in his wheelchair. Review of R156's Care Plan read, in part, "The resident is an elopement risk r/t Disoriented to place, History of attempts to leave facility unattended, impaired safety awareness. Resident wanders aimlessly ...Interventions: Distract resident from wandering by offering pleasant diversion structured activities, food, conversation, television, book; Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Date initiated: 7/24/24 ..." R221 Review of R221's EMR revealed admission to the facility on 9/6/24 with diagnoses including Alzheimer's disease, restlessness, agitation, and anxiety. R221 was noted upon admission to the facility to have severe impaired cognition. On 9/16/24 at 1:37 p.m., R221 was observed wandering through the hallways of the locked memory care unit. During this observation, R221 would enter other residents' rooms, grab various items in the bathroom or bedroom and move or take items that did not belong to her. During this approximately 15-minute observation, staff did not know where R221 was located or intervene with her touching other resident's property. On 9/17/24 at 9:15 a.m., R221 was observed wandering out of the dining room, down the hallway to open a fire exit door. Staff were unable to redirect resident back to the dining	F689		

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F689	Continued From page 29 room to finish her meal. Review of R221's care plan read, in part, "The resident is an elopement risk/wanderer d/t Disoriented to place, impaired safety awareness. Resident wanders aimlessly ...Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Date initiated: 9/6/24 ..." An interview was conducted with Assistant Director of Nursing (ADON) "G" on 9/18/24 at approximately 11:15 a.m. The ADON stated, staff attempt to redirect and supervise all residents on the locked memory care unit, but that it was difficult to keep track of all the residents and tasks. An interview was conducted with the Director of Nursing (DON) on 9/18/24 at 2:21 p.m. The DON confirmed that residents should not be allowed to wander into other residents' rooms. The DON stated staffing continues to be a top priority for the memory care unit. Review of the facility's policy "Elopements" undated read, in part, " ...When a departing individual returns to the Organization, nurse/designee shall: examine the resident for injuries; Notify the Attending Physician; Notify the resident's legal representative (sponsor) of the incident; Complete and file an incident report; and Document the event in the resident's medical record ..."	F689		
F695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F695	F695 Respiratory / Tracheostomy Care and Suctioning 1. Resident #83 oxygen orders have been clarified with specific oxygen parameters.	10/10/24

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F695	Continued From page 30 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide oxygen services per standards of practice for one Resident (#83) out of two residents reviewed for respiratory care. This deficient practice resulted in the potential for hypoxia (oxygen deficiency), respiratory complications, and the potential for re-hospitalization. Findings include: Resident #83 (R83) Review of R83's electronic medical record (EMR) revealed admission to the facility on 8/21/24 with diagnoses including pneumonia, shortness of breath, and sleep apnea (a sleep disorder in which breathing repeatedly stops and starts). Review of R83's Minimum Data Set (MDS), dated 8/27/24, revealed a score of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicative of intact cognition. On 9/16/24 at 2:08 PM, R83 was observed sitting in a recliner in her room with an oxygen concentrator to her left. R83 did not have supplemental oxygen applied. When R83 was asked about her care satisfaction level, R83 stated, "I would like to know what's going on. Am I getting oxygen or not?"	F695	2. The facility has determined that all residents requiring supplemental oxygen have the potential to be affected. 3. An audit has been performed of residents receiving oxygen therapy to ensure appropriate orders and monitoring are in place. Licensed Nursing staff have completed education on appropriate ordering and monitoring of oxygen therapy. 4. Care will be reviewed for a random sample of 3 residents requiring supplemental oxygen per week for 4 weeks to ensure proper use and orders in place. Random audits will then be completed monthly to ensure continued compliance. Audit records will be reviewed by the QAPI committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. 5. Director of Nursing is responsible for sustained compliance.	

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F695	Continued From page 31 On 9/17/24 at 8:01 AM, R83 was observed rolling into the dining room with an oxygen canister secured to the back of her wheelchair. R83 had oxygen applied via nasal cannula (NC). On 9/17/24 at 12:42 PM, R83 was observed in dining room, eating the lunch time meal. R83 did not have supplemental oxygen applied, nor oxygen tubing connected to the oxygen canister. Review of the EMR revealed the following active physician's orders for R83: 1. "Continuous Oxygen 2 L [Liters] via NC," initiated 8/21/24. 2. "Wean O2 [oxygen] as able," initiated 9/4/24. On 9/17/24 at 1:20 PM, R83 was observed sitting in her recliner without oxygen applied. R83 acknowledged feeling, "a little short of breath." On 9/17/24 at 1:28 PM, an interview was conducted with Registered Nurse (RN) "H" who stated he had just reapplied R83's supplemental oxygen because her oxygen saturation was 88%. When asked what the acceptable range of oxygen saturation was for R83, RN "H" stated there were not specific parameters in the physician order, but he personally liked to maintain the oxygen saturation at 92% or above. On 9/18/24 at 3:20 PM, an interview was conducted with Assistant Director of Nursing (ADON) "F" who agreed physician orders for both continuous oxygen and to "wean oxygen as able" were contradictory and confusing for clinical staff. ADON "F" verified supplemental oxygen orders should have defined oxygen saturation parameters to better direct floor staff.	F695		

