GRAND TRAVERSE COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES BOARD

REGULAR MEETING
February 23, 2023

Open to the public
9:00 AM Garfield Township Hall – Upstairs Main Hall
3848 Veterans Dr, Traverse City, MI 49684

Persons with disabilities which the foregoing opportunities for participation will not address should contact Darcey Gratton at (231) 932-3010 or dgratton@gtpavilions.org with questions or concerns.

AGENDA

1. **CALL TO ORDER** – 9:00 a.m. Garfield Township Hall – Cecil McNally, Chair, Grand Traverse County Department of Health and Human Services Board

2. **ROLL CALL** the member must announce his or her physical location by stating the county, city, township, or village and state from which he or she is attending the meeting remotely.

3. **FIRST PUBLIC COMMENT**
   Any person shall be permitted to address a meeting of the Grand Traverse County Department of Health and Human Services Board which is required to be open to the public under the provisions of the Michigan Open Meetings Act, as amended. (MCLA 15.261, et.seq.) Public comment shall be carried out in accordance with the following Board Rules and Procedures:
   1. Any person wishing to address the Board shall state his or her name and address.
   2. Persons may address the Board on matters which are relevant to Grand Traverse Pavilions issues.
   3. No person shall be allowed to speak more than once on the same matter, excluding time needed to answer Board Members questions. The Chairperson shall control the amount of time each person shall be allowed to speak, which shall not exceed three (3) minutes.
      a) Chairperson may, at his or her discretion, extend the amount of time any person is allowed to speak.
      b) Whenever a group wishes to address the Board, the Chairperson may require that the group designate a spokesperson; the Chairperson shall control the amount of time the spokesperson shall be allowed to speak, which shall not exceed fifteen (15) minutes.

   The Board shall not comment or respond to a person who is addressing the Board. Silence or non-response from the Board should not be interpreted as disinterest or disagreement by the Board.

   Please be respectful and refrain from personal or political attacks.

4. **COUNTY LIAISON REPORT**

5. **APPROVAL OF AGENDA**

6. **CONSENT CALENDAR**
   The purpose of the consent calendar is to expedite business by grouping items to be dealt with by one Board motion without discussion. Any member of the Board, or staff may ask that any item on the consent calendar be removed and placed elsewhere on the agenda for discussion. Such requests will be automatically respected.

If any item is not removed from the consent calendar, the item on the agenda is approved by a single Board action adopting the consent calendar.

			HANDOUT#
A.	Review and File		
	(1)	Minutes of the 1/26/23 Board Meeting	1
	(2)	Closed Minutes of the 1/26/23 Board Meeting	Handout
	(3)	Minutes of the 2/15/23 Board Meeting	2
	(4)	Closed Minutes of the 2/15/23 Board Meeting	Handout

7. ITEMS REMOVED FROM CONSENT CALENDAR

(1)

8. GRAND TRAVERSE MEDICAL CARE – Rose Coleman

A.	General Information		
	(1)	August 2022 Annual State Survey	3
	(2)	OPEB Accounting Report	4
B.	Chief Executive Officer Board Report		5
C.	Business		
	(1)	Financials - added	
D.	General Discussion		
	(1)		

G.T.P. Announcements

	(1)	Next Board Meeting March 30, 2023	
	(2)	January Service Excellence Award	6

9. SECOND PUBLIC COMMENT

Refer to Rules under First Public Comment above.

10. CLOSED SESSION

(1)

11. ADJOURNMENT

GRAND TRAVERSE COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES BOARD

1000 Pavilions Circle, Traverse City, MI 49684

MINUTES OF THE JANUARY 26, 2023 MEETING

PRESENT:	Cecil McNally, Gordie LaPointe, Mary Marois	Board
	Rose Coleman, Lindsey Dood, Holly Kazim, Diane Mallory	Staff
	Darcey Gratton	
	Penny Morris	Commission
ABSENT:		

GUESTS:

The regular meeting of the Grand Traverse County Department of Health and Human Services Board was called to order at 9:01 am by Board Chair Cecil McNally at the Garfield Township Hall.

First Public Comment

Claudia Bruce
Andi Gerring
Greg Kish
Nicole Farkas
Robert Barnes

Approval of Agenda – Chair McNally asked if there were additions, changes or corrections to the agenda. Motion was made by Marois to approve the Agenda as presented, seconded by LaPointe and carried unanimously.

The purpose of the **Consent Calendar** is to expedite business by grouping items to be dealt with by one Board motion without discussion. Any member of the Board or staff may ask that any item on the **Consent Calendar** be removed and placed elsewhere on the agenda for discussion. Such requests will be automatically respected.

REVIEW AND FILE

(1) Minutes of the 12/29/22 Board Meeting
(2) Closed Minutes of the 12/29/22 Board Meeting
(3) Minutes of the 1/6/22 Board Meeting
(4) Closed Minutes of the 1/6/22 Board Meeting
(5) Minutes of the 1/12/23 Board Meeting

Motion was made by LaPointe to approve the Consent Calendar as presented. Motion seconded by Marois and carried unanimously.

Items Removed From Consent Calendar – none

Morris in 9:10 am

PACE Executive Director Report & Financials – Coleman asked if there were any questions on the PACE North Executive Director's report and financials for January and stated she planned on bringing the report quarterly. LaPointe thanked new Executive Director Nicole Farkas on the amount of detail provided in the report.

Fourth Quarter Overtime Report – Coleman reviewed the report and answered board member's questions.

Dining Services – Coleman stated GTP continues to work through contractual dining services and noted there has been a slight improvement.

Chief Executive Officer Report – Coleman reviewed the CEO monthly report for December and answered board member's questions. The board agreed to meet twice a month . Adding 2nd Thursday's of every month to discuss specific items in more detail. Coleman stated strategic planning is scheduled for discussion for the first meeting in February. Dood stated that December's financials will be brought to the February meeting.

PACE Board Appointments – The Board reviewed a total of eleven candidates for the six open PACE Board seats. All previous PACE Board members up for renewal, re-submitted their letter of intent and resumes which included, Kory Hansen, Bob Schlueter, Linda Root, Dr. James Whelan, Elizabeth Aderholdt and Greg Kish. Other local candidates included Robert Barnes, Dawn McLaughlin, Marie Manty, Tom Mair and Lana Payne. The board shared who they interviewed and qualifications for each candidate. To determine who would be on the PACE North Board, each DHHS Board member submitted their top six candidates to Gratton to tally up all votes during a recess. Hansen, Schlueter, Root, Aderholdt and Kish all received three votes from the DHHS Board. Candidate Robert Barnes received two votes from Lapointe and Marois. Payne received one vote from McNally. After sharing their support for both candidates, it was decided by the full board to move forward with Barnes to take the sixth PACE Board Seat. Motion was made by Marois to accept Hansen, Schlueter, Root, Aderholdt, Kish and Barnes to fill the six open PACE North Board seats for 2023. Seconded by LaPointe and carried unanimously.

General Discussion – none

Nichole Kelenske, NP – Attending Privileges - Coleman reviewed the request of Nichole Kelenske, NP, to have attending privileges as recommended by Medical Director Dr. April Kurkowski, M.D. Nichole is joining Sound Physicians, to serve nursing homes and assisted living facilities. Motion was made by Marois to approve Nichole Kelenske, NP, for attending privileges, seconded by LaPointe and carried unanimously.

Grand Traverse Pavilions Announcements

(1) December Service Excellence Award - Coleman reviewed weekly winners

Second Public Comment

Claudia Bruce
Andi Gerring
Deb Jackson
Robert Barnes

Motion was made by Marois seconded by LaPointe to go into Closed Session at 10:58 am for the purpose of discussing Resident Quarterly Incidents and QAPI Quarterly Update which includes discussion of Protected Health Information.

Roll Call - McNally - yes, LaPointe – yes, Marois - Yes

Motion was made by Marios to come out of Closed Session at 11:25 pm, seconded by LaPointe and carried unanimously.

Meeting adjourned at 11:25 pm

Signatures:

_____
Cecil McNally – Chair
Grand Traverse County Department of Health and Human Services Board

_____
Rose Coleman, Assistant-Secretary

Date: _____ Approved
_____ Corrected and Approved

DRAFT

GRAND TRAVERSE COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES BOARD

1000 Pavilions Circle, Traverse City, MI 49684

MINUTES OF THE FEBRUARY 15, 2023 MEETING

PRESENT:	Cecil McNally, Gordie LaPointe, Mary Marois	Board
	Rose Coleman, Lindsey Dood, Holly Kazim, Diane Mallory	Staff
	Darcey Gratton, Elissa Riffle	
ABSENT:	Penny Morris	Commission
GUESTS:	Rob Long, Plante Moran, Steve Wolock of Maddin Hauser (virtual) and Jeff Segal of Warner Norcross + Judd (virtual)	

The regular meeting of the Grand Traverse County Department of Health and Human Services Board was called to order at 9:00am by Board Chair Cecil McNally at the Garfield Township Hall.

First Public Comment - None

Approval of Agenda – Chair McNally asked if there were additions, changes or corrections to the agenda. Coleman requested to move the Business items first on the agenda due to the strategy analysis review and add Dining Services contract under B. (2). Motion was made by Marois to approve the Agenda with the additions/changes as presented, seconded by LaPointe and carried unanimously.

The purpose of the **Consent Calendar** is to expedite business by grouping items to be dealt with by one Board motion without discussion. Any member of the Board or staff may ask that any item on the **Consent Calendar** be removed and placed elsewhere on the agenda for discussion. Such requests will be automatically respected.

REVIEW AND FILE – None

Financial Report – Dood presented the financial operations and social accountability reports for December 2022 and offered to answer any questions. Motion made by Marois to accept the financial operations report as presented. Motion seconded by LaPointe and carried unanimously.

Dining Services – Coleman reviewed the final dining services contract with Forefront and highlighted on their guaranteed pricing with no overages and much faster grievance process if there happened to be any concerns with quality and cleanliness. Marois requested for monthly updates on the Dining Services for the first six months following their official start date on April 14, 2023. LaPointe offered to do a site visit before Coleman signs off on the contract. Motion made by Marois to accept the contract with Forefront Healthcare pending a site visit by Lapointe to determine what Forefront satisfaction level is before the contract is signed. Motion seconded by LaPointe and carried unanimously.

Guest Presentation – Rob Long, Plante Moran – Long shared he is a partner with Plante Moran and has been with the firm since 1992. Long is part of the management consulting group with the focus on long-term healthcare. Long reviewed the Plante Moran Edge benchmarking

report that was shared with the board in November of 2022 and answered board members questions. Long also reviewed a handout of Plante Moran's Strategic Analysis of December 2022 and highlighted market assessment and financial sustainability regarding occupancy trends and work force challenges in the area. Long gave an overview of interviews with key community members.

Kazim, Mallory, Gratton, Riffle and Long out 10:45am

Motion was made by Marois seconded by LaPointe to go into Closed Session at 10:45 am for the purpose of closed session pursuant to section 8(h) of the Open Meetings Act to consider material exempt from disclosure by section 13(1)(g) of the Michigan Freedom of Information Act, which exempts from public disclosure information or records subject to the attorney-client privilege..

Roll Call - McNally - yes, LaPointe – yes, Marois - Yes

Motion was made by Marios to come out of Closed Session at 11:49 pm, seconded by LaPointe and carried unanimously.

Kazim, Mallory, Gratton, Riffle and Long in 10:45am

Motion was made by Marios to accept the attorney's recommendation as presented. Seconded by LaPointe and carried unanimously.

Guest Presentation – Rob Long, Plante Moran - continued – Long reviewed current operations and provided recommendation of four strategies to produce sustainable performance results, and provided a roadmap for implementing recommended strategies.

Grand Traverse Pavilions Announcements

(1) Next meeting February 23, 2023

Second Public Comment - none

Meeting adjourned at 1:45pm

Signatures:

_____

Cecil McNally – Chair
Grand Traverse County Department of Health and Human Services Board

_____

Rose Coleman, Assistant-Secretary

Date: _____ Approved
_____ Corrected and Approved

DRAFT

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 08/04/2022

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 8/4/2022. Intakes: MI00130050, MI00130051, MI00130052, MI00130053, MI00130054, MI00130055, MI00129685. Census= 132	F000		
F550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) 483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. 483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. 483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. 483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F550	1. Resident #15, #18, and 82s care plans were reviewed and revised to include interventions for meal assistance. We were unable to identify residents #32 and #78. Resident #15 and Resident #82 continue with dining assistance. The CNA staff have been instructed to sit and engage residents during mealtime. 2. All residents have the potential to be affected. Dietary and Nursing staff have received education on a dignified dining experience which includes but is not limited to engaging with the resident, making eye contact, sitting rather than standing when assisting, describing the food as it is served, and serving the food shortly after it is delivered to the unit and offering choice and alternatives as necessary. The Meal Service Policy (formerly Nutrition/Food Service on Units and Assisted Dining Rooms Policy) was updated to include ways to make the dining experience dignified. Nursing education will be completed by 8/29/22. 3. CQI and the ADON's will audit the 3-5 meal services per week to ensure a dignified dining experience is taking place until otherwise directed by the QA committee. Any concerns identified will be addressed at the time of identification. The results of these audits will be forwarded to	8/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	08/27/2022

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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F550	Continued From page 1 483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. 483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure there was meal dignity provided for five Residents (#15, #18, #32, #78, and #82) of 27 residents reviewed for dignity. This deficient practice resulted in a lack of personal dignity, feelings of embarrassment, and the potential for other Residents to have their dignity compromised. Findings include: On 8/1/22 at 1:15 p.m., an observation of the small dining room located on Dogwood was observed to have residents eating their lunch meal. During this observation it was noted that Resident #18, Resident #32, and Resident #82 were asleep with their meals sitting in front of them uncovered, with no staff members attempting to wake them up or encourage the residents to begin eating. Located in the corner of the dining room, Resident #78 was sitting at the end of the table with two other residents eating their meals. Resident #78 did not have his lunch meal. On 8/1/22 at 1:25 p.m., Resident #78 continued	F550	the QA committee for review. 4. DON responsible for compliance.	

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F550	Continued From page 2 to sit at the end of the dining table in the corner of the small dining room without a tray. When asked, Certified Nurse Aide (CNA) "S" stated, "His meal is probably still on the cart," but did not make an attempt to retrieve his meal. CNA "S" stated that staff feel rushed to get the meals once the kitchen does send them down the hallway, and that everyone should have their meals together. On 8/2/22 at 10:15 a.m., an observation of Resident #15 was made in the small Dogwood dining room. Resident #15 was in his wheelchair and was being assisted by CNA "U" for his breakfast meal. CNA "U" was observed in a standing position over Resident #15 assisting him with his meal. CNA "U" continued to assist Resident #15 in a standing position during the entire meal observation. Review of the facility "Know your Rights -Your Medicaid Care And Coverage In A Nursing Facility" dated 10-13 and provided in all admission packets read, in part, " ...You have the right to receive necessary nursing, medical and social services to reach and maintain the highest practicable physical, mental and social well-being, as determined by the comprehensive assessment and care plan. These services must be given in a confidential and dignified manner that meets your treatment and personal needs ..."	F550		
F656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) 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	F656	1. Resident #60 had a therapy screen completed on 8/4/22. Resident #60s transfer status was upgraded to a one assist with ambulation in her room and continues with her ambulation program in the hall. 2. Residents who require assistance with transfers have the potential to be affected.	8/30/22

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F656	Continued From page 3 483.10(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 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F656	The Transferring a resident policy has been reviewed with staff. Additionally, staff received education on interpreting therapy recommendations for those with complex transfers. Education will be completed by 8/29/22. 3. CQI will observe staff and residents during transfers 3-5 tines a week until otherwise directed by the QA committee. Any concerns identified will be addressed as needed. Results will be forwarded to the QA committee for review. 4. DON is responsible for compliance.	

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F656	Continued From page 4 review, the facility failed to implement care planned interventions for safe transfers (how a resident moves from one surface to another) for one Resident (#60) of two Residents reviewed for care plan implementation. This deficient practice resulted in the potential for injury. Findings include: Resident #60 was admitted to the facility on 9/13/2021 and had diagnoses including dementia and vertigo (dizziness, sensation of spinning). A review of Resident #60's Minimum Data Set (MDS) assessment, dated 5/31/2022, revealed Resident #60 required extensive, one-person physical assistance with transfers and had moderate cognitive impairment. A review of Resident #60's Resident Care Card with Certified Nurse Aide (CNA) "KK", on 8/04/2022 at 9:08 a.m., revealed the Resident #60 was to be transferred using a sit-to-stand lift (wheeled device used to assist a resident to stand and be wheeled to another surface then lowered down). Further review of Resident #60's care plan revealed the following, in part: "I have an alteration in my ability to perform my ADLs independently and be independent with my mobility (related to): progressive weakness, gait disturbance and intermittent confusion ... Status: Active (current) ... Interventions: Transfer and ambulate me per my Resident Care Card instructions: The way I transfer is: one person assist with (sit-to-stand lift, brand name redacted) ..." An observation on 8/04/2022 at 9:24 a.m., revealed CNA "LL" transferring Resident #60 from a recliner to the bathroom toilet using a gait belt and stand-by assistance. During an	F656		

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F656	Continued From page 5 interview immediately following the observation, CNA "LL" confirmed she did not used the sit-to-stand lift to transfer Resident #60 from the recliner to the bathroom toilet. CNA "LL" stated the lift was only used when Resident #60 was feeling weak. A review of Resident #60's "Physical Therapy (PT) Discharge Summary," signed and dated 4/11/2022 at 3:58 p.m., revealed the following, in part: "Education, Summary and Recommendations: (Resident #60) is now using a (sit-to-stand lift, brand name redacted) very successfully, for all sit to stand transitions from recliner, toiled and (wheelchair). This approach works best for her because it avoids the turning aspect of transitional movements from chair and toilet which remain difficult at times..." During an interview on 8/04/2022 at 11:30 a.m., the Unit Manager, Registered Nurse (RN)"JJ" reported residents should be transferred per care planned interventions to ensure maintenance of function and safety. A review of the facility policy titled "Care Planning," dated 7/25/2022, revealed the following, in part: "The Organization will develop a comprehensive care plan for each resident to meet a resident's clinical and psychosocial needs and to maintain the resident's highest practicable, physical, mental and psychosocial well-being ... 3. The services provided or arranged by the Organization will meet professional standards of quality and be provided by qualified persons in accordance with each resident' written plan of care." A review of the facility policy titled "Transferring a Resident," dated 6/30/2021, revealed the following, in part: "To safely transfer a resident,	F656		

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F656	Continued From page 6 in accordance with the Resident Care Card. 1. All residents are assessed by therapy or nursing for appropriate mode of transfer... 2. Transfer status will be placed in the Resident Care Card. 3. It is the responsibility of the CNA and Nurse to review the Resident Care Card prior to administering care to the resident."	F656		
F676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) 483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: 483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... 483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: 483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, 483.24(b)(2) Mobility-transfer and ambulation, including walking, 483.24(b)(3) Elimination-toileting, 483.24(b)(4) Dining-eating, including meals	F676	1. Resident #60 had a therapy screen on 8/4/22. Resident #60 was upgraded a one assist with ambulation in her room and continues with her ambulation program in the hall. Staff assist Resident #60 with her ambulation program which calls for daily ambulation outside of her room. This is being documented daily by staff. The plan of care and resident care card has been updated to reflect these changes. 2. All ambulatory residents have the potential to be affected. Residents with an ambulation program have been reviewed for modification needs, and a treatment added for the nursing staff to summarize their ambulation in a weekly clinical note. This may include but is not limited to tolerance, length of ambulation and/or time spent ambulating, and refusals. The list of residents with ambulation programs is shared during huddles as a reminder to staff of the residents on an ambulation program. The Ambulation policy (formerly Ambulating a resident) has been updated to include refer to the resident care card for ambulation and transfer instructions. Education included how to complete ambulation documentation. Nursing staff education will be completed by 8/29/22. 3. CQI will review ambulation documentation which includes the daily documentation of an ambulation program and the weekly clinical note summarizing	8/30/22

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F676	Continued From page 7 and snacks, 483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide timely assistance with ambulation according to therapy recommendations for one Resident (#60) of two Residents reviewed for restorative services. This deficient practice resulted in the potential for loss of functional ability and feelings of helplessness. Findings include: Resident #60 was admitted to the facility on 9/13/2021 and had diagnoses including dementia and vertigo (dizziness, sensation of spinning). A review of Resident #60's Minimum Data Set (MDS) assessment, dated 5/31/2022, revealed Resident #60 required one-person physical assistance with ambulation and had moderate cognitive impairment. Further review of "Section G - Functional Ability," of Resident #60's MDS assessment, dated 5/31/2022, revealed Resident #60 had walked in her room "once or twice" and did not walk in the corridor at all during the seven-day assessment period. An observation on 8/01/2022 at 12:15 p.m., revealed Resident #60 sitting in a recliner with her feet up on the footrest. Resident #60 reported she was not being assisted with daily walking according to physical therapy recommendations and was afraid she would lose her ability to walk.	F676	their program. These reviews will encompass 3-5 record reviews bi-weekly to ensure those with ambulation programs are being carried out and documented. Additionally 3-5 weekly observations of staff and residents during ambulation will occur until otherwise directed by the QA committee. Any concerns identified will be addressed as needed. Results will be forwarded to the QA committee for review. 4. DON is responsible for compliance.	

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F676	Continued From page 8 A review of Resident #60's "Physical Therapy (PT) Discharge Summary," signed and dated 4/11/2022 at 3:58 p.m., revealed the following, in part: "Education, Summary and Recommendations: (Resident #60) is most successful when she ambulates in a straight path with (wheeled walker) ... (Resident #60) is able to ambulate (sic) with CGA (contact guard assistance) up to 125 feet x 2 trials with good cadence, equal step lengths and step height with less shuffling and without freezing episodes. Restorative program for weekly use of (wheeled walker) and daily ambulation has been recommended." A review of Resident #60's care plan revealed the following, in part: "I have an alteration in my ability to perform my ADLs independently and be independent with my mobility (related to): progressive weakness, gait disturbance and intermittent confusion ... Interventions: I have a unit ambulation program with the goal to maintain my ability to walk. Ambulate with client in hallways with (wheeled walker) and assist of 1 ... She is able to ambulate up to 125 feet x 2 trials with (wheeled walker) and (wheelchair) follow ... I have a restorative (wheeled walker) program with the goal of maintaining my function ..." A review of Resident #60's "ADL (Activity of Daily Living) Worksheet(s)," provided by unit Manager, Registered Nurse (RN) "JJ' dated 4/11/2022 through the end of the survey on 8/04/2022, revealed Resident #60 was assisted with ambulation per PT recommendations, as follows: A total of five times from 4/12/2022 through 4/30/2022 (18 days).	F676		

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F676	Continued From page 9 A total of three times from 5/01/2022 through 5/31/2022 (31 days). A total of nine times from 6/01/2022 through 6/30/2022 (30 days). A total of nine times from 7/01/2022 through 7/31/2022 (31 days). A total of one time from 8/01/2022 through 8/04/2022 (four days). During an interview on 8/04/2022 at 9:01 a.m., RN "JJ" reported Resident #60 was to participate in the facility's ambulation program according to PT recommendations. RN "JJ" confirmed PT recommended Resident #60 ambulate with staff assistance daily to help maintain and prevent loss of function. A review of Resident #60's "ADL Verification Worksheet(s)," from 4/11/2022 through 8/04/2022, with RN "JJ" revealed no documented Resident refusal of ambulation during the review period. RN "JJ" stated if Resident #60 refused to ambulate, staff should alert the licensed nurse caring for the Resident so the refusal could be documented in the Resident's progress notes and an assessment completed to determine the cause of the refusal. A review of Resident #60's "Clinical Notes," from 4/11/2022 through 8/04/2022 revealed no documentation that Resident #60 refused to ambulate. A review of the facility policy titled "Ambulating a Resident," dated 8/26/2008, revealed Resident ambulation was to be documented "per Organization guidelines." It was noted the policy did not reference checking Resident care plans for appropriate interventions prior to ambulating	F676		

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F676	Continued From page 10 residents.	F676		
F677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) 483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure adequate feeding assistance for one Resident (#5) out of eight resident reviewed for nutrition. This deficient practice resulted in decreased intake and the potential for additional weight loss, and subsequent malnutrition, dehydration, and functional decline. Findings include: Review of Resident #5's face sheet revealed readmission to the facility on 5/29/22, with an original admission of 4/12/22, with diagnoses including failure to thrive, dementia with behaviors, history of cancer, muscle weakness, difficulty walking, cognitive communication deficit, and depression. Review of Resident #5's Minimum Data Set (MDS) assessment dated 7/13/22 revealed Resident #5 required one-person assistance for bed mobility, transfers, dressing, toileting, and supervision (including oversight, encouragement, or cueing) and set-up for eating. Resident #5 scored 14/27 on the PHQ-9, a depression assessment, which revealed Resident #5 had moderate depression. Resident #5 was 60" tall and weighed 116#. On the MDS dated 4/18/22, Resident #5 weighed 123#.	F677	1. Resident #5s prefers to eat in her room despite being encouraged to have her meals in a dining room where staff can be of more assistance. OT screen completed 8/5/22 with recommendations for staff to monitor alertness and, when a resident is very tired or lethargic, provide supervised dining with cueing/assist prn during meals. Resident #5s care plan was reviewed and revised to reflect her preferences and these changes. 2. All residents have the potential to be affected. Residents with recommendations for assistance at meals will be encouraged to have their meals in the dining room. For those that continue to wish to have their meals in their room despite these recommendations, staff will be asked to assist with dining assistance if they are unable to eat independently. This is now included in the Meal Service Policy. Nursing staff education will be completed by 8/29/22. 3. CQI will observe 3-5 meal services weekly to observe resident and staff interactions and the dining assistance provided until otherwise directed by the QA committee. Any concerns identified will be addressed immediately. Results will be forwarded to the QA committee for review. 4. DON is responsible for compliance.	8/30/22

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F677	Continued From page 11 Review of Resident #5's weight logs showed an admission weight on 4/12/22 of 124.8#, and a weight on 7/03/22 of 116#, showing a 7.05% weight loss in one quarter. An observation on 8/03/22 beginning at 9:17 a.m. revealed Resident #5 seated in her manual wheelchair on the [unit name] resident care unit at the nurses circle, with her breakfast meal tray in front of her. The tray contained a bowl of oatmeal and beverages. Resident #5's meal tray ticket showed Resident #5 was on a regular diet, and her breakfast was designated as oatmeal. Resident #5 appeared tired, with her head down, nodding off occasionally. Resident #5 was observed attempting to feed herself with small, adapted utensils (also on her meal ticket). It was observed she would attempt to bring her hand to her mouth with a small spoon (about the size of a dessert spoon), but would then fatigue and set the spoon down. Resident #5 attempted to bring her hand to her mouth several times without success, and then began stirring her oatmeal with a straw. An activities staff member, Staff "X", stopped by while walking, and then stood and asked Resident #5 why she was drinking her oatmeal with a straw. Resident #5 reported she liked to stir her oatmeal first, then Staff "X" walked away. At 9:21 a.m., Resident #5 still had not taken a bite of oatmeal; her spoon was in the oatmeal with no hand to mouth motion observed, as she would start taking a bite and then drop the spoon. Several unit nursing staff walked by and greeted resident but none offered assistance. At approximately 9:25 a.m., she took a bite of the oatmeal, and followed it slowly with four more small spoonfuls. By 9:29 a.m., Resident #5 had consumed eight bites, and was nodding off. It was noted she drank her orange juice. Assistance was not offered to Resident #5.	F677		

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F677	Continued From page 12 Surveyor asked Resident #5 if she usually ate breakfast at this time. Resident #5 then rested her head down. Surveyor continued to observe, and by 9:46 a.m. Resident #5 was alert again and with effort took three more bites, and attempted to drink her hot chocolate. It was noted the straw was in Resident #5's mouth and she had the cup tilted to take a sip, however she could not drink the liquid. With extensive effort, she was soon after able to take a couple sips. She remained in the nurses circle during these continuous observations with no staff assistance, and demonstrated poor intake. When she was done, her oatmeal bowl appeared full, as the spoonfuls were very small when she did take bites, with some spillage noted. It was observed there was a smaller dining room on this resident care unit just outside the nurses circle, where some of the residents were receiving supervision, cueing, and assistance. Resident #5 was not provided supervision, cueing, or encouragement with the meal. By 9:50 a.m., Resident #5 was done and had no additional interest in her meal. Review of the Electronic Medical Record (EMR) revealed Resident #5 had an admission nutritional assessment on 4/12/22, however there was no follow-up quarterly assessment, which would have been due in July (2022). There were also no additional nutritional notes which would have reflected Resident #5's weight loss and any interventions. Review of physician notes since admission revealed no mention of Resident #5's weight loss or interventions. Review of physician orders received from the facility via email on 8/04/22 did not reveal any nutritional supplements, or interventions. The orders confirmed Resident #5 was on a regular diet with thin liquids.	F677		