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F695	Continued From page 32 On 9/18/24 at 3:36 PM, an interview was conducted with the Director of Nursing (DON) who verified orders to wean oxygen should include oxygen saturation parameters. Review of facility policy titled, "Oxygen Therapy," dated 2/2/23, read, in part: " ...Administer oxygen via the nasal cannula/prongs or face mask as ordered by the physician ... observe ... if PRN [as needed] monitor lung sounds and O2 sat [saturation] BID [twice per day] ..."	F695		
F756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) 483.45(c) Drug Regimen Review. 483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. 483.45(c)(2) This review must include a review of the resident's medical chart. 483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist	F756	F756 Drug Regimen Review, Report Irregular, Act On 1. A review of the medication regimen and identified irregularities was conducted by the Director of Nursing Services for residents # R61 & R91. Irregularities were addressed and responses were documented. The physician was notified for those irregularities requiring MD notification. 2. All residents of the facility have the potential to be affected by this practice. 3. A facility procedure regarding the timely review and action taken on identified medication irregularities as a result of the monthly MRR was developed on 10/1/24 by the QAA team. Education has been provided to licensed nursing and providers on timely MRR review and documentation. 4. All MRRs will be tracked x3 months to ensure they are received timely by the provider, orders are processed in applicable, and MRRs are filed in residents chart or EMR. Random audits will then be completed monthly to ensure continued compliance. Audit records will be	10/10/24

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F756	Continued From page 33 identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. 483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Medication Regimen Reviews (MRRs) were addressed by the physician and maintained in the clinical records for two Residents (R61 and R91) of five residents reviewed for MRR. Findings include: Resident #61 (R61) Medication orders for R61 included three different antianxiety medications and an order for melatonin, a medication used for insomnia. The pharmacist MRR on 4/21/24 recommended the physician evaluate R61 to determine if the dosages of the antianxiety medications could be reduced. The report to the physician read, in part: "...If you feel that no GDR (Gradual Dose Reduction) should be attempted, please document your reasoning for clinical contraindication at the bottom of this form or in	F756	reviewed by the QAPI committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. 5. Director of Nursing is responsible for sustained compliance.	

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F756	Continued From page 34 your next progress note..." The portion of the report for the physician's written response to the recommendation was blank, unsigned, and undated. Physician visit notes documented a visit on 5/10/24. The physician documentation did not include reasoning for declining the pharmacist's recommendation for GDR. The pharmacist MRR report to the physician on 7/25/24 recommended a reduction of R61's melatonin dosage. The portion of the report for the physician's written response to the recommendation was blank, unsigned, and undated. The Director of Nursing (DON) was interviewed on 9/18/24 at 4:03 p.m. The DON said there was no documented physician follow-up on the pharmacist's MRR recommendations. The DON said she could not confirm the physician had been provided the pharmacist's recommendations and was not able to provide the documented clinical rationale by the physician for declining the recommendations of the pharmacist. Resident #91 (R91) The Electronic Medical Record (EMR) for R91 revealed an original admission date of 10/2/2019 and recent admission of 1/9/2024 with a primary diagnoses of Lewy body dementia (a type of dementia which affects thinking, memory and movement). The MDS (Minimum Data Set) assessment included a BIMS (Brief Interview for Mental Status) score of 3 of 15 indicating R91 had severe cognitive impairment.	F756		

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	235088	A. BUILDING _____ B. WING _____	C 09/19/2024

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F756	Continued From page 35 The DON provided the pharmacist recommendations (MRRs) for R91 which read in part: " "For Recommendations Created Between 4/1/2024 and 4/30/2024 ... Could a current AIMS (Abnormal Involuntary Movement Scale) assessment be done to monitor?" " "For Recommendations Created Between 5/1/2024 and 6/30/2024 ... Could a current AIMS assessment be done to monitor?" (Two months of recommendations were included in this document.) The EMR did not contain an AIMS following the recommendations above. During an interview on 9/18/24 at 11:25 AM, the DON reviewed the EMR and noted AIMS assessments had been completed for R91 on 11/28/23, 01/2024, 7/11/24 and 8/8/24. No AIMS assessment had been completed after the April pharmacist recommendations and one had not been done until 7/11/24. The DON said, "I was under the impression when pharmacy put the recs (recommendations) in, he did not just say 'see report' (in the EMR), but he also sent them to us ... There was not a follow up (to his recommendations for R91). It is an opportunity for process improvement." The "Pharmacy Consultant Reports Policy" was received on 9/18/24. The document was dated 7/3/2019. It read in part: "Every month, the pharmacist will share the consulting recommendations with the DON. The DON will print the reports and share them ... Additionally, they will provide the ADON with a copy. The provider (physician) is responsible for reviewing the recommendations and either agreeing, disagreeing, or writing an alternate response. Nursing staff is responsible for noting these	F756		

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F756	Continued From page 36 orders and filing the recommendations in the chart under the orders tab. If there is an order, the nurses will need to co-note the order. The ADON will follow-up after one week and ensure all the recommendations have been addressed and filed". .	F756		
F758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) 483.45(e) Psychotropic Drugs. 483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- 483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; 483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; 483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F758	F758 Free from Unnecessary Psychotropic Meds / PRN Use 1. Resident R136 has had PRN Psychotropic medication order updated to link PRN administration to behavior documentation that includes non-pharmacological interventions attempted. 2. All residents have the potential to be affected. 3. PRN Psychotropic medication orders have been updated to link PRN administration to behavior documentation that includes non-pharmacological interventions attempted prior to administration. Licensed nursing staff have completed education on order entry for PRN Psychotropic medications, documentation of targeted symptoms and/or behaviors for all PRN Psychotropic medication administration, and non-pharmacological interventions must be attempted and documented prior to pharmacological interventions. 4. Audits will be randomly conducted on 5 residents per week to ensure PRN Psychotropic medication orders have linked behavior documentation in the order, and PRN Psychotropic medication that has been administered has targeted symptoms and/or behaviors documented with non-pharmacological interventions attempted before administration. Random audits will then be completed monthly to ensure	10/10/24

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F758	Continued From page 37 in the clinical record; and 483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. 483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation of targeted behaviors and use of non-pharmacological interventions prior to administration of as needed anti-anxiety medication for one Resident (#136) of five residents reviewed for unnecessary medications, resulting in the potential for over-medication and decreased quality of life. Findings include: Resident #136 (R136) Review of R136's Minimum Data Set (MDS) assessment, dated 7/23/2024, revealed admission on 4/23/2024 with diagnoses including dementia with psychotic disturbance, depression and anxiety disorder. Further review of the MDS revealed R136 has severely impaired cognition.	F758	continued compliance. Audit records will be reviewed by the QAPI committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. 5. Director of Nursing is responsible for sustained compliance.	

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F758	Continued From page 38 Review of R136's June 2024 through September 2024 Medication Administration Records (MARs) revealed the following order: "Lorazepam (a controlled anti-anxiety medication) Oral Tablet 0.5 MG (milligram). Give 0.5 mg by mouth every 6 hours as needed for anxiety..." Further review of the MARs revealed R136 was administered as needed doses of lorazepam 0.5 mg on the following dates and times: 6/15/2024 at 8:24 a.m. 6/17/2024 at 9:29 a.m. 6/22/2024 at 6:10 a.m. 7/14/2024 at 10:15 p.m. 7/15/2024 at 2:23 p.m. 7/19/2024 at 4:31 p.m. 7/23/2024 at 12:19 p.m. Review of R136's EMR revealed no documentation of the reason for administration for the referenced doses of as needed lorazepam 0.5 mg. No behaviors or symptoms targeted by administration of the medication were observed documented. No use of non-pharmacological interventions prior to administration of the medication were observed documented. During an interview on 9/19/2024 at 8:31 a.m., Assistant Director of Nursing (ADON) "G" reported targeted behaviors and/or indications for use should be documented for each administration of as needed psychotropic medications, including lorazepam. ADON "G" stated use of non-pharmacological interventions should be used prior to the use of any as needed psychotropic medication. During review	F758		

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F758	Continued From page 39 of R136's EMR, including progress notes, evaluations and point of care documentation at the time of the interview, ADON "G" confirmed no documentation of the behaviors targeted by the administration of as needed lorazepam 0.5 mg or use of non-pharmacological interventions on the referenced dates. Review of the facility policy titled, "Psychoactive Medication Use," dated 7/20/2022, revealed the following, in part: "Quality of Life Team will regularly review each resident for possible symptoms of mood and/or behavior changes, with the goal of determining underlying causes. Symptoms will be recorded by staff ... When prn [as needed] psychoactive medication is prescribed, the following steps must be taken ... Prior to administration of prn medication, non-pharmacological interventions must be attempted and proven ineffective ...	F758		
F791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) 483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. 483.55(b) Nursing Facilities. The facility- 483.55(b)(1) Must provide or obtain from an outside resource, in accordance with 483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; 483.55(b)(2) Must, if necessary or if requested, assist the resident-	F791	F791 Routine / Emergency Dental Services in NFs 1. R61 and R49 are schedule to be seen by mobile medical dental services on October 17th (per resident and representative preferences). R56 was provided dental services outside of facility. 2. All residents have the potential to be affected. 3. Licensed nurses and scheduling personnel will be educated on the facilities policies and procedures r/t dental services. Services for Pavilions residents will be provided or obtained for routine and emergency dental needs. In the case of acute dental condition, the facility will take measures to ensure residents will be able to eat and drink while awaiting services. 4. Audits will be randomly conducted	10/10/24

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F791	Continued From page 40 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; 483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; 483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and 483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely dental services were provided for three Residents (R49, R61, and R56) of three residents reviewed for dental services. Findings include: Resident #49 (R49) During an interview on 9/16/24 at 3:14 p.m., R49 said, "I broke my tooth last month." R49 opened her mouth and pointed to the left upper part of the front of her mouth revealing what appeared to be a tooth fragment in the gum line. R49 said	F791	on five residents per week for four to determine the last time resident received dental care, the next time they are scheduled to receive dental care and any outstanding dental issues that have not been addressed. Random audits will then be completed monthly to ensure continued compliance. Audit records will be reviewed by the QAPI committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. 5. Director of Nursing is responsible for sustained compliance.	

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F791	Continued From page 41 she did not know when she would be able to see the dentist. R49 admitted to a history of issues with dentition and said she has went to dental appointments with a dentist in the community but was waiting to see the dentist in the facility. A progress note in the medical record dated 8/16/24 documented, in part: "...Resident had a tooth fall out today...Son has denied consent for inhouse services. Resident is still her own person and would like to consent for those services..." A form "Consent for Services" that included dental services was signed by R49's son on 7/31/24 with a checkmark next to the box that read "I wish to use the services." The social worker (Staff "D") was interviewed on 9/18/24 at 11:02 a.m. Staff "D" said R49 had not been deemed incompetent to make her own decisions and did not have an activated Power of Attorney (POA). Staff "D" said R49 was on the list to be seen by the contracted provider of dental services. When asked the date of the next scheduled visit by the contracted dental provider, Staff "D" said she did not know when the dentist was scheduled. Staff "D" said, "she's on the list, but I don't know a date for the next dental visit." Staff "D" was asked if a community dentist was considered. Staff "D" said she did not schedule an appointment for R49 with a dentist in the community and suggested the nursing department may have made an outside appointment. Staff "D" reviewed documentation and said, "I don't think there was any follow up for an outside appointment. There's none documented." Staff "D" confirmed she was the staff member who usually scheduled dental	F791		