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F677	Continued From page 13 During an interview on 8/04/22 at 3:10 p.m., the Rehabilitation Coordinator, Physical Therapist (PT) "Z", was asked if Resident #5 was being seen by occupational therapy due to her increased need for assistance with eating, and about her cognition. PT "Z" reported Resident #5 was last seen by occupational therapy in May (2022) and was feeding herself with set-up and extra time upon discharge. PT "Z" confirmed nursing staff had not reported Resident #5 needed increased assistance with feeding, and the therapy department would screen Resident #5 for self-feeding. PT "Z" reported Resident #5 did need cueing for safety, and her SLUMS (Saint Louis University Mental Status) Exam (a clinician administered assessment of cognitive function) score on 5/03/22 upon therapy discharge was 15/30, which was indicative of dementia and marked cognitive impairment.	F677		
F679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) 483.24(c) Activities. 483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide meaningful regularly scheduled activities to fully meet the	F679	1. Resident #108 has been reassessed to review and determine any additional activity interests. This information has been added to the Life Enrichment care plan. From the Confidential Resident Council meeting: a. Outings: Many of the residents throughout the building have been able to go out with family members/friends for day trips, appointments, family gatherings, etc. Facility outings will begin to take place based upon current outbreak status within the facility, the current county transmission rate and weather conditions. Residents will be informed of this via monthly resident council meetings and the Pavilions Post newsletter. Residents will be asked to sign up for outings with the Certified Therapy Recreational Specialist (CTRS).	8/30/22

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F679	Continued From page 14 activity needs of all facility residents, including six Confidential Residents from group meeting (C1, C2, C3, C4, C5, and C6), and Resident #108. This deficient practice resulted in decreased activity participation, feelings of isolation, boredom, and frustration, and the potential for psychosocial decline. Findings include: During a group meeting on 08/02/22 beginning at 3:05 p.m. to review the Resident Council task, residents present were selected to represent each resident care unit. Residents expressed activity program concerns as follows: Confidential Resident (C1) stated, "There is no program...I'm surprised we can be in here. We are told we can't have activities (group) for a long time (over the past year or more)." Resident C1 expressed feeling isolated and frustrated. Confidential Resident (C6) stated, "I don't remember anything but BINGO [being done]." Confidential Resident (C5) stated, "There are no outings or activities; we have birthdays selectively with not many people are around, and we play BINGO four different ways. I play it in my room." Resident C5 expressed being bored and wanting other types of activities. Confidential Resident (C2) stated, "I have money to spend and there are no trips to the store." Resident C2 added they would like to have someone to go to the store for them if they can't go anymore, and had asked. Confidential Resident (C3) stated, "I have suggested a concierge [to go to the store for the other residents]." Resident C3 expressed there was not enough for her to do, and feeling bored. Confidential Resident (C4) stated, "I would like yoga, or the exercise group they did before; I miss that." Resident C4 reported the facility had exercise groups in the past but now there were	F679	b. Concierge/spending of money: Social Workers (SW) and CTRS have done personal shopping for residents based upon their request and needs. The availability of this will be made known to all residents at monthly resident council meetings and the Pavilions Post newsletter, and will ask residents to notify their pavilion social worker (SW) or Assistant Director of Nursing (ADON) and arrangements will be made. c. Group activities: Life Enrichment will offer a daily group activity to all residents; the activity will be rotated between pavilions so that all residents have the opportunity to participate. Residents will be informed of group activities via verbal invitations and encouragement to attend from CTRS and staff; residents will be informed via the daily calendar flip sheets located in the bulletin boards of each pavilion and also the Pavilions Post newsletter. d. Room visits: Each week when the Pavilions Post is delivered to each resident, CTRS will ask resident (if they are present in their room at time of delivery) if there are any independent activity supplies or materials that they need (i.e. books, magazines, craft supplies, letter writing materials, word puzzle books, jigsaw puzzles, CD/radio player & CDs, and DVDs). Residents will be informed of independent activity supplies or material needs that CTRS can supply to them via monthly resident council meetings and Pavilions Post. 2. All residents have the potential to be affected Activity interests of residents are reviewed quarterly with care plans updated to reflect any changes. Residents	

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F679	Continued From page 15 none. Six of the eight residents reviewed for activities reported their activity needs were not being met, either with group activities, or with 1:1 room activities. Residents collectively said they would like to see more activities, such as art, games, social activities, exercise, outings, shopping, and further added there were no longer room visits, or books, movies, or magazines offered. Residents expressed they were appreciative of BINGO but bored as this was almost the only activity offered. All six Residents collectively agreed if they cannot go to stores since the pandemic (COVID) it would help if they had someone that could go to the store for them to get them personal or preferential supplies they needed which the facility did not carry. Residents reported they had continued to request this and mention their activity concerns during resident council meetings with the current management team and nothing changed. The residents reported this had been occurring over the past year, and even longer. Residents collectively reported this significant decrease in activities caused them feelings of isolation, frustration, and boredom. Observations on [name of] resident care unit were as follows: 08/01/22 beginning at 2:17 p.m.: Six residents were seated in the common area outside the nursing office, and appeared bored, with no activities observed. Resident #108 was observed seated in common area with the other residents. Resident #108 appeared bored and disengaged, however made eye contact during a greeting, smiled, and appeared to enjoy the social interaction.	F679	will be queried in resident council as to the offerings of activities and outings to obtain feedback into what the residents would like to see and do. 3. CQI and CTRS will monitor and review monthly the types of activities scheduled & held. Resident council minutes will be reviewed and summarized regarding the activities offered and attended. The results will be forwarded to the QA committee for review. 4. CTRS will be responsible for compliance.	

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F679	Continued From page 16 08/02/22 beginning at 2:38 p.m.: Observations on same unit showed Resident #108 seated in common area with other facility residents. Nursing staff were in area; no activities were observed. Surveyor had made frequent observations on this unit since 08/01/22 survey entry and no activities had been observed. 08/03/22 beginning at 12:47 p.m.: Seven residents were seated in the common with no activities. Resident #108 was seated in her manual wheelchair with her back positioned away from the other residents, looking down the hallway and appeared bored and disengaged. This was observed again with a second observation later that same afternoon. Continued observations on this resident care unit over the next few minutes revealed no unit activities, activities staff, or 1:1 activities. Resident #108 made eye contact when approached by Surveyor and attempted to converse when greeted at eye level. Resident #108 appeared eager to participate in conversation. Observations on 8/01/22, 08/02/22, and 08/03/22 during the morning, before and after lunch, and into the afternoon revealed no activities on this same resident care unit, and no observations of Resident #108 participating in any unit activities, either 1:1, group activities, or sensory activities. In addition, thus far during the survey there were no passive activities observed, such as movie watching or music listening. During a brief interview with Activity Aide, Staff "I", on 08/03/22 at 1:55 p.m., Staff "I" was observed exiting the activity room on [name] unit hall carrying a small birthday cake and present.	F679		

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	235088	A. BUILDING _____ B. WING _____	C 08/04/2022

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F679	Continued From page 17 Staff "I" reported they were running two hours late delivering the cake to a facility resident, as they had to take another resident for lab work, and were working as a CNA (certified nurse aide) on the floor [resident care unit]. Staff "I" reported she was doing both, assisting in activities and working the floor, and appeared rushed. During an interview on 08/04/22 at 8:58 a.m., Activity Aide, Staff "J", was asked about the facility activities program. Staff "J" reported they were moved to the unit (for resident care) and were not doing activities with residents regularly anymore. Staff "J" added they get to do activities with the residents maybe once a month, and said it was never a full day, and it was only if they have enough floor staff. Staff "J" reported it had been a big change for residents, as they and Staff "I" had been full time activity aides, but since the pandemic there were only two staff doing activities, the activity director and assistant, instead of four. Staff "J" related they did need more activity coverage due to the large size of the building, multiple units, and high number of residents, and confirmed they were now working as a CNA. Staff "J" reported BINGO and church were the only activities being done, and music concerts outside one evening a week. When Staff "J" was asked about residents with dementia and impaired cognitive/sensory needs receiving 1:1 activities, Staff "J" indicated the activities department had not been able to do 1:1 activities for a long time (since the pandemic due to staffing needs). Staff "J" reported this lack of activities was not due to infection precautions but rather staffing shortages since the pandemic. Surveyor asked for documentation of 1:1 activities on [name] resident care unit including	F679		

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F679	Continued From page 18 Resident #108 where Surveyor was observing as had not seen participating in activities. No residents on the unit were marked as receiving these activities for the past two weeks, despite their names being on the logs, including Resident #108. Staff "J" reported residents in the book were supposed to receive activities one to two times per week. When asked if residents activity needs were being met, Staff "J" affirmed residents were not receiving adequate activities, and were reporting symptoms of boredom, frustration, and demonstrating psychosocial decline due to decreased interaction and implementation of their activity interests. Staff "J" confirmed outings had stopped when the pandemic occurred, well over a year ago, and no room visits were being provided since the aides were moved to the units for resident care. An activity calendar was requested; there was no monthly calendar and Surveyor was provided a weekly calendars for the past few weeks. Upon review with Staff "J", they confirmed there were only about three to four activities a week, and some days there were no activities, especially on the weekends. The only activities noted were BINGO, religious services, and a weekly music concert. Staff "J" confirmed Resident #108 was marked as having no 1:1 visits over the past two weeks, and would benefit from 1:1 activities. During an interview on 08/04/22 at 09:39 a.m., Staff "I" was asked about the activities program, as they had earlier reported they also worked primarily as a CNA. Staff "I" reported they also were not doing any 1:1 activities with residents as they did formerly. Staff "I" reported when they worked as an aide on the memory care unit they did provide some unit activities while providing CNA care but not on any other resident care units when assigned due to staffing needs.	F679		

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F679	Continued From page 19 When asked about Resident #108, Staff "I" reported in the past activities staff would take her to many activities, and the facility had more music activities where she would participate. Staff "I" confirmed they are not doing room visits with Resident #108 as prior. Staff "I" reported they used to go room to room doing 1:1 activities prior to the pandemic. When asked if this was affecting facility residents, Staff "I" reported she saw the higher [cognitive] level residents declining due to significantly reduced activity participation with significantly decreased group activities available. During an interview with Activity Director (AD) "H" on 08/04/22 at 11:42 a.m., AD "H" was asked about the facility activities program. AD "H" reported BINGO was on Tuesdays, and in room activity supplies had been provided. They reported they do spontaneous activities on the units such as nail care but did not always chart on it. When asked if the activities programming was significantly reduced, AD "H" affirmed and acknowledged additional staff would be of benefit. AD "H" added they do the weekly music concert, family visits (set up video chats), and ordered lunches in from restaurants as an activity intermittently, so they were providing some scheduled activities, and reiterated some were not documented or scheduled ahead. AD "H" acknowledged there were no outings and the facility did not shop for residents. AD "H" confirmed they and the assistant activity director were the staff working in the activities program primarily at that time. A policy was requested related to the activities program/programming from the facility nursing management during the survey, with report there was no such policy.	F679		

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F679	Continued From page 20 Review of Resident #108's Minimum Data Set (MDS) assessment revealed Resident #108 was admitted to the facility on 01/07/2022, with diagnoses including dementia and anxiety disorder. Resident #108 required extensive two-person assistance for bed mobility, transfers, dressing, and toileting, and fed herself with one-person assistance. Per the assessment, Resident #108 was able to sometimes understand others and sometimes be understood. The Brief Interview for Mental Status (BIMS) assessment revealed Resident #108 scored a 99, which indicated Resident #108 had severe cognitive impairment. Resident #108 had no pain or falls marked on the assessment during the review period. Review of Resident #108's Care Plan, accessed 08/04/2022, revealed Resident #108 enjoyed participation in group activities including music and passive participation, as well as television, reading books or magazines, pet visits, church services, and BINGO. There were no interventions noted for 1:1 activities. Given Resident #108's BIMS score of 99, she would have difficulty participating in only group activities, and would have benefitted from 1:1 activities such as quiet conversation, assistance with magazines and/or reading a book, or sensory activities per their Care Plan. Observations of Resident #108 on 8/01/22 through 08/03/22 did not reveal participation in any activities of interest. She was observed watching television at the nurses station circle on her unit on 08/04/22, and appeared to be actively engaging, by looking up at the television and watching. An observation of Resident #108's room yielded no books, magazines, movies, or other activities, and staff were not observed assisting Resident #108 engage in	F679		

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F679	Continued From page 21 these activities on the unit, or any music activities. Review of Resident #108's activity summary, provided by AD "H" showed Resident #108 had weekly video calls with her daughter who lived out of state, with Resident #108 responding with many smiles and a few words of conversation, with description of Resident #108 able to engage in the conversation and social interaction. This showed Resident #108 enjoyed listening to music especially concerts, and would actively observe those around her. Resident #108's activity log provided by AD "H" from 6/07/22 though 7/28/22 showed Resident #108 participated in video visits with family, and 6 group activities (over a near 8 week period), with no sensory activities noted. Four of the activities were music, and the meaning of "con" was unclear for the remaining two activities, as not reflected on the log. Review of the most recent weekly facility activity publication, titled, "[facility name] Post", provided by AD "H" upon request for facility calendars, revealed for the week of 07/24/2022 through 07/30/2022 [the most recent week provided] the activities for the week were listed for all facility units on the back page. These included: Monday July 25th, a music activity, Tuesday, July 26th BINGO, Wednesday, July 27th, Resident Council meeting, Thursday, July 28th, Resident Council (other units), and a Concert on the Lawn as well the same day. Television sports events were noted as well, as well as a famous person biography and word search. There were no activities noted for Friday through Sunday, nor any mention of 1:1 visits, or other alternates. Prior weekly publications were reviewed as provided by AD "H" since May, 2022, and revealed the same, including the week prior	F679		