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F791	Continued From page 42 appointments. Resident #61 (R61) During an interview on 9/17/24 at 1:15 p.m., R61said he had a tooth that was causing him a lot of pain. R61 said staff was aware of the toothache and he has been waiting to see the dentist. On 9/18/24 at 2:51 p.m., R61's family member said R61 had been asking to see the dentist for over two weeks because of a tooth that has been causing pain. The family member said, "I've asked but nobody in the building knows when the dental clinic is coming to see him." On 9/19/24 at approximately 7:30 a.m., the Assistant Director of Nursing (ADON) "I" confirmed R61 had not been seen by the dentist. ADON "I" was asked for the list of residents waiting to see the dentist. ADON "I" said someone else had the information and she would obtain the requested information. ADON "I" admitted she did not know the frequency of dental visits or the date of the last dental visit or when the dentist was next due to visit the facility. The staff Scheduler (Staff "J") provided a dental clinic list documented as updated on 9/19/24 at 12:05 p.m. R49, R61, and Resident #56 (R56) were on the list. The list was stamped "Tentative" and had a date of 10/17/24 as the next scheduled visit by the dentist. Resident #56 (R56) On 9/16/24 at 12:17 PM, R56 was observed and was not wearing his dentures. R56 stated he had lost "about 60 pounds" and his dentures did	F791		

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F791	Continued From page 43 not fit. He said the food was hard to chew and he was eating breakfast food like eggs and hashbrowns every meal. R56 said he could chew those. R56 said he recently found out a dentist did come into the building, but he had not seen one. He also said he just found out he could see his own dentist. He said he was going to call his dentist. During an interview on 9/18/24 at 12:33 PM, ADON "U" stated there had been an issue with consents with the contracted provider of dental services. ADON "U" stated R56 needed to have his dentures realigned and he had "not been wearing his dentures for quite some time". ADON "U" stated, "Back in July we reached out to (the contracted provider of dental services)." ADON "U" said she had received an email dated 7/17/24 from social services. The email revealed social services was working with R56 on filling out the needed dental paperwork. However, the social services personnel had changed, and an appointment was not set up. ADON "U" said the dental clinic comes into the building, but R56 was not seen." The medical record included a care plan for R56 which read in part: "Increased Nutrition and Hydration risk r/t (related to) dx (diagnoses) ... AEB (as evidenced by) significant weight loss, edentulous (dentures do not fit), hx (history) of refusing weights/skin assessments, variable meal intake, and risk for further weight/fluid/skin changes." There was a further related care plan which read in part: "ORAL CARE: (R56) has upper/lower dentures. (R56) requires oral inspection daily Report changes to the Nurse." The medical record included Registered Dietitian (RD) progress notes which read in part:	F791		

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F791	Continued From page 44 - "4/10/24 RD High Risk review ... triggering for significant weight loss x 1 month and x 3 months Weights:12/24/23 220# (pounds) ...3/15/24 183.8# ...4/9/24 174#..." - "5/31/24 RD Quarterly/High Risk ... Continues to show sig (significant) weight loss from admission weights, but stable 165=169# over the past month Weights: 3/15/24 admission 183.8#...4/26/24 173# ... 5/31/24 166.6# ..." - "8/15/2024 Note Text: ...met with resident this afternoon to follow-up on any further food concerns. Resident requesting to have cheese omelets with ham and mushrooms (well done) with hashbrowns for all meals in addition to his scheduled boosts (supplement). Plan: RD updated preferences and meal to ticket with requested items. RD continues to follow resident monthly r/t high risk..." Resident Care Policies dated 3/20/24 were presented. The "Dental Services" policy embedded in this set of policies read in part: "A. The Organization will assist residents in obtaining routine and twenty-four (24) hour emergency dental care. B. Residents are encouraged to use good dental hygiene. Nursing employees provide routine oral hygiene to those residents who are unable to do so. C. An Organization designee will assist residents with transportation arrangements to and from the dentist's office. D. The Organization has arrangements for emergency dental services." .	F791		
F812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) 483.60(i) Food safety requirements. The facility must -	F812	F812 Food Procurement, Store, Serve Sanitary 1. All residents are affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice.	10/10/24

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F812	Continued From page 45 483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. 483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among any and all 164 residents of the facility. Findings include: On 9/16/24 at approximately 11:10 AM, kitchen staff were observed in the kitchen, near the dish washing area removing trays containing soiled dishes, utensils and uneaten food from wheeled Cambro insulated transport carts. These carts were returned to the kitchen with trays removed from residents' eating areas. Once the soiled trays, utensils and uneaten food were removed from the wheeled transport carts, the carts were relocated to an unused dining area west and adjacent to the kitchen. No cleaning of the carts	F812	3. Education was given to the dietary staff on P&P for Food Safety Requirements and Professional Standards for food service safety. This included the process for cleaning and sanitizing the food transport carts: Thoroughly spray the entire interior of the cart with Spartan Sani T-10 Plus sanitizing solution. Keep the doors open, allow surfaces to air-dry for the required contact (dwell) time. Verify that the sanitizer has completely dried inside the cart before use. The pre-clean inspection requires removal of any trash or leftover food from the cart. Cleaning of the exterior of the transport carts included the use the approved detergent on all exterior surfaces, edges and handles. Training also included instruction on proper hand washing immediately before engaging in food preparation as well as the proper cleaning of transport carts following the removal of soiled trays and uneaten food. 4. Random weekly audits will be conducted of proper handwashing immediately before engaging in food preparation and the proper cleaning of transport carts following the removal of soiled trays and uneaten food. Audits will be reviewed by the QAPI committee monthly until such time that consistent, substantial compliance has been achieved as determined by the committee. 5. The Director of Nutrition Services is responsible for sustained compliance.	

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F812	Continued From page 46 had been conducted following the removal of the soiled trays and uneaten food. At approximately 11:35 AM Food Service Worker (FSW) "B" was observed filling a small bucket from a disinfectant dispenser in the kitchen and going to the unwashed carts in the adjacent area. FSW "B" then was observed dabbing a few areas inside two carts coming in contact with less than 2% of the surface area of the internal portions of the cart. At approximately 11:38 AM, Kitchen Manager (KM) "A" was requested to watch FSW "B" conducting the activity at the carts through the window of the door between the kitchen and the carts. FSW "B" again dabbed a few spots on the interior of a third cart, closed the door and opened the door to a fourth cart. An interview with KM "A" at this time was conducted who stated that the process of cleaning the carts by FSW "B" was inappropriate. KM "A" stated he would speak to FSW "B" and ensure the carts were properly sanitized before being used for the transportation of the noon meal trays to residents. The FDA Food Code 2017 states: 4-603.15 Washing, Procedures for Alternative Manual Warewashing Equipment. If washing in sink compartments or a WAREWASHING machine is impractical such as when the EQUIPMENT is fixed or the UTENSILS are too large, washing shall be done by using alternative manual WAREWASHING EQUIPMENT as specified in 4-301.12(C) in accordance with the following procedures: (A) EQUIPMENT shall be disassembled as necessary to allow access of the detergent solution to all parts; (B) EQUIPMENT components and UTENSILS shall be scraped or rough cleaned to remove FOOD particle accumulation; and	F812		

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F812	Continued From page 47 (C) EQUIPMENT and UTENSILS shall be washed as specified under 4-603.14(A). On 9/16/24 at approximately 12:55 PM, Cook "C" was observed washing his hands and drying with a paper towel. Cook "C" then pushed down on the swivel top trash container with his bare hands, disposed of the towel and returned to serving line. The FDA Food Code 2017 States: 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (I) After engaging in other activities that contaminate the hands.	F812		
F825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) 483.65 Specialized rehabilitative services. 483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at 483.120(c), are required in the resident's comprehensive plan of care, the facility must- 483.65(a)(1) Provide the required services; or 483.65(a)(2) In accordance with 483.70(g), obtain the required services from an outside	F825	F825 Specialized Rehab Services 1. Resident #119 was evaluated by occupational therapy. 2. All residents with therapy services could be affected. 3. Education was given to therapy staff on P&P for Therapy Services to be followed per physician orders. Nurses were educated on following physician orders and the need to follow-up when orders are not implemented. 4. Random weekly audits will be conducted of residents with orders for therapy services to ensure substantial compliance. Audits will be reviewed by the QAPI committee monthly until such time that consistent, substantial compliance has been achieved as determined by the	10/10/24

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F825	Continued From page 48 resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: . Based on observation, interview and record review the facility failed to follow to evaluate and treat one resident (R119) of two residents reviewed for therapy services. This deficient practice caused R119 to be uncomfortable each day when she sat in her wheelchair. Findings include: On 9/16/24 at 12:52 PM, R119 was observed seated in a high back wheelchair with her legs elevated and fully extended. R119's feet were observed pushed up against the foot cradle. R119 stated, "This chair is too long. It is uncomfortable." The Electronic Medical Record (EMR) was reviewed. On 8/7/2024 at 13:32 (1:32 PM) a progress note was written titled: "Therapy Communication to Nursing" and read, "Note Text: Recommend OT (occupational therapy) eval and tx (treatment orders) to address positioning. The EMR also contained a physician order written on 8/8/24 which read, "OT to evaluate and treat if indicated." During an interview on 09/18/24 at 4:50 PM, Physical Therapist (PT) "N" stated there should be an OT screen and evaluation, but PT "N" looked in the EMR for R119 and did not find these OT documents. PT "N" stated, "We did not do it."	F825	committee. 5. The Director of Rehabilitation is responsible for sustained compliance.	

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F825	Continued From page 49 During an interview on 9/19/24 at approximately 10:00 AM, the Director of Nursing (DON) stated she would expect the nursing staff to follow up on physician orders.	F825		
F849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) 483.70(o) Hospice services. 483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. 483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in 418.112 (d) of this chapter.	F849	F849 Hospice Services 1. R137 has received a hospice visit since survey, it is documented in the resident's chart, and the resident's representative has been updated. 2. All residents on hospice have the potential to be affected. 3. The facility will communicate with hospice to ensure that contractual agreements are being met and appropriate documentation is being provided. Facility will review documentation to ensure hospice is communicating with resident representatives. 4. All residents that are served by Hospice will be audited weekly to ensure hospice is meeting contractual agreements and providing appropriate documentation x 4 weeks. Random audits will then be completed monthly to ensure continued compliance. Audit records will be reviewed by the QAPI committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. 5. The Director of Nursing is responsible for sustained compliance.	10/10/24

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F849	Continued From page 50 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility	F849		

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F849	Continued From page 51 personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. 483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness,	F849		

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F849	Continued From page 52 related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. 483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at 483.24.	F849		