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F679	Continued From page 22 which showed activities (group) only on Tuesday and Thursday. A policy was requested related to the activities program/programming from the facility nursing management and the activity staff during the survey, with report that there was no such policy.	F679		
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: Based on interview and record review, the facility failed to monitor for and recognize signs of sepsis for one Resident (#92) out of two reviewed for urinary tract infections (UTI's). This deficient practice resulted in a change of condition for Resident #92 where he went unresponsive and received two round of cardiopulmonary resuscitation (CPR) prior to being hospitalized for sepsis. Findings include: A review of Resident #92's medical record revealed he admitted to the facility on 10/8/19 with diagnoses including stroke, hydronephrosis, and chronic kidney disease. A review of his 6/26/22 Minimum Data Set (MDS) assessment revealed he scored 14/15 on the Brief Interview	F684	1. Resident #92 was treated at the hospital 6/14/22 through 6/18/22 for urosepsis and returned to the facility on an antibiotic. Resident #92 received sepsis screening 6/18/22 through 6/24/22. He remains at the facility in stable condition. Resident #92's care plans were reviewed and updated upon readmission. 2. All residents have the potential to be affected. Sepsis Screening Policy has been finalized, and all nursing staff has been educated on its content which includes when to initiate the sepsis protocol and where to find the treatments to initiate within the EMR processes. Nursing education will be completed by 8/29/22. 3. Sepsis alerts are attached to the EMR infection order set processes. When resident triggers a sepsis screening, the process is initiated, and the Infection Control Preventionist will receive an alert in the EMR. The resident's chart and sepsis screening documentation will be reviewed at that time to ensure all screening and documentation is complete. Additionally when a resident is placed on an antibiotic, or develops an infectious process the ICP will audit the resident's chart to ensure the sepsis screening process was initiated. The results of these audits will be forwarded to the QA committee for review.	8/30/22

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F684	Continued From page 23 for Mental Status (BIMS) assessment, indicating intact cognition and assessed to be continually incontinent of urine. A review of a progress note for Resident #92 (R2) dated 6/14/22 revealed, "This nurse was called at approx (approximately) 0500 (5:00 a.m.) to assess resident post possible seizure. Upon entering room, resident's eyes are opened and breathing is unlabored. Very soon after, resident's eyes rolled back in head and resident began a snore-like breathing which lasted 5-6 breaths. Resident then became completely unresponsive, color turned gray. Resident's code status checked and it was noted that resident is full-code. Code nurse initiated. Resident not breathing at this time. Resident immediately moved to floor to begin CPR. Mottling noted on legs. RN (Registered Nurse) x3 unable to palpate pulse in carotid artery. Chest compressions begin at this time. After two rounds of CPR, resident observed trying to open eyes. Resident was reassessed and noted to be breathing on own. Oxygen 74-percent on room air, pulse 150's. Oxygen applied at 20 lpm (liters per minute). Oxygen saturation eventually maintained at 94-percent on 8 lpm. Pulse remained 140-150 for duration of code. Resident became alert and responsive. Denies pain. BS (blood sugar) checked and is within acceptable range. EMTs (Emergency Medical Technicians) arrive and take over. Resident to (name of Hospital)." A review of a progress note dated 6/10/22 (four days prior to the event) revealed, "New order for Lidocaine patch to low back for pain. Resident is aware. Provider will f/u (follow up) in 1 week." A review of the hospital notes for R92 dated 6/14/22 revealed, "...acutely ill in appearance,	F684	4. DON is responsible for compliance.	

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F684	Continued From page 24 much more alert on the afternoon of the 14th after fluids and IV antibiotics initiated.... the sepsis seems to be the ultimate trigger here. Potentially infectious/sepsis etiology as etiology to arrhythmia.... Assessment/plan: 1. Sepsis. Pt (patient) presents with fevers/chills, questionable rigors with fevers, tachycardia and hypotension... 2. Shock due to systemic infection and cardiogenic. Pt with pyuria (white blood cells or pus in the urine) - recent left ureteral stent removal 6/2 in urology office for obstructive kidney stones... had subsequent c/o (complaints of) LBP (lower back pain) on 6/10 per progress notes at (name of facility)..." A review of the labs drawn on 6/14/22 at the hospital revealed, "...Appearance, urine: Hazy (A- abnormal)... Protein, urine: 30 mg/dl (milligrams per deciliter) (A - Abnormal)... Bacteria, urine: Many (A- abnormal) A review of R92's vitals page revealed the last pulse documented on 6/13/22 at 7:32 p.m. was 104 beats per minute (bpm), but was normally between 70-80 bpm. The last blood pressure on the vitals page was documented as 6/12/22 at 8:26 p.m. of 106/71 (low). On 8/3/22 at approximately 5:00 p.m., the Director of Nursing (DON) was asked to provide documentation as to why R92 was not monitored closely for signs and symptoms of infection post a urology procedure or why the low back pain was not considered a sign of potential urinary tract infection (UTI). Documentation was provided as follows: "back pain was addressed 6/10/22" and a physician note was provided which revealed, "Resident is seen as requested by nursing staff to evaluate the above (back pain). Resident has never reported back pain to staff before and often has	F684		

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F684	Continued From page 25 little to no physical complaints upon assessment..." A transfer/consult form was provided dated 6/14/22 which revealed a pulse of 157 (high) and a blood pressure of 106/71 (low). A print out of a medication administration showed that the blood pressure was 131/86 when the blood pressure medication was given on 6/13/22 at 9:15 a.m. but was not documented in the vitals log. A review of the facility policy titled, "Sepsis Screening Policy" (noted as a Draft) with no date revealed, "... Symptoms of sepsis include fever, difficulty breathing, low blood pressure, fast heart rate, and mental confusion. Sepsis can progress very quickly. Purpose and Procedure: to aide in the prevention of sepsis, a sepsis screen will be completed by licensed nursing staff every 8 hours... A sepsis screen will be completed every 8 hours for the duration of antibiotic use, duration of infection, change in condition or at any time nursing staff suspects infection of sepsis..."	F684		
F686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) 483.25(b) Skin Integrity 483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F686	1. Resident #4 was seen by the registered dietician for a nutrition review, including documentation and a review of the care plan. An intervention was added to weigh monthly and document. Her supplement order was updated to include a supplement substitution as needed- when med pass is not available. The administration of the nutritional supplement is being documented in the MAR. The care plan for her PI was reviewed and treatment was deemed appropriate. Resident #4's PI is being assessed weekly and documented in the clinical notes, the physical assessment of the wound is occurring daily and documented in the treatment record along with treatment provided.	8/30/22

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F686	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure interventions and treatments were in place to prevent the development of facility acquired pressure ulcers for three Residents (#4, #46, and #76) out of eight reviewed for pressure ulcers. This deficient practice resulted in the development of pressure ulcers and potential for further skin breakdown. Findings include: Resident #4 On 8/1/22 at 12:04 p.m., Resident #4 (R4) was observed in her wheelchair in the common area. Registered Nurse (RN "FF") was asked about any open areas and reported the resident had a pressure ulcer near her coccyx that was facility acquired. A review of R4's medical record revealed she admitted to the facility on 3/4/20 with diagnoses including Alzheimer's disease, depression, and anxiety. A review of her 7/13/22 Minimum Data Set (MDS) assessment revealed she scored 3/15 on the Brief Interview for Mental Status (BIMS) assessment indicating severely impaired cognition and had one facility acquired stage two pressure ulcer. A review of R4's progress note dated 7/5/22 revealed, "Res (Resident) observed to have a 0.7 x 0.5 cm (centimeter) stage 2 pressure injury on her right gluteal fold. Surrounding skin erythmetous. Wound bed red/pink and appears moist. Wound cleansed and 3x3 optifoam applied to site. Added to providers board. Family	F686	Resident #40 was seen by the registered dietician for a nutrition review including documentation and review of care plan. No new interventions were added. Her supplement order was updated to include a supplement substitution as needed when med pass is unavailable. The administration of the nutritional supplement is being documented in the MAR. Resident #40's PI is being assessed weekly and documented in the clinical notes, the physical assessment of the wound is occurring daily and documented in the treatment record along with treatment provided. Resident #46's PI was due to her shoe. The family was contacted and provided alternate footwear that does not cause any areas of pressure to her feet. Resident #46 was seen by the registered dietician for a nutrition review including documentation and review of care plan. Fortified pudding was added to her evening meal. Her supplement order was updated to include a supplement substitution as needed when resource is unavailable. The administration of the nutritional supplement is being documented in the MAR. Resident #46's PI is being assessed weekly and documented in the clinical notes, the physical assessment of the wound is occurring daily and documented in the treatment record along with treatment provided. Resident #76 was seen by wound care consultant on 8/11/22. Wound resolved on 8/15/22. Resident #76 was seen by the registered dietician for a nutrition review	

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F686	Continued From page 27 to be notified in AM (morning)." There were further narrative note about this wound in the progress notes. The only documentation found of the wound was on the treatment record. On 8/2/22 at 9:05 a.m., R4 was observed seated at table in the dining room with her meal in front of her. R4 stated to Certified Nurses Aide (CNA) "GG", I don't like these. CNA "GG" asked if R4 was talking about not liking the eggs and R4 stated, "Yes, I've never liked them." CNA "GG" reported they would tell the kitchen staff. R4 only had a bagel on her tray apart from the beverages, and no alternative protein item was offered. On 8/3/22 at 9:00 a.m., R4 was observed at a table in the dining room with her meal as follows: scrambled eggs, toast, and oatmeal. R4 was observed to eat the toast and oatmeal, but did not eat the eggs. No alternative protein was provide to aid in wound healing. On 8/4/22 at 9:31 a.m., R4 was observed at a dining table with all of her food (toast and oatmeal) eaten, but her scrambled eggs were untouched. No alternative protein was provide to aid in wound healing. A review of R4's undated skin care plan revealed, "...Please encourage fluids and adequate nutrition..." as an intervention. A review of a physicians order dated 7/6/22 by Registered Dietitian (RD) "EE" revealed, "Recommend Prostat (protein supplement) 1 pkt (packet) with 30 mL (mililiters) fluid BID (twice per day) and Med Pass 2.0 (nutritional supplement) (90 mL) BID to promote weight stabilization and wound healing."	F686	including documentation and review of care plan. No new interventions are warranted at this time. Her supplement order was updated to include a supplement substitution as needed when resource or med pass is unavailable. The administration of the nutritional supplement is being documented in the MAR. Resident #76's PI is being assessed weekly and documented in the clinical notes, the physical assessment of the wound is occurring daily and documented in the treatment record along with treatment provided. Occupational therapy determined that an equagel cushion is to be utilized in resident #76's chair. An equagel cushion was provided to resident #76 and placed in her chair. 2. Residents have the potential to be affected. Residents with pressure injuries now have a treatment for a weekly skin assessment. Residents with a Braden score of 9 (very high risk) or below will have weekly skin assessments added to their treatments. Residents with skin breakdown or those with a Braden Score of 9 (very high risk) or less will have a nightly turning schedule added to their plan of care and a turn schedule clock posted in their room. The Pressure Injury policy and the Pressure Injury Prevention Policy has been updated to reflect these changes. The New or Worsening Pressure Injury Assessment now includes a section for staff to document unavoidability if applicable. A weekly tracker is sent to the nursing management group and registered dieticians. A wound care consultant from American Medical Technologies will be rounding on those with qualifying insurance	

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	235088	A. BUILDING _____ B. WING _____	C 08/04/2022

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F686	Continued From page 28 A review of the Medication Administration Record (MAR) revealed that in June 2022 14 doses of the Med Pass supplement were not given, twice for Resident refusal, twice with no documentation noted, twice for it not being available, and the remaining eight doses did not indicate why it was not given. A review of the August 2022 MAR from 8/1/22 through 8/4/22 indicted that no doses of the ordered Med Pass had been given, and on only one day was it documented as not given due to "none to give/kitchen to reorder". Resident #40 A review of Resident #40's (R40) medical record revealed she admitted to the facility on 9/22/17 with diagnoses including dementia, major depression, and debility. A review of her 5/17/22 MDS assessment revealed she was assessed by staff to be severely impaired in cognition, and was at risk for pressure ulcer development. A review of R40's progress note dated 7/5/22 revealed, "Family was updated on medication change. Resident was observed with a 2.0 cm x 2.5 cm DTI (deep tissue injury) on the rt (right) heel. DTI is observed with a white center and reddish brown in color surrounding. Family updated." There were no further progress notes in her medical record regarding the status of the wound. The only documentation of the wound was found on the Treatment Administration Record (TAR). A review of a Physician Progress note dated 7/7/22 for R40 revealed, ".... She has developed a new deep tissue injury to her right heel since previous visit... continue nutritional	F686	where additional wound support is needed. The supplement orders have been updated to include staff may document if a substitute was provided. Nursing has been given an equivalency chart of appropriate supplement substitutes. Nursing staff will complete education on all of the items listed above by 8/29/22. 3. CQI will audit 3-5 residents to ensure their turning schedule is adhered to, weekly skin assessments are completed, and supplement documentation is completed bi-weekly until otherwise directed by the QA committee. Results of these audits will be forwarded to the QA committee. 4. DON is responsible for compliance.	