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F849	Continued From page 53 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure collaboration and communication between the facility and hospice provider for one Resident (R137) of one resident reviewed for hospice services. This deficient practice resulted in gaps in communication for coordination of care. Findings include: Review of R137's Electronic Medical Record (EMR) revealed admission to the facility on 1/11/24 with diagnoses including Alzheimer's disease, dementia with behavioral disturbance, and dysphagia. Review of R137's 6/26/24 Minimum Data Set (MDS) assessment revealed he was unable to complete the Brief Interview for Mental Status (BIMS) and had severely impaired cognition. R137 was admitted to the facility on hospice services and had a Designated Power of Attorney (DPOA) for medical and financial decisions. On 9/16/24 at 1:40 p.m. an interview was conducted with R137's DPOA, who stated there is a lack of communication between R137's hospice services and the facility. The DPOA stated, "I know that they are here, but I don't know what's happening." Review of R137's "IDG (Interdisciplinary Group) Meeting Review" written on 8/14/24 read, in part, " ...RN (Registered Nurse) 1x (time)/week, HHA (hospice health aide) 1x/week. Patient is a 69 year-old with diagnosis of Alzheimer's disease ...patient is non-verbal, unable to make his needs know ...dependent of 6/6 ADL's (activities of daily living) ...certification period 8/5/24-10/3/24 ..."	F849		

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F849	Continued From page 54 On 9/18/24 at 3:30 p.m. an interview was conducted with Assistant Director of Nursing (ADON) "G" who stated that R137's Hospice Notes would be in the [Hospice Name] binder located at the nurse's station. During observation and review of this folder, there were only two documented hospice visits in August 2024. ADON "G" stated hospice staff are visiting R137 and that the wife knew there was a care conference. A request was made for R137's hospice visit notes since 8/5/24. Review of R137's Hospice Notes from 8/5/24 through 9/19/24 revealed two hospice visits on 8/16/24 and 8/23/24. An interview was conducted with the Director of Nursing (DON) on 9/19/24 at 11:30 a.m. The DON confirmed there was no additional documentation from R137's hospice provider since 8/23/24. Review of the facility's "[Hospice Name] Standing Nursing Home Hospice Care Agreement" dated 3/16/22 read, in part, "Hospice will provide and document the following information to the Facility in accordance with the Coordination of Care protocols established with the Facility to facilitate coordination of care: ...a clinical summary of each nursing, social work and spiritual care visit made by Hospice staff members to each Hospice Patient, visits to each Hospice patient by Hospice aides ...Facility Coordination of Care: Facility shall designate a member of the Facility's interdisciplinary team who is responsible for working with Hospice representatives to coordinate care provided to the Hospice Patient by the Facility staff and Hospice staff ...the designated interdisciplinary team member is responsible for the following:	F849		

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F849	Continued From page 55 Collaborating with Hospice representatives and coordinating Facility staff participation in the Hospice care planning process for Hospice Patients ..."	F849		
F867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) 483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: 483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. 483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at 483.70(e) and including how such information will be used to develop and monitor performance indicators. 483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. 483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate,	F867	F867 QAPI / QAA Improvement Activities 1. The facility will adhere to their QAPI Policy regarding Adverse Events. 2. All residents have the potential to be affected 3. Members of the IDT have been educated on the need to perform a root cause analysis on Adverse Events and follow through with QAPI recommendations to prevent resident harm. 4. Incidents identified by IDT as meeting criteria for an Adverse Event (defined in 483.5 as an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof) will be logged by the Director of Nursing or designee, have a root cause analysis completed, analysis reviewed by the QAPI Committee monthly, and performance improvement measures implemented as applicable to each event. 5. Staff Development Coordinator is responsible for sustained compliance.	10/10/24

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F867	Continued From page 56 analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. 483.75(d) Program systematic analysis and systemic action. 483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. 483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. 483.75(e) Program activities. 483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. 483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms	F867		

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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 _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F867	Continued From page 57 that include feedback and learning throughout the facility. 483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at 483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. 483.75(g) Quality assessment and assurance. 483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement an effective Quality Assurance & Performance Improvement (QAPI) program that included development, monitoring,	F867		

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F867	Continued From page 58 and evaluation of adverse events to correct quality deficiencies and maintain sustained compliance. This deficient had the potential to affect all 164 residents in the facility. Findings include: On 9/19/24 at 10:10 AM, an interview was conducted with Registered Nurse (RN)/Staff Educator "P" who verified she oversaw the QAPI process. When asked if adverse events such as a death in the facility, were reviewed in QAPI. RN/Staff Educator "P" stated these events were discussed in Interdisciplinary Team (IDT) meetings but not in QAPI. RN/Staff Educator "P" verified she considered an unexpected death an adverse event but, "It's just something we never really discussed [in QAPI]." RN/Staff Educator "P" was unable to explain how medical errors or adverse resident events were identified, analyzed, corrected, or monitored to ensure desired outcomes throughout the QAPI process. Review of facility policy titled, "Quality Assurance Performance Improvement Plan," reviewed 7/12/24 read, in part: " ... [Facility Name] has a Performance Improvement Program which systematically monitors, analyzes and improves its performance to improve resident/patient outcomes ...The following data is monitored through QAPI (not limited to): ...Adverse events ... Daily interdisciplinary team (IDT) notes are reviewed including adverse events/complaints on a daily basis. We have a mechanism for communicating patterns, trends identified during IDT meetings to the broader QAPI Committee ..."	F867		

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E000	Initial Comments On September 17, 2024, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Grand Traverse Pavilions was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E000		

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Electronically Signed | 10/07/2024

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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K000	INITIAL COMMENTS On September 17, 2024, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Grand Traverse Pavilions was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 482.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a two story building of type II (111) construction, built in 1997. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 240 certified beds. At the time of the survey the census was 166.	K000		
K293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by:	K293	K293 Exit Signage 1. Removed Exit sign and replaced ceiling tile in Beech Gym on 09/19/2024. 2. Exit sign was in place for an old entrance into building that is no longer there. a. All exits from Beech gym were checked for proper signage on 09/19/2024. 3. Staff were in-serviced on removal of sign and correct signage in place for current exits on 09/20/2024. 4. Environmental Services Director will conduct periodic inspections of the facility and ensure current monthly work order inspections have been completed.	10/10/24

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	Electronically Signed	10/07/2024

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K293	Continued From page 1 Based on observation and interview, the facility failed to provide exit signage as required by NFPA. This deficient practice could affect approximately 10 occupants in the event of a fire emergency. Findings Include: On September 17, 2024, at approximately 11:08 AM, observation revealed EXIT sign in the Beech Gym is positioned so that it does not direct people to a clear exit egress door and if the treatment divider curtain is pulled closed the EXIT sign is obscured from visibility per NFPA 101, 19.2.10 & 7.10. The findings were confirmed through interview with the Environmental Services Manager at the time of observation.	K293	Any concerns will be addressed immediately and reported to the QAPI committee monthly meeting. 5. The Environmental Services Director will ensure compliance.	
K321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K321	K321 Hazardous Areas 1. Removed and stored all extra laundry and trash can carts from Birch, Cherry and Dogwood exit corridors on 09/23/2024. 2. Completed inspection of Elm and Maple exit corridors on 09/23/2024. 3. Staff were in-serviced on exit corridor requirements and proper storage of laundry and trash can carts. 4. Environmental Services Director will conduct periodic inspections of the facility and ensure current monthly work order inspections have been completed. Any concerns will be addressed immediately and reported to the QAPI committee monthly meeting. 5. The Environmental Services Director will ensure compliance.	10/10/24

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K321	Continued From page 2 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide Hazardous areas protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. This deficient practice could potentially affect occupants, staff and visitors within the smoke compartment in the event of a fire due to the increase combustible fuel load in the exit corridor at the time of a fire. Findings Include: On 9/17/24 between 10:30 AM and 3:00 PM, during a tour of the facility, observation revealed laundry and trash carts with contents stored in the exit corridor of unit halls birch, cherry and dogwood. This finding was confirmed by	K321		

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K321	Continued From page 3 interview with facility Maintenance #1 at the time of observation. As required by 8.7.1.1	K321		
K324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure cooking facilities are protected in accordance with NFPA 96, unless meeting the requirements of 19.3.2.5.2, 19.3.2.5.3 or 19.3.2.4.4, as required by 19.3.2.5.1 through 19.3.2.5.5, 9.2.3 and TIA 12-2. This deficient practice could potentially affect kitchen staff and occupants in the nearest smoke compartment at the time of a fire within the kitchen at the hood	K324	K324 Cooking Facilities 1. Moved trash can away from griddle and out from underneath kitchen hood on 09/18/2024. 2. Inspected all cooking areas for combustible materials on 09/18/2024. 3. Staff were in-serviced on proper placement of combustible materials in all cooking areas on 09/23/2024. 4. Environmental Services Director will conduct periodic inspections of the Kitchen and ensure current monthly work order inspections have been completed. Any concerns will be addressed immediately and reported to the QAPI committee monthly meeting. 5. The Environmental Services Director will ensure compliance.	10/10/24

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K324	Continued From page 4 where ordinary combustibles are stored.. Findings Include: On 9/17/24, at approximately 2:15 PM, observation revealed a twenty gallon plastic trash container full of combustible trash items stored underneath the kitchen hood between the griddle and large soup kettle located in the main kitchen. This finding was confirmed by interview with the facility Environmental Services Manager at the time of observation. As required by 9.2.3 and NFPA 17 A	K324		
K353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K353	K353 Sprinkler System 1. a. Replaced all 4 spare fire sprinkler boxes with 2 large boxes for a total of 72 available slots for the 66 spare sprinklers on 09/30/2024. b. Scheduled inspection and replaced all gauges in fire pump room on 10/07/2024. 2. Updated spare sprinkler inventory sheet and labeled all gauges with install date. 3. Staff were in-serviced on new spare sprinkler layout and 5-year requirements on all fire pump room gauges. 4. Environmental Services Director will conduct quarterly reviews of spare sprinkler boxes report. Any concerns will be addressed immediately and reported to the QAPI committee monthly meeting. 5. The Environmental Services Director will ensure compliance.	10/10/24

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K353	Continued From page 5 failed to provide sprinkler system maintenance and testing as required by NFPA. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: 1. On September 17, 2024, at approximately 11:25 AM, observation revealed four spare sprinkler boxes in the fire pump room, in two of the spare sprinkler boxes there are several spare sprinkler heads unsecured laying in the bottom of the sprinkler boxes leaving the spare sprinkler heads prone to damage. 2. On September 17, 2024, at approximately 11:01 AM, observation revealed sprinkler gauges in the fire pump room were dated 2019, with not marking of installation date. Sprinkler gauges shall be recalibrated or replaced every 5-years, per NFPA 25, 5.3.2.1. These findings were confirmed through interview with the Environmental Services Manager at the time of observation.	K353		
K374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging	K374	K374 Subdivision of Building Spaces 1. Adjusted Aspen room 106/107 door latch and striker plate on 10/01/2024. 2. Inspected all doors on Aspen, Birch, Cherry, Dogwood, Elm and Maple for proper operation. 3. Staff was in-serviced on door latch requirements. 4. Environmental Services Director will conduct periodic inspections of the facility and ensure current monthly work order inspections have been completed. Any concerns will be addressed immediately and reported to the QAPI committee monthly meeting. 5. The Environmental Services	10/10/24