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F686	Continued From page 29 supplementation. Staff to report any worsening in condition." A review of a physician order for R40 revealed she was ordered Med Pass (Resource - a nutritional supplement with calories and protein) 90 ml's twice per day as of 6/24/22. A review of the July MAR for this order revealed it was not given as ordered 15 times out of 32 possible administrations. A review of R40's July TAR with the "Daily Pressure Injury Documentation" revealed the following dated wound bed descriptions: 7/6/22 Deep tissue injury; 7/7/22 Deep tissue injury, necrotic or eschar; 7/9/22 epithelium - pink shiny - grows in from the edge; 7/13/22 Deep tissue injury; 7/16/22 epithelium - pink shiny; 7/17/22 Deep tissue injury; 7/22/22 Necrotic or eschar; 7/30/22 deep tissue injury. The wound descriptions were not consistent throughout the healing of the wound an were conducted by whichever nurse was on that day. Resident #46 On 8/1/22 at approximately 12:10 p.m., Resident #46 (R46) was noted sleeping in her wheelchair in her room with cushioned boots on. On 8/1/22 at 1:15 p.m. Assistant Director of Nursing (ADON) "K" reported that R46 had a healing stage III facility acquired pressure ulcer to her right bunion. A review of R46's medical record revealed she admitted to the facility on 9/30/19 with diagnoses including Alzheimer disease, hypothyroidism, and weight loss. A review of her 5/24/22 MDS revealed she scored 0/15 on the BIMS assessment indicating severely impaired	F686		

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F686	Continued From page 30 cognition and had one stage III facility acquired pressure ulcer. A review of a 4/6/22 dietary progress note for R46 revealed, "Resident with new stage 3 pressure injury to right bunion. Risk factor includes shoes being too tight and intervention includes no shoes, gripper socks only. Weight: 128.8#, stable x 30, 90, 180 days. Food acceptance is fair with average 72% intake at meals the past month. Resident receives Resource 2.0 BID with med pass. Expect her to be able to meet close to estimated nutritional needs to support wound healing through intake and additional nourishments. No new dietary interventions at this time." There were no other progress notes regarding the measurements or progression of the wound. Further review of R46's progress notes revealed the last documented assessment of her skin was 11/27/21 revealing "Skin is warm, dry, and no s/s (signs or symptoms) of skin breakdown." There was no evidence that daily and weekly skin checks were being completed prior to the development and discovery of the stage III pressure ulcer. On 8/4/22 at 8:25 a.m., R46's right foot was observed with ADON "K". The pressure injury was observed to be pinpoint in nature, and per ADON "K" was still being monitored but was left open to air. ADON "K" confirmed that the pressure ulcer was a result of R46's shoes being too tight and causing excess pressure to her bunion. A review of the undated ADL (activities of daily living) care plan revealed the following, "...I will not develop skin breakdown. Review quarterly... Nurse aide will assess my skin daily and report	F686		

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F686	Continued From page 31 any red areas to nurse. Nurse to assess my skin weekly..." Resident #76 On 8/1/22 at 12:05 p.m., Resident #76 (R76) was observed up in a gerichair in the common area. RN "FF" was asked if R76 had any areas of breakdown and reported that they had just found a stage II pressure ulcer that same morning. A review of a progress note dated 8/1/22 for R76 revealed, "Resident has a new stage 2 PI (pressure injury) to Coccyx measuring 1.1x0.3x0.1cm. Wound has a scant amount of clear/pink drainage. Wound cleansed with saline, Z-guard applied. Resident is not showing signs of pain. PI process initiated, new interventions added to care plan/RCC (resident care card). Roho cushion requested from central supply. Family to be notified at a more appropriate time." A review of Resident R76's medical record revealed she admitted to the facility on 10/27/16 with diagnoses including dementia, history of a stage III pressure area, and peripheral vascular disease. A review of her 6/15/22 MDS assessment revealed she was assessed by staff to be severely cognitively impaired and was at risk for developing pressure ulcers. A review of R76's ADL careplan dated 3/8/22 revealed, "I have a pressure reducing mattress on my bed and sit on a pressure reducing cushion in my wheelchair." This intervention was supposed to be in place prior to the development of the pressure area on 8/1/22.	F686		

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F686	Continued From page 32 A review of the facility policy titled "Skin Assessment" dated 2/24/11 revealed in handwriting written on the document, "...Weekly skin assessments are added after admission x 4 weeks and when someone is comfort measures on hospice. We also complete a monthly summary on everyone with a skin check. Staff are educated to report all skin issues noted with care." A review of the facility policy titled, "Pressue Injury Prevention" dated 5/13/20 revealed, "... 7. Watch for skin redness and report it to the charge nurse... 9. Maintain proper nutrition and hydration. a. assist resident with meal if unable to feed self. b. encourage food intake..."	F686		
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	F688	1. An OT screen for resident #82 was completed on 8/24/22. She was provided with new palm protectors. The reason for use was also clarified as the palm protectors are used to prevent skin breakdown and not for contracture management. 2. Residents have the potential to be affected. Residents with therapy recommended range of motion programs and/or bracing have had a treatment added to complete a weekly clinical note regarding skin integrity, tolerance, and refusals. Nursing education will be completed by 8/29/22. 3. CQI will audit the documentation and observe residents whom wear bracing for contractures and have ROM programs bi-weekly. Results of these audits will be directed to the QA Committee for review. 4. DON responsible for compliance.	8/30/22

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F688	Continued From page 33 by: Based on observation, interview, and record review, the facility failed to implement interventions to address range in motion (ROM) for one Resident (#82) of one resident reviewed for limited range in motion. This deficient practice resulted in the protentional for extreme pain, discomfort and worsening of contractures. Findings include: Review of Resident #82's Electronic Medical Record (EMR) revealed an admission date of 1/19/18 and diagnoses including: dementia, Parkinson's disease, and weakness. Her 6/22/22 Quarterly Minimum Data Set (MDS) assessment revealed she was unable to complete the Brief Interview for Mental Status (BIMS) score and was marked with severely impaired cognition. In Section O of her 6/22/22 MDS, she was noted to have received zero days treatment in a Restorative Nursing Program which included Range of Motion (passive), Range of Motion (active) or Splint or brace assistance. On 8/1/22 at 1:15 p.m., Resident #82 was observed in the small dining room located in the Dogwood hallway. Resident #82 was asleep in her high-back wheelchair at a dining room table. It was noted that residents right and left hand had contractures with the fingers folding into the palms. Resident #82's right hand was located to be at her chest with her left hand on her lap. There were no splints or pads in place. On 8/2/22 at 9:06 a.m., Resident #82 was observed in the small dining room waiting for her breakfast meal. Resident #82 appeared to be asleep in the small dining room. Her right and left hands were again noted to be contractured, with no protectors or padding in place.	F688		

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F688	Continued From page 34 On 8/2/22 at 2:45 p.m., Resident #82 was observed lying in her bed, her right and left hands continued to be contracted with no protectors or padding in place. On 8/4/22 at 8:30 a.m., Resident #82 was observed in the small dining room waiting for breakfast. Her right and left hand continued to be contracted with no protectors or padding in place. An interview was conducted with Registered Nurse (RN) "V" regarding Resident #82's contractures. RN "V" stated that Resident #82 was supposed to wear palm protectors when up and when she tolerates them. RN "V" confirmed that staff do not document if Resident #82 is not tolerating the palm protectors or refusing to wear them. Also, at this time Certified Nurse Aide (CNA) "W" was interviewed and asked where Resident #82's palm protectors are located. CNA "W" stated that they were in her room. This Surveyor, RN "V" and CNA "W" went to locate Resident #82's palm protectors in her room. RN "V" and CNA "W" were unable to locate the palm protectors, and stated they were probably in the laundry. When asked if Resident #82 had a back up pair of protectors for such instances, RN "V" stated she did not believe so. On 8/4/22 at 9:35 a.m., an interview was conducted with Occupational Therapist (OT) "MM" and Physical Therapist (PT) "Z" regarding Resident #82's palm protectors. PT "Z" stated that Resident #82 was last seen in 2021 and stated that the recommendation was to continue to use palm protectors on her right and left hand to prevention the continuation of contractures. PT "Z" then stated that a call was placed down to the therapy department today to find additional palm protectors for Resident #82, but	F688		

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F688	Continued From page 35 the therapy department only had a right-hand protector and would need to order a left palm protector. OT "MM" was asked what the expectation was of the nursing staff to help Resident #82 and stated that the expectation would be to continue the use of palm protectors for the right and left hand, request an additional screening of Resident #82 if she was not tolerating the protectors, and to document the refusals of use. A review of Resident #82's "Therapy Communication to IDT (Interdisciplinary team) dated 9/28/2021 read, in part, "Recommendations: continue with previous recommendations of palm protectors during daytime hours ...If any regression or problems are noted that pertain to his/her therapy programs, please notify the Therapy Department ..." On 8/4/22 at 1:28 p.m. Resident #82 was observed sitting in the dining room being assisted with her lunch meal by staff. There were no palm protectors in place on either her right or left hand. A review of the facility policy, "Range of Motion" dated 3/1/2011 did not address the need to implement assistive devices to prevent contractures, to document refusals of assistive devices, or to notify therapy if there was a change in condition of the resident.	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	F689	1. Resident #50s and #56s care plan has been reviewed and revised. Resident #50s fall care plan interventions have been revised. Resident #56 was provided with a sensor call light as she is cognitively unable to use a push button call light. The toilet bar in the bathroom of	8/30/22

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F689	Continued From page 36 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 ensure that fall interventions and safety devices were in place to prevent falls for three Residents (#50, #56, and #73) out of eight reviewed. This deficient practice resulted in falls and the potential for injury. Findings include: Resident #50 On 8/1/22 at approximately 1:20 p.m., Resident #50 (R50) was observed standing up from his wheelchair in the dining room. Two Certified Nurse Aides (CNA "BB" and "GG") were observed to go to R50 and assist him in walking. R50 was observed to be very unsteady on his feet and attempted to squat down to the floor. A review of R50's progress notes revealed a note dated 8/1/22 "Resident had a fall this shift at 1225 (12:25 p.m.); resident lowered self to floor in center of pavilion hallway while walking with CNA to be weighed; did not have gait belt on at time of fall; no injury was noted; resident did not show or say he was in pain... will remind staff to utilize gait belt at all times when resident is up/if resident is willing due to sometimes resident resisting care/to also have either a FWW (four wheeled walker) or wheelchair nearby for safety." A review of R50's medical record revealed he	F689	Resident #73 was replaced with a toilet riser. Resident #73 was seen by the provider on 8/1/22. Imaging was completed 8/5/22 and the conclusion was modest osteoarthritis of the pelvis, and mild degenerative changes of the lumbar spine. A follow-up provider visit was performed 8/8/22 where resident #76 reported adequate pain control. Resident #76 has been given a wrist call light. 2. Residents have the potential to be affected. Environmental Service department will audit assist bars in the room monthly with room inspections. An Equipment Safety policy has been developed. All staff education includes how to proceed when malfunctioning equipment is discovered. Education will be completed by 8/29/22. 3. CQI will audit the residents with adaptive equipment to ensure equipment is not loose or broken. These audits will take place bi-weekly. Results of these audits will be directed to the QA Committee for review. 4. DON responsible for compliance.	

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F689	Continued From page 37 admitted to the facility on 1/10/19 with diagnoses including dementia, difficulty walking, and osteoporosis. A review of his 5/26/22 Minimum Data Set (MDS) assessment revealed he scored 3/15 on the Brief Interview for Mental Status (BIMS) assessment, indicating severely impaired cognition and had two or more falls with injury since the last assessment. On 8/4/22 at 10:39 a.m., R50 was observed sitting in his room in a chair by himself. R50 was looking around the room and when asked how he was, he reported he didn't know what to do. A review of R50's 2/4/19 Activities of Daily Living (ADL) care plan for falls revealed, "... Please redirect me out of my room unless I am laying in bed... 2 staff with GB (gait belt) for transfers and ambulation..." Resident #56 On 8/1/22 at approximately 12:10 p.m., Resident #56 (R56) was observed sitting in her wheelchair in the common area sleeping. A review of R56's medical record revealed she admitted to the facility on 7/13/17 with diagnoses including dementia, anxiety, and insomnia. A review of her 6/1/22 MDS assessment revealed she was assessed by staff to be severely cognitively impaired and had two more falls since the last assessment. A review of R56's progress notes revealed a note dated 4/25/22, "Resident was heard crying "Help!" and observed on the floor on her bottom beside her bed. Resident had been extremely sleepy and put into bed to rest, however, sensor light had been replaced with a push button light and remaining staff were not aware. Resident	F689		

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F689	Continued From page 38 was assessed for pain and injuries, none observed, resident moved at baseline. Resident brought out to common area to be monitored. Family will be notified at a more appropriate hour." A review of the facility policy titled, "Fall and Injury Reduction" dated 7/25/22 revealed, "Purpose: To prevent or minimize resident falls and injury, while promoting the highest level of resident independence possible..." Resident #73 Review of Resident #73's face sheet revealed Resident #73 was admitted to the facility on 03/07/2022, with diagnoses including dementia, stroke, physical debility, cognitive disorder, and atrial fibrillation (irregular heart rhythm). Review of Resident #73's Minimum Data Set (MDS) assessment, dated 06/07/2022, revealed Resident #73 required supervision with transfers, walking, dressing, and toileting. Resident #73 was always continent of bowel and bladder. The Brief Interview for Mental Status (BIMS) assessment revelaed a score of 12/15, which indicated Resident #73 had moderate cognitive impairment. The pain assessment revealed no pain during the review period. The fall review showed Resident #73 had two non-injury falls since admission, and one fall with minor injury, unspecified. During an interview with 08/01/22 at 1:52 p.m., Resident #73 stated, "I had a fall today." Resident #73 described a fall he had this morning at 6:00 a.m., when he transferred	F689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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 08/04/2022

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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F689	Continued From page 39 without assistance to the toilet which had a raised toilet seat, with rails attached to the plastic commode seat, in his bathroom. Resident #73 explained when he tried to stand up from the toilet with raised toilet seat and reach back for the call light, the raised toilet seat armrest on his left side moved away from the base, causing him to fall into the space between the toilet and the sink. Resident #73 wheeled his wheelchair into his bathroom, positioned his wheelchair in front of the toilet with raised toilet seat, demonstrated the fall, and showed surveyor how the left armrest of the raised toilet seat remained broken. Surveyor observed the left armrest of the white plastic raised toilet seat with attached plastic armrest with metal rail rotated 3" away from the raised toilet seat, at the armrest anchor. Surveyor asked if staff were aware of his fall, and the raised toilet seat armrest moving away from the raised toilet seat and toilet bowl where it sat. Resident #73 reported he had told nursing staff, including the Assistant Director of Nursing, ADON "K". It was also observed the plastic encasement for the toilet paper holder was broken, with Resident #73 reporting when he fell he hit this and broke it when he hit the floor. Resident #73 reported his back was hurt, and he pulled a muscle in his arm, both of which had been hurting since the fall on 08/01/22. Resident #73 showed Surveyor over his clothing how the right side of his lower back was hurting (beneath the ribs and above the pelvis), but could not quantify the pain. Resident #73 reported he had received pain medication, and had no other interventions since the fall. Resident #73 denied hitting his head. During an interview on 08/01/22 at 1:33 p.m., ADON "K" was asked about Resident #73's fall. ADON "K" reported they were aware of the fall in the bathroom. ADON "K" reviewed Resident	F689		

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	235088	A. BUILDING _____ B. WING _____	C 08/04/2022

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F689	Continued From page 40 #73's accident and incident report with Surveyor which revealed Resident #73 fell when "I grabbed the handlebar [of the commode] and it moved." Report further revealed Resident #73 was observed with his right bicep [a large muscle on the upper arm] in between the toilet tank and handle on the toilet, sitting on the floor. When [Resident #73] fell his back hit the toilet holder and broke it. Denies head involvement ..." Descriptions of injury revealed, "Abrasions to the back and redness to the back and bilateral bicep ..." ADON "K" was aware Resident #73 was having pain since the fall which was being addressed. ADON "K" denied any other tests or interventions at that time. During an observation on 08/01/22 at approximately 1:45 p.m. with ADON "K" and the Environmental Services Director, Staff "L", Resident #73's bathroom and plastic raised toilet seat were observed, and it was noted the left arm (if seated on the commode) of the raised toilet seat (with armrests attached from the commode plastic seat to under the plastic and over the toilet bowl) was wobbly, and moved 3" side to side. This could easily contribute to a fall when a person was transferring on and off the commode, and presented a current safety concern. Staff "L with ADON "K" acknowledged the concern, reported both sides of the commode were unstable, and said they would replace the commode seat immediately, as it was not safe for Resident #73 to use. It was noted Resident #73's bathroom call alarm was approximatley 6" behind the toilet seat on the wall, which would not be readily accessible to Resident #73 during a commode transfer. Staff "L" also noted this concern. During an interview on 08/02/22 at 02:50 p.m., Resident #73 reported he had hip/back pain on	F689		

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	235088	A. BUILDING _____ B. WING _____	C 08/04/2022

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F689	Continued From page 41 his right side of 8/10, which improved with medication (acetaminophen) he had requested but did not resolve. Resident #73 confirmed there had been no interventions other than medication, and he had not seen a physician or nurse practitioner since the fall. It was observed Resident #73 had a bedside commode (stationary commode or toilet safety frame) over his toilet, with extended supports to the floor, unlike the prior less stable raised toilet seat over the toilet. The toilet safety frame had the armrests attached to the toilet frame, verses the raised toilet seat, for improved stability and safety. Resident #73 reported he was happy with the new toilet safety frame, and felt it was stable for transfers. During an interview on 08/03/22 at 10:05 a.m., Resident #73 was in his room up in his manual wheelchair. Resident #73 showed Surveyor how he could only sit at midline (90 degree angle), and demonstrated how if he moved his trunk forward or back he experienced high level of hip pain, and stated, "Here's where it catches (pointing to his right hip and back). I think I need an x-ray." Resident #73 reported he told everyone (nursing staff) about the pain and what happened, and [ADON "K"] had been in [to his room] daily and was aware. Resident #73 stated staff would say it's a pulled muscle. He reported his pain was a 2 to 3 (with 10 being the highest) on Tylenol but it increased to very high with movement. Resident #73 reported he had to sleep on his back and not his side, and placed a pillow under his hip to sleep. Resident #73 then left his room and was observed wheeling down the hall in his wheelchair to the nurses station, reportedly to ask for an x-ray. During an interview on 08/03/22 at 11:33 a.m., Resident #73 nurse, Registered Nurse (RN) "M",	F689		

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	235088	A. BUILDING _____ B. WING _____	C 08/04/2022

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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F689	Continued From page 42 was asked about Resident #73's pain and any interventions. RN "M" reported they had made a note on 08/02/22 of the hip discomfort and pain in Resident #73's right lower back, and placed him on the provider list to request review of pain. During an interview on 08/04/22 at 11:44 a.m., ADON "K" was asked about Resident #73 and his reported hip/back pain. ADON "K" reported an order had been put in for a pelvic and lumbar x-ray by the facility nurse practitioner, but had not yet completed. ADON "K" reported Tylenol was helping pain, and a [brand name] pain patch was ordered. Review of Resident #73's fall Care Plan, accessed 08/03/22 at 1:30 p.m., revealed, "Problems: I had a FALL: FALL AEB [as evidenced by] observed sitting on floor in bathroom. Active. Monitor for subsequent injury x 72 hours. Status: Active. Goal date: 08/03/22. Update CP [Care Plan] ...as needed, i.e. change in transfer status, interventions implemented ..." The Care Plan included monitoring of Resident #73 post fall but did not include reasons for fall risk or specific interventions implemented after the 08/01/22 fall. Review of Resident #73's August 2022 Medication Administration Record (MAR), accessed 08/03/22 at 9:21 a.m., revealed Resident #73 received "acetaminophen 325 mg tablet oral as needed every four hours, starting 04/13/2022, order date 04/13/2022 ...[for] pain unspecified". Record review revealed acetaminophen was adminstered five times after Resident #73's fall: - On 08/01/22 at 14:17 [2:17 p.m.] pain 6/10 designated as generalized. - On 08/01/22 at 20:20 [8:20 p.m.] pain	F689		

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F689	Continued From page 43 7/10 designated as generalized. - On 08/02/22 at 10:11 [a.m.] pain 5/10 right hip. - On 08/2/22 at 14:11 [2:11 p.m.] pain 5/10 right hip. - On 08/03/22 at 5:25 [a.m.] pain 8/10 generalized. Review of Resident #73's July 2022 MAR, prior to this fall, did not reveal any doses of acetaminophen were administered. Review of the Electronic Medical Record (EMR) revealed no x-ray results for the pelvic and lumbar x-ray by the end of the survey, and no provider (physician visit) report. The facility nursing management reported they had not yet received the x-ray results or the provider report by the time of survey exit on 8/04/22 end of day. Surveyor requested a policy for equipment safety from the Director of Nursing (DON) during the survey. It was confirmed via email from the DON on 08/04/22 the facility did not have a policy for equipment safety respective to bathroom equipment or durable medical equipment.	F689		
F692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) 483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- 483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight	F692	Element 1: Resident #4: Nutritional status was reviewed and updated on 8/12/22 to include a dietary progress note with food preferences reviewed and updated to include alternative protein options. Nutrition/Hydration care plan updated. Resident #40: Nutritional assessment was completed on 8/5/22 to ensure nutritional interventions are current and appropriate for pressure injury and weight loss. Assessment included meal observations. Nutrition/Hydration care plan reviewed.	8/30/22

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F692	Continued From page 44 or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; 483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; 483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure nutritional asesssment, monitoring, and interventions were in place for wound healing and to prevent significant weight loss for four Residents (#4, #40, #76, and #82) out of eight reviewed for nutrition. This deficient practice resulted in significant weight loss, and the potential for further skin breakdown and functional decline. Findings include: Resident #4 On 8/1/22 at 12:04 p.m., Resident #4 (R4) was observed in her wheelchair in the common area. Registered Nurse (RN "FF") was asked about any open areas and reported the resident had a pressure ulcer near her coccyx that was facility acquired. A review of R4's medical record revealed she admitted to the facility on 3/4/20 with diagnoses including Alzheimer's disease, depression, and anxiety. A review of her 7/13/22 Minimum Data Set (MDS) assessment revealed she scored 3/15 on the Brief Interview for Mental Status	F692	Resident #76: MDS for 6/15/22 corrected with correct weight from the reference timeframe. Nutritional assessment completed on 8/12/22 which includes current weight review and re-estimation of needs related to pressure injury. Interventions reviewed along with collaboration with speech therapist regarding feeding strategies to align with comfort care. Nutrition/Hydration care plan reviewed. Resident #82: Nutritional assessment was completed on 8/8/22 addressing weights, intake, and interventions with respect to comfort care. Nutrition/Hydration care plan reviewed. Element 2: All residents have the potential to be affected. Residents who have weight loss or pressure injuries are being reassessed including nutrition assessment and/or progress note and care plan updates completed as warranted to ensure interventions are being implemented as directed and plan of care accurately reflect current treatment regime. These assessments will be ongoing. Element 3: A process was implemented to include weekly meetings between nursing and the dietician to review the weights and ensure the weight process implemented appropriately. The Registered Dietitians were educated on the weight process, the EMR alerts, use of the EMR weight reports, and newly created excel weight report. Per the weight process, the registered dietitians complete timely nutritional assessment along with appropriate interventions and monitoring. Education was provided on 8/25/2022.	

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F692	Continued From page 45 (BIMS) assessment indicating severely impaired cognition and had one facility acquired stage two pressure ulcer. A review of R4's progress note dated 7/5/22 revealed, "Res (Resident) observed to have a 0.7 x 0.5 cm (centimeter) stage 2 pressure injury on her right gluteal fold. Surrounding skin erythmetous. Wound bed red/pink and appears moist. Wound cleansed and 3x3 optifoam applied to site. Added to providers board. Family to be notified in AM (morning)." There were further narrative note about this wound in the progress notes. The only documentation found of the wound was on the treatment record. On 8/2/22 at 9:05 a.m., R4 was observed seated at table in the dining room with her meal in front of her. R4 stated to Certified Nurses Aide (CNA) "GG", I don't like these. CNA "GG" asked if R4 was talking about not liking the eggs and R4 stated, "Yes, I've never liked them." CNA "GG" reported they would tell the kitchen staff. R4 only had a bagel on her tray apart from the beverages, and no alternative protein item was offered. On 8/3/22 at 9:00 a.m., R4 was observed at a table in the dining room with her meal as follows: scrambled eggs, toast, and oatmeal. R4 was observed to eat the toast and oatmeal, but did not eat the eggs. No alternative protein was provide to aid in wound healing. On 8/4/22 at 9:31 a.m., R4 was observed at a dining table with all of her food (toast and oatmeal) eaten, but her scrambled eggs were untouched. No alternative protein was provide to aid in wound healing. A review of R4's undated skin care plan	F692	Element 4: Registered Dietitian or designee will audit 5 residents monthly with weight loss as defined by the CMS RAI Manual and/or with pressure injury to ensure appropriate nutrition assessment, care planning, monitoring, and interventions. Findings and trends will be submitted to the Director of Nursing (DON) and regional Director of Nutrition weekly and presented at QA committee for review. The dietician is responsible for compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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F692	Continued From page 46 revealed, "...Please encourage fluids and adequate nutrition..." as an intervention. A review of a physicians order dated 7/6/22 by Registered Dietitian (RD) "EE" revealed, "Recommend Prostat (protein supplement) 1 pkt (packet) with 30 mL (milliliters) fluid BID (twice per day) and Med Pass 2.0 (nutritional supplement) (90 mL) BID to promote weight stabilization and wound healing." A review of the Medication Administration Record (MAR) revealed that in June 2022 14 doses of the Med Pass supplement were not given, twice for Resident refusal, twice with no documentation noted, twice for it not being available, and the remaining 8 doses did not indicate why it was not given. A review of the August 2022 MAR from 8/1/22 through 8/4/22 that no doses of the ordered Med Pass had been given, and on only one day was it documented as not given due to "none to give/kitchen to reorder". On 8/4/22 at 11:38 a.m., a phone interview was conducted with Registered Dietitian (RD) "F". When asked about food preferences, RD "F" reported that the facility didnt have them documented prior to her starting in June of 2022 and that she was in the process of getting them updated. When asked how often residents with significant weight loss should be reviewed, RD "F" stated, "It should be monthly." When asked when Residents with new pressure ulcer should be assessed, RD "F" stated, "Right away." When asked about the intake monitoring of the supplements, RD "F" reproted that when she started in June 2022 she had requested that nursing start to document how much of the supplements were accepted.	F692		

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F692	Continued From page 47 Resident #40 A review of Resident #40 (R40's) medical record revealed she admitted to the facility on 9/22/17 with diagnoses including dementia, major depression, and debility. A review of her 5/17/22 MDS assessment she was assessed by staff to be severely impaired in cognition, and was at risk for pressure ulcer development. A review of R40's progress note dated 7/5/22 revealed, "Family was updated on medication change. Resident was observed with a 2.0 cm x 2.5 cm DTI (deep tissue injury) on the rt (right) heel. DTI is observed with a white center and reddish brown in color surrounding. Family updated." There were no further progress notes in her medical record regarding the status of the wound. The only documentation of the wound was found on the Treatment Administration Record (TAR). A review of a Physician Progress note dated 7/7/22 for R40 revealed, ".... She has developed a new deep tissue injury to her right heel since previous visit... continue nutritional supplementation. Staff to report any worsening in condition." A review of a physician order for R40 revealed she was ordered Med Pass (Resource - a nutritional supplement with calories and protein) 90 ml's twice per day as of 6/24/22. A review of the July MAR for this order revealed it was not given as ordered 15 times out of 32 possible administrations. A review of R40's weight log revealed the following: 2/1/22 139.6 pounds	F692		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F692	Continued From page 48 5/1/22 142.0 pounds 7/2/22 136.2 pounds 8/1/22 127.6 pounds (-14.4 pounds or 10% in 3 months, and -8.6 pounds or -6.3% in month - significant). On 8/3/22 at 8:55 a.m., R40 was observed sitting in a wheelchair at the dining table. Her meal tray was covered and pushed approximately 1 foot inward to the center of the table, out of R40's reach. Licensed Practical Nurse (LPN) "AA" came and sat next to R40 to start mixing a packet of Carnation Instant Breafast powder into her milk. At 9:10 a.m., the surveyor approached R40, who had still not received any food, only sips of milk. R50 was asked how her breakfast was and stated, "I want food." LPN "AA" stated to R40 that she would need to heat the breakfast food up. LPN "AA" continued to give R40 sips of chocolate milk instead of trying to feed her the breakfast meal. A review of R40's nutrition care plan initiated on 9/23/17 revealed, "... My diet order is: Puree solids/level 4 with nectar liquids/ level 2. Encourage small sips/bites at a slow rate, upright after meals... Provide resource 2.0 BID with med pass. Offer me fortified foods with meals. Offer carnation instant breakfast as the breakfast meal." On 8/3/22 a review of R40's medical record revealed the last nutrition note was dated 5/18/22 by RD "EE", indicating the significant weight loss and new pressure ulcer development were not reviewed by any qualified nutrition professionals. On 8/4/22 a review of the R40's record revealed a nutrition note had been written on 8/3/22. It did not reveal any new nutritional interventions and	F692		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F692	Continued From page 49 did not document any observations of the assistance that R40 was receiving at meals. Resident #76 On 8/1/22 at 12:05 p.m., Resident #76 (R76) was observed up in a gerichair in the common area. RN "FF" was asked if R76 had any areas of breakdown and reported that they had just found a stage II pressure ulcer that same morning. A review of a progress note dated 8/1/22 for R76 revealed, "Resident has a new stage 2 PI (pressure injury) to Coccyx measuring 1.1x0.3x0.1cm..." A review of Resident R76's medical record revealed she admitted to the facility on 10/27/16 with diagnoses including dementia, history of a stage III pressure area, and peripheral vascular disease. A review of her 6/15/22 MDS assessment revealed she was assessed by staff to be severely cognitively impaired and was at risk for developing pressure ulcers. This assessment did not answer the questions of whether or not she had experienced significant weight loss and listed her weight as 187 pounds. Per weight records R76 weighed 136.2 pounds on 6/12/22 and has not weighed anywhere near 187 in the past year. A review of R76's weight log revealed the following: 2/2/22 143.4 pounds 5/1/22 134.2 pounds 7/3/22 131.0 pounds 8/1/22 129.0 pounds (-14.4 pounds or 10% in 6 months) A review of the most recent note regarding	F692		

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	235088	A. BUILDING _____ B. WING _____	C 08/04/2022