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K374	Continued From page 6 or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors in smoke barriers are 1-3/4 inch solid bonded wood-core doors or construction that resists fire for 20 minutes, are self-closing or automatic-closing and provide a minimum width of 32 inches as required by 19.3.7.6, 18.3.7.8 and 19.3.7.9. This deficient practice could potentially affect occupants within the smoke compartment in the event the smoke barrier doors failed to prevent the passage of smoke to the adjacent smoke compartment at the time of a fire. Findings Include: On 9/17/24 at approximately 10:10 AM, observation revealed the cross corridor smoke doors located at aspen hall near rooms 106/107 failed to completely close during testing. This finding was confirmed by interview with the facility Maintenance #1 at the time of observation. As required by 19.3.7.8	K374	Director will ensure compliance.	
K511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by:	K511	K511 Utilities 1. Replaced Cooler plug and ceiling outlet with locking plug to prevent strain on cord on 10/01/2024. 2. Inspected all Kitchen electrical equipment cords for evidence of cord strain. 3. Staff were in-serviced on requirements for electrical equipment. 4. Environmental Services Director will conduct periodic inspections of the Kitchen and ensure current monthly work order inspections have been completed. Any concerns will be addressed	10/10/24

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K511	Continued From page 7 Based on observation and interview, the facility failed to provide electrical equipment as required by NFPA 70. This deficient practice could affect approximately 15 occupants in the event of a fire emergency. Findings Include: On September 17, 2024, at approximately 14:25 PM, observation revealed two drawer cooler near the cook's line in the kitchen plugged into the ceiling without a strain relief. The electrical plug showed signs of tension on the electrical plug which could cause arching. These findings were confirmed through interview with the Environmental Services Manager at the time of observation.	K511	immediately and reported to the QAPI committee monthly meeting. 5. The Environmental Services Director will ensure compliance.	
K521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on records review and interview, the facility failed to provide and maintain heating, ventilating, and air conditioning systems in accordance with LSC Sections 19.5.2.1, 9.2 and NFPA 90A. This deficient practice could potentially affect all occupants of the facility in the event of a fire damper failure. Findings include: On 9/17/24 between 9:30 am and 3:30 pm, during the review of facility records, there was	K521	K521 HVAC 1. Scheduled and completed 4-year inspection and testing of all mechanical fire dampers. 2. Updated building layout with correct locations of all mechanical fire dampers and installed tags with current inspection date. 3. Staff was in-serviced on mechanical dampers operation and access to updated map with correct locations. 4. Environmental Services Director will ensure all mechanical damper locations are correctly labeled with date of inspection. Any concerns will be addressed immediately and reported to the QAPI committee monthly meeting. 5. The Environmental Services Director will ensure compliance.	10/10/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235088	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K521	Continued From page 8 no documentation provided for the 4-year fire damper inspection and testing which is violation of NFPA 80, 19.4.1. These findings were confirmed in an interview with the Environmental Services Director at the time the records were reviewed.	K521		
K522 SS=E	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure any heating device other than a central heating plant is designed and installed so combustible materials cannot be ignited by the device, has a safety feature to stop fuel and shut down the equipment if there is excessive temperature or ignition failure and meets all additional provisions as required by 19.5.2.2. This deficient practice could potentially affect the occupant within the room and others within the smoke compartment in the event the electric heating devices fails or malfunctions and causes a fire. Findings Include:	K522	K522 HVAC Any Heating Device 1. Removed heating pad from Cherry room 320/321 on 09/18/2024. 2. Completed walk through of all resident rooms to ensure no heating devices were used. 3. Staff was in-serviced on the use of any heating devices in resident rooms other than building heat. 4. Environmental Services Director will conduct periodic inspections of the facility and ensure current monthly work order inspections have been completed. Any concerns will be addressed immediately and reported to the QAPI committee monthly meeting. 5. The Environmental Services Director will ensure compliance.	10/10/24

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	235088	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/17/2024

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GRAND TRAVERSE PAVILIONS	**1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684**

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K522	Continued From page 9 On 9/17/24 at approximately 11:30 AM, observation revealed a heating pad in a large recliner chair with a covering, the heating pad located at cherry hall in room 320/321 was unattended. The heating pad was observed plugged into the electrical outlet near the reclining chair. This finding was confirmed by interview with the facility Maintenance #1 at the time of observation. As required by 19.5.2.2	K522		
K920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K920	K920 Electrical Equipment Power Cords 1. Removed multi-plug outlet adapter from Birch room 218/219 on 09/18/2024. 2. Completed walk through of all resident rooms to ensure no unauthorized multi-plug outlet adapters are used. Staff was in-serviced on the requirements for using any power strips or adapters. 3. Environmental Services Director will conduct periodic inspections of the facility and ensure current quarterly work order inspections have been completed. Any concerns will be addressed immediately and reported to the QAPI committee monthly meeting. 4. The Environmental Services Director will ensure compliance.	10/10/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235088	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/17/2024

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K920	Continued From page 10 failed to ensure power strips are listed for the area in which they are used as required by 10.2.3.6 of NFPA 99, 400-8 of NFPA 70 and TIA 12-5, and extension cords are placed in use only temporarily as required by 10.2.4 of NFPA 99 and 590.3(D) of NFPA 70. This deficient practice could potentially affect the occupant within the room and other occupants within the smoke compartment in the event of an electrical fire as a result of the use of non-approved outlet adapters. Findings Include: On 9/17/24 at approximately 11:03 AM, observation revealed a multi-plug cubed electrical receptacle adapter plugged into an electrical receptacle in room 218/219 located at birch hall. This finding was confirmed by interview with the facility Maintenance #1 at the time of observation. As required by NFPA 99, 10.2.4	K920		

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