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F692	Continued From page 50 R76's nutrition was written by Registered Nurse (RN) "II" on 7/21/22 indicating a significant weight loss of 10% in 180 days. The most recent note provided from a qualified nutrition professional was dated 3/22/22. A review of R76' meal ticket revealed, "... Diet: General. Texture: Liquid Puree. Fluid: thin...mugs with lids and straws... CIB (carnation instant breakfast) with whole milk..." A review of a progress note for R76 dated 7/8/22 revealed, "Resident was noted by staff to be letting her liquid pureed diet run out of her mouth during feeding/has been difficult to feed lately; ST (speech therapy) screen sent in to re-evaluate." On 8/2/22 at 9:16 a.m., R76 was observed at a table in the dining area and was sucking on her hand. At 9:18 a.m. CNA "CC" put clothing protector on R76 and proceeded to start opening and setting up her tray. Each time CNA "CC" picked up a cup, R76 would open her mouth very wide and glare at CNA "CC". At approximately 9:24 a.m., CNA "CC" finally gave R76 a sip of juice which took approximately 12-15 seconds for her to swallow before opening her mouth wide again. CNA "CC" used a spoon to give R76 small bites of food. On 8/3/22 at 8:55 a.m., CNA "CC" was observed standing near R76 at the dining table. R76's meal was pushed toward the center of the table and R76 was starting at the cups. The meal was noted to be untouched. At 8:59 CNA "CC" sat down beside R76 and proceeded to scoop the brown sugar off the top of the oatmeal. R76 was observed staring at CNA "CC" opening her mouth very wide to signal she wanted to eat/drink. CNA "CC" then left the table to	F692		

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	235088	A. BUILDING _____ B. WING _____	C 08/04/2022

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F692	Continued From page 51 retrieve a packet of thickener and then went to the opposite side of the table to assist another resident in eating. R76 watched as the other Resident was fed and continued to open her mouth wide for a bite. CNA "CC" finally returned to R76 at approximately 9:07 a.m. and gave her a sip of cranberry juice. CNA "CC" then started to feed the resident next to R76 who was sleeping with her eyes closed. CNA "CC" proceeded to give R76 a small bite of food on a plastic spoon. On 8/4/22 at 9:26 a.m., CNA "BB" was observed assisting R76. CNA "BB" was observed using a squished paper cup to dump milk into R76's mouth. R76 appeared to be struggling to clear the amount of food that was being given to her and food was dribbling out of the corners of her mouth and onto her clothing protector. CNA "BB" repeated "Swallow it.," over and over to R76 in rapid succession. The Carnation Instant Breakfast packet was uponed on the tray and had not been mixed into the milk that R76 was being given. A review of R40's nutrition care plan initiated on 9/23/17 revealed, "... My diet order is: Puree solids/level 4 with nectar liquids/ level 2. Encourage small sips/bites at a slow rate, upright after meals... Provide resource 2.0 BID with med pass. Offer me fortified foods with meals. Offer carnation instant breakfast as the breakfast meal." On 8/4/22 at 1:55 p.m., an interview was conducted with Speech Therapist (ST) "OO" and the Director of Rehab "PP". When asked about the observations of how CNA "BB", CNA "CC", and LPN "AA" were feeding residents, the Director of Rehab reported that their department had done many educations on proper feeding	F692		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F692	Continued From page 52 techniques as well as the Nursing Education department. Neither ST "OO" or the Director of Rehab could answer as to why the staff were not feeding the residents per the care plan, but indicated that residents who are awake and alert should be fed, especially if showing signs of hunger, before residents who are sleeping. A review of the facility policy titled, "Monitoring monthly weights and vital signs" dated 11/3/21 revealed, "... 2. The nurse will complete the (Name of Facility) Weight loss-gain process, which alerts the designated group (including the dietician) of the weight change... the process includes, but is not limited to, documenting potential contributing factors, notification to the provider and responsible party, as well as appropriate care planning..." A review of the facility policy titled, "Sunroom dining room service" dated 6/29/10 revealed, "...12. Assigned CNAs will observe residents' food preferences/dislikes, changes in eating habits, increase/decrease in food intake, chewing/swallowing difficulties, problems with or need for adaptive devices, and will report observations to the (name of Facility) ADON (assistant director of nursing) or designee accordingly..." Resident #82 Review of Resident #82's Electronic Medical Record (EMR) revealed an admission date of 1/19/18 and diagnoses including: dementia, Parkinson's disease, dysphasia, and weakness. Her 6/22/22 Quarterly Minimum Data Set (MDS) assessment revealed she was unable to	F692		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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 08/04/2022

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F692	Continued From page 53 complete the Brief Interview for Mental Status (BIMS) score and was marked with severely impaired cognition. She was also noted to need extensive one person assist for eating, and was not marked for a significant weight loss. On 8/1/22 at 1:15 p.m., Resident #82 was observed in the small dining room located in the Dogwood hallway. Resident #82 was asleep in her high-back wheelchair at a dining room table. On 8/2/22 at 9:06 a.m., Resident #82 was observed in the small dining room waiting for her breakfast meal. Resident #82 appeared to be asleep in the small dining room. A review of Resident #82's weights included the following: 1/2/22 130.6 lbs 2/2/22 124 lbs (significant weight loss 5% times one month) 3/2/22 123 lbs 4/2/22 121.2 lbs 5/2/22 120.0 lbs 5/22/22 116.8 lbs 5/29/22 117.6 lbs 6/2/22 118 lbs 7/2/22 116.6 lbs (significant weight loss 10% times six months) 7/31/22 114.8 lbs 8/1/22 114.4 lbs A review of Resident #82's "Nutritional Quarterly Assessment" dated 4/1/22 and written by RD "Z" read, in part, "No significant weight change x (times) 30, 90, or 180 days however weigh is down -5# (pounds) over the past 180 days ..." A review of Resident #82's "Nutritional Quarterly Assessment" dated 6/22/22 and written by RD "EE" read, in part, " ...No significant weight	F692		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F692	Continued From page 54 changes but has continued to gradually lose weight over the past 6 months of which approximately 50% occurred over the past 3 months ..." A review of the most recent note regarding Resident #82's nutrition was written by Registered Nurse (RN) "II" on 7/18/22 indicating a significant weight loss of 10% in 180 days. A review of Resident #82's nutritional care plan read, in part, "I am at risk for alterations in my nutritional and hydration status r/t (related to) dx (diagnoses) of Parkinson's and dementia. I need assistance at meals. My intake is usually good though my weight has been gradually trending downward ..." An active date of 1/26/22 read, "Offer me fortified foods with meals and instant Breakfast TID for an additional 1400 kcals and 54 gms protein daily." There were no additional interventions noted or attempted to prevent Resident #82's weight loss.	F692		
F740 SS=D	Behavioral Health Services CFR(s): 483.40 483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by:	F740	1. Nursing staff attempted to make contact with the family of Resident #40 on 8/3/22 and 8/5/22. They did reach family on 8/8/22. Family was in agreement with medication dose reduction. Resident #40 was seen by the provider on 8/23/22. Her Remeron reduction remained appropriate. Resident #50s wife was updated on his Seroquel reduction on 7/19/22 and in agreement. Resident 50 was seen by the provider on 7/25/22 following his Seroquel dose reduction of which remained appropriate for him. Resident #56s family was updated and is in agreement of medication dose reductions on 7/1/22. Resident #56 was	8/30/22

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F740	Continued From page 55 Based on observation, interview, and record review, the facility failed to ensure that Gradual Dose Reduction (GDR) recommendations were reviewed individually, discussed with family, and monitored to ensure effectiveness for three Residents (#40, #50, #56) out of five reviewed for medication management. This deficient practice resulted in the potential for unmet psychosocial needs. Findings include: Resident #40 A review of Resident #40 (R40's) medical record revealed she admitted to the facility on 9/22/17 with diagnoses including dementia, major depression, and debility. A review of her 5/17/22 Minimum Data Set (MDS) assessment she was assessed by staff to be severely impaired in cognition, and per this assessment was not marked as having any behaviors. A review of R40's 8/3/22 progress note revealed, "Resident has NO (new order) of Remeron (antidepressant) reduction from 30mg to 15mg once daily for 14 days. process initiated. family needs to be notify (sic) at the most convenient time." A review of a 7/29/22 Medication Regimen Review (MRR) revealed, "... Psychotropic medication(s) reviewed for appropriate use and timely GDR evaluations... Potential irregularity found. See report for physician recommendation..." The recommendation report was not received as part of the MRR as requested. A review of an 8/2/22 Physician progress note revealed, "... considering for vaginal (sic - gradual) dose reduction of Remeron... does	F740	seen by the provider on 8/10/22 and the Paxil dose reduction remains appropriate. 2. Residents taking psychoactive medication have the potential to be affected. The process of notifying families and having collaborative discussion was reviewed with the medical director. The Medical Director has asked the medical group to complete progress notes with medication changes during the daytime hours to allow for family notification during wake hours. Additionally, the Medical Director will ask the team to include the GDR recommendations in their Medical Record Reviews. Nursing and Social Work received education regarding notification and discussion of GDRs with families. The policy and procedure for family notification remains in place. 3. CQI will audit the residents undergoing a GDR bi-weekly to ensure family discussion took place. Results of these audits will be directed to the QA Committee for review. 4. DON responsible for compliance.	

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F740	Continued From page 56 appear to be having hallucinations and delusions during my visit... She had been taking mirtazapine but in the setting of ongoing weight loss will trial discontinuation..." There was no discussion that family was involved and approving of the medication change. On 8/4/22 at 2:38 p.m., an interview was conducted with Social Worker (SW) "HH". When asked about families not being part of the decision to reduce a medication or not being notified until after the change was made, SW "HH" reported that it was not their policy to do so. SW "HH" confirmed that families should be part of the discussion and should always be notified first before medication changes are made. When asked about the Gradual Dose Reductions (GDR's) SW "HH" reported it was often driven by the pharmacy recommendations. Resident #50 A review of R50's medical record revealed he admitted to the facility on 1/10/19 with diagnoses including dementia, difficulty walking, and osteoporosis. A review of his 5/26/22 Minimum Data Set (MDS) assessment revealed he scored 3/15 on the Brief Interview for Mental Status (BIMS) assessment, indicating severely impaired cognition and had two or more falls with injury since the last assessment. A review of R50's physician note dated 7/6/22 revealed, "... He (R50) continues to show behavioral disturbance and hallucinations/delusional thought process with significant agitation and anxiety and aggression towards staff..." A review of R50's physician note dated 7/19/22 revealed, "Resident is seen for evaluation of	F740		

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F740	Continued From page 57 response to recent dose reduction of quietiapine to 12.5 mg once daily on 7/14/22. Nursing documentation is reviewed. Resident has not developed any new adverse behaviors. He continues to wander, have little spatial awareness, require frequent redirection and assistance with meals and has occasional episodes of aggressive and resistant behavior but theses are not outside of his previous baseline prior to dose reduction of quetiapine... Discontinue [brand name of quietiapine]. Suspect this is contributing very little to adverse behaviors..." R50's Seroquel was reduced from 25 mg to 12.5mg on 7/14 and then was discontinued entirely on 7/19, just five days later despite documented behaviors. There is no documentation that family had a part in this conversation or were agreeable. A review of R50's progress notes revealed the following: 7/14/22, "(R50's wife) updated on [brand name of quietiapine] decrease. She had questions on why [brand name of quietiapine] is being decreased, educated (name of R50's wife) on GDR's, states understanding." 7/16/22, "Resident recently had a reduction in his [brand name of quietiapine]; he was noted this AM (morning) to being resistive with care again/hard to feed at times; no combativeness noted thus far; has been resting on/off." 7/26/22, "...Resident remained in bed much of the day occupied with folding and refolding his bedding. Daughter in for visit. Daughter voiced concern with father's preoccupation with sheets distracting him from visiting with her. resident resistive with staff and cares this shift but participates with encouragement. Resident does continue preexisting behavior of hitting staff when they attempt to perform ADLs as he does appear to get over stimulated and triggered with movements that are too quickly performed."	F740		

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F740	Continued From page 58 Resident #56 A review of Resident #56 (R56's) medical record revealed she admitted to the facility on 7/13/17 with diagnoses including dementia, anxiety, and insomnia. A review of her 6/1/22 MDS assessment revealed she was assessed by staff to be severely cognitively impaired and had two more falls since the last assessment. A review of a "Note to Attending Physician/Prescriber" for R56 dated 6/28/22 revealed, "(R56) is currently due for a dose reduction evaluation of Paxil 30 mg QD (every day). Her dose was increased from 20 mg to 30 mg QD on 4/9/2020 and a dose reduction had not been trialed since that time. Please review this resident to determine if a GDR would be appropriate for this medication at this time per state and CMS regulations. This will help protect the facility during survey." This recommendation was signed and "agree" was checked on 7/1/22. There was no documentation that family was a part of the discussion of whether the GDR was desired or appropriate. A review of R56's progress notes revealed the following: 7/1/22 "Resident has new orders (see orders); family was updated/agreed to." 7/13 "Resident is resting in bed with eyes closed at this time. She was observed awake, talking, and hollering out "(Name)" for the last 2 days. No adverse effects r/t (related to) decrease in paxil." 7/22 "Resident has very flat affect this shift and yesterday. Resident responds neither positively or negatively since Paxil reduction. No manic episodes observed since reduction." 7/25/22 "Resident awake throughout night, very restless and calling out "(Name)".	F740		

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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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F740	Continued From page 59 A review of the facility policy titled, "Psychoactive Medication Use" dated 7/20/22 revealed, "...4. Discontinuing or Eliminating a Psychoactive Medication - initiate change regardless of whether you make contact with the family or not. There should be an attempt made to notify family. Consent is not needed... 8. Potential for gradual dose reduction or discontinuation will be reviewed and requested by the Quality of Life Team per Federal Regulatory requirements..."	F740		
F802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) 483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at 483.70(e). 483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide sufficient staff with the appropriate competencies and skills to	F802	Element 1: Department was provided immediate support staff comprised of: dietitians, executive chefs, vice president, regional director of operations, general manager and project managers to carry out the functions of the food and nutrition department. Element 2: An additional general manager has been placed to oversee the dietary operations, review all hourly and management schedules, daily, to ensure proper coverage for the department to carry out the functions required. Ongoing recruitment of staff continue. Element 3: Weekly staffing reports will be provided to Regional Director of Operations and Nursing Home Administrator for review. Staffing numbers and recruitment efforts will be presented to the QA committee for review. The Dietary Manager is responsible for compliance	8/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F802	Continued From page 60 carry out the functions of the food and nutrition services. The deficient practice was evidenced by the lack of scheduled and working staff in the kitchen during food preparation, service and cleaning, as well as the demonstrated lack of knowledge and oversight related to cleaning, delivery of meals to residents, food temperature control and the cleaning of dishes to ensure a sanitary environment, potentially affecting all 132 residents in the form of a food borne illness outbreak. Findings include: On 8/1/22 at 10:45 AM, the initial tour of the kitchen was conducted. Only two scheduled food service staff were present in the kitchen conducting the noon meal preparations. Soiled dishes, cooking utensils, pans and pots were piled around the three compartment sink and the dish machine. Floors were observed to be filthy, attached equipment soiled and unclean. Molded and spoiled food were observed in the walk in cooler, an uncovered large pan of scrambled eggs, expired food, three pans of cooked intact turkey breasts (with no date of cooking) and 6 pans of large intact cooked beef roasts in stainless steel pans. The internal temperature of the roasts ranged from 43F to 41F. An interview with Chef " A " was conducted at this time and asked if only the two staff were responsible for the current meal prep and cleaning. Chef " A " responded " Yes. " When asked where the kitchen manager was, Chef " A " replied " She ' s off today. " On 8/1/22 at 2:30 PM, a review of the staffing schedule was conducted and showed four persons scheduled for this time of the day. Chef "A" was not scheduled to be working on this day 8/1/22. When asked where the other staff were, Chef "A" stated " I don ' t know. That's for {CDM "B"}" . Chef "A" was asked about cooling procedures and documentation (known as cooling logs) for the scrambled eggs and the	F802		

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	235088	A. BUILDING _____ B. WING _____	C 08/04/2022

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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F802	Continued From page 61 beef roasts in the walk in cooler. Chef "A" stated " I don ' t know anything about cooling logs. " On 8/2/22 at 8:20 AM, the morning meal service was observed in the kitchen. Only two scheduled food service workers were present setting up trays and transporting the trays to the individual resident unit/rooms. The NHA and CDM were present in the kitchen assisting in these duties. On 8/1/22 at 1:45 PM, an interview with CDM "B" was conducted in the kitchen. CDM "B" was shown the rotting and spoiled food (cucumbers, strawberries) along with the beef roasts. When asked about documentation for the cooling process of the turkey breasts, scrambled eggs and beef roasts, CDM "B" replied " I don ' t have any of those. I don ' t know " . Observations were made at the three compartment sink where the soiled end was piled high (over 4 ' above the drain boards) with soiled and dirty pans, utensils, pots and other cooking equipment. At the sanitizing compartment, this surveyor, using the facility test strips, measured 150 ppm (parts per million) quaternary disinfectant. When CDM "B" was asked what sanitizer they were using in the sanitizing compartment, CDM "B" replied "I'm not sure " . When asked what the concentration of the sanitizing chemical was supposed to be during the sanitizing process, CDM "B" replied " 50? " . The directions for use on the container and dispensing system were reviewed, with CDM "B" . The container identified the disinfectant to be a quaternary compound with a minimum concentration of 200 ppm. When asked where staff documented the concentration of sanitizing chemicals in the sink, CDM "B" replied " I don ' t think they do." On 8/2/22 at 10:57 AM observations of the mechanical dish machine were made. The	F802		

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F802	Continued From page 62 digital final rinse temperature gauge, on the top of the machine was observed during the placement of 10 racks being pushed through. On the tenth rack through, using this surveyor ' s tools, including a self adhesive 160F Thermolable, heat sensitive irreversible strip was attached to a ceramic plate, and a Dish Temp irreversible maximum registering thermometer were placed on a rack and allowed to go through the wash, rinse and sanitize cycle of the machine. When the rack exited the conveyor of the machine, the strip had not turned black, indicating the plate surface had not reached the minimum temperature of 160F and the maximum registering thermometer read 154F. this temperature corresponded to the temperature read out on the top of the dish machine. When the temperature on the machine read out was pointed out to CDM "B" , she responded by stating " Oh, I think the thermostat isn ' t working. " When CDM "B" was shown the irreversible thermometer matched the read out on the machine, CDM "B" stated " Oh. " CDM "B" was then requested to conduct a test of the dish machine using the facility procedure. CDM "B" brought out a box of " T-sticks " , removed one, and placed it on a plastic caf tray and placed the tray on a dish machine rack. CDM "B" stated " It ' s probably going to just get washed off. " On the same rack, another plate with an irreversible Thermolable and the maximum registering thermometer were placed to go through the machine cycle concurrently. The maximum temperature the final rinse gauge read was 158F during the cycle. When the rack exited the machine, the " T-Stick " was not present, the maximum registering thermometer read 158F and the Thermolable had not turned black, indicating the food contact surface had not reached the minimum 160F. CDM "B"	F802		

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F802	Continued From page 63 opened the dish machine and retrieved the " T-stick " and showed it had also not reached 160F. The container of " T-sticks " was then retrieved and the directions shown to CDM "B" for testing the water temperature of the machine. The container directions were clear as to place the cardboard part of the device within the tines of a fork to hold it in place. (this prevents it from being washed away). Further, the " T-sticks " are not approved for the demonstration of the food contact surface temperature compliance, rather, only indicates if the water temperature reached the temperature for which the " T-stick " is engineered to measure. CDM "B" stated, following the reading of the directions, " I didn ' t know that. What do we do now? " CDM "B" was then asked to produce documentation the dish machine had been properly sanitizing food contact surfaces prior to this time. CDM "B" stated " We don ' t have any documentation for that. " When asked when the dish machine was last documented properly sanitizing dishes, CDM "B" stated " That was before me. " When asked how long that was, CDM "B" stated " over three months. " On 8/1/22 at 10:15 AM, during an interview with the Nursing Home Administrator (NHA) It was learned the dietary operations for the facility were provided by an outside vendor, and the facility was not involved in the day to day management and operations of the kitchen or its staffing. This included the registered dietician(s), kitchen manager and all kitchen staff. The vendor was responsible for all scheduling and personnel. On 8/2/22 at 10:35 AM CDM "B" confirmed her responsibilities for hiring, scheduling and management of the kitchen function. ..	F802		

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F806 F806 SS=D	Continued From page 64 Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) 483.60(d) Food and drink Each resident receives and the facility provides- 483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; 483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that food preferences were obtained and followed for one Resident (#4) out of 24 sampled residents. This deficient practice resulted in unmet food preferences and reduced protein intake and the potential for delayed wound healing. Findings include: Resident #4 On 8/1/22 at 12:04 p.m., Resident #4 (R4) was observed in her wheelchair in the common area. Registered Nurse (RN "FF") was asked about any open areas and reported the resident had a pressure ulcer near her coccyx that was facility acquired. A review of R4's medical record revealed she admitted to the facility on 3/4/20 with diagnoses including Alzheimer's disease, depression, and anxiety. A review of her 7/13/22 Minimum Data Set (MDS) assessment revealed she scored 3/15 on the Brief Interview for Mental Status	F806 F806	Element 1: Resident #4: Nutritional plan of care reviewed and updated on 8/12/22 to include a dietary progress note with food preferences reviewed and meal ticket updated to include alternative protein options. Nutrition/Hydration care plan updated. Element 2: All residents have the potential to be affected. Food preferences are gathered a variety of ways: nursing staff assists residents daily with menu choices; at time of service, residents, nursing as needed may request alternative options. The registered dietitians obtain food preferences when interacting with residents and families during assessments and as applicable. Preferences will be entered into the residents profile in the dining office/menu management system. Preferences will be reviewed at least quarterly thereafter. Element 3: Dietary staff will be educated on how to read the tray tickets noting the preferences to ensure the resident receives their desired food items. The dieticians will be educated on the process of obtaining food preferences and documenting them into the menu management system. This education will be completed by 8/29/2022. Element 4: Registered dietitians will audit 5 resident charts weekly to ensure food preferences are completed. Findings and trends will be submitted to the Director of Nursing (DON) and regional Director of Nutrition weekly and presented at QA committee. The dietician is responsible for compliance	8/30/22

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F806	Continued From page 65 (BIMS) assessment indicating severely impaired cognition and had one facility acquired stage two pressure ulcer. A review of R4's progress note dated 7/5/22 revealed, "Res (Resident) observed to have a 0.7 x 0.5 cm (centimeter) stage 2 pressure injury on her right gluteal fold..." On 8/2/22 at 9:05 a.m., R4 was observed seated at table in the dining room with her meal in front of her. R4 stated to Certified Nurses Aide (CNA) "GG", I don't like these. CNA "GG" asked if R4 was talking about not liking the eggs and R4 stated, "Yes, I've never liked them." CNA "GG" reported they would tell the kitchen staff. R4 only had a bagel on her tray apart from the beverages, and no alternative protein item was offered. On 8/3/22 at 9:00 a.m., R4 was observed at a table in the dining room with her meal as follows: scrambled eggs, toast, and oatmeal. R4 was observed to eat the toast and oatmeal, but did not eat the eggs. No alternative protein was provide to aid in wound healing. On 8/4/22 at 9:31 a.m., R4 was observed at a dining table with all of her food (toast and oatmeal) eaten, but her scrambled eggs were untouched. No alternative protein was provide to aid in wound healing. A review of R4's meal ticket revealed no indication that her preference to not have scrambled eggs had ever been documented or communicated. A review of R4's care plan revealed no documentation regarding her preference to not have scrambled eggs.	F806		

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F806	Continued From page 66 A review of a facility policy titled, "Resident Food Preferences" revised 1/18 revealed, "... Residents are served meals that offer choices, including portion size, and comply with food preferences.... Dietitian/Designee: Interviews the resident within 24-48 hours of admission. Obtain food and dining preferences, dislikes, allergies, and cultural, religious, and ethnic preferences. Records the information in the resident's nutrition file. Updates preferences on a regular basis, minimally quarterly..."	F806		
F809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) 483.60(f) Frequency of Meals 483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. 483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. 483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by:	F809	Element 1: Timeliness of Meals: " Reviewed processes required for timely meal service including food production. Initiated tracking of cart delivery times. Between Meal Snacks: " Developed a floor stock list which includes items specifically for between meal snacks. Attended resident council for feedback. Nursing was provided the list of snacks available and the units are being stocked daily. Element 2: Timeliness of Meals: " Dining service staff will be educated by 8/29/2022 on established meal times and required start times for timely tray service delivery. Between Meal Snacks: " Floor stock / snack list has been implemented. Educated team members responsible for between meal snack assembly and delivery on this process by 8/29/2022. Nourishment policy reviewed and updated. A dietary representative will attend resident council for continued feedback.	8/30/22

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F809	Continued From page 67 This citation pertain to intake MI00129685 Based on observation, interview, and record review, the facility failed to consistently provide meals in a timely manner and provide a nourishing snack to all 132 residents. This deficient practice resulted in the potential for resident to not have a hot meal or to have more than 14 hours between a substantial evening meal and breakfast the following day, decreased oral intake, and the potential for weight loss. Findings include: On 8/1/22 at 12:07 p.m., an interview was conducted with Resident #122 who was laying in her bedroom. Resident #122 stated that the meals provided by the facility are constantly late and expressed frustration having to wait. Resident #122 stated that it normal to wait over an hour to receive meals. On 8/1/22 at 1:27 p.m., Certified Nurse Aide (CNA) "S" was observed using the microwave to warm up the lunch meal for residents in the main dining area. CNA "S" stated that she needed to reheat the meal because it had been sitting out so long and was cold. Three residents in the main dining area were waiting for their meals to be reheated. On 8/2/22 at 9:17 a.m., an observation of the small dining room located inside the Dogwood hallway noted eight residents waiting for their breakfast meal. On 8/2/22 at 9:40 a.m., an observation of the same small dining room located in Dogwood showed the same eight residents currently waiting for their breakfast meal. On 8/2/22 at approximately 10:00 a.m., the	F809	Element 3: Timeliness of Meals: " Interim General Manager and/or Dining Service Director completes regular observation rounding to ensure that meals are served within the time and audits twice a week to document compliance. Completed audits provided to the administrator and presented at QA. Between Meal Snacks: " Interim General Manager and/or Dining Service Director will audit pantries twice a week to assess snack par levels. Based on resident preferences / usage and input from resident council, snack list will be updated as warranted. The results of these audits will be presented to the QA committee. The dietary manager is responsible for compliance.	

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F809	Continued From page 68 breakfast meal cart was in front of the small dining room of Dogwood with staff members passing out the trays to residents. An interview was conducted with Registered Nurse (RN) "T" regarding the meal service. RN "T" stated, "This is awful. I have some residents who prefer to have their medication with meals, so now med (medication) pass is delayed. They (residents) will either skip their lunch meals or will just refuse this breakfast." During a group meeting to review the Resident Council task on 8/02/22 at approximately 3:30 p.m., group residents were asked if they received evening snacks, with responses as follows: Confidential Resident C1: Resident C1 reported sometimes there were not any evening snacks, and the aides had to go to other halls to look for snacks. Resident C1 reported this had been since about May (2022) when [new kitchen vendor] started. Resident C1 explained she was speaking of dry snacks primarily, such as tortilla chips or similar items. Resident C1 reported they had brought the concerns to the dietary department manager (Certified Dietary Manager (CDM) "B") and other managers during resident council meetings, with no improvement. Resident C1 reported the kitchen was closed at 7:00 p.m., which was confirmed by other group meeting participants. Review of the Electronic Medical Record (EMR) revealed Resident C1 scored 15/15 on the Brief Interview for Mental Status (BIMS) cognitive	F809		

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F809	Continued From page 69 cognitively intact. Confidential Resident C2: Resident C2 reported sometimes there were no evening snacks, and they were supposed to be put in the unit refrigerator. Resident C2 explained she wanted yogurt and it was often not there, and there were no protein snacks available such as eggs, cheese, or sandwiches with protein. C2 explained she was speaking of refrigerated snacks primarily. Review of the EMR revealed Resident C2 scored 13/15 on the BIMS assessment which revealed Resident C2 was cognitively intact. During an interview 8/03/22 at 11:55 a.m., the Assistant Director of Nursing, (ADON) "K", was asked if there was a shortage of snacks for residents. ADON "K" confirmed during June (2022) staff were struggling to obtain evening snacks for residents, due to the transition from the former to new kitchen services vendor. During an interview on 8/03/22 at 12:00 p.m., CDM "B" was asked about the reports of snack shortages by resident council residents. CDM "B" reported they provided yogurt however eggs or cheese would require too much monitoring, and staff were too short on units to monitor this (dates of expiration). CDM "B" reported they did provide peanut butter and jelly to unit refrigerators for staff to make sandwiches, but confirmed there were no ready made sandwiches on the unit. Other sandwiches could be requested before the kitchen closed in the evening. CDM "B" reported the kitchen did not close until 8:00 p.m., which was a later time than residents reported during the group meeting. CDM "B" reported they provided the snacks to	F809		

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F809	Continued From page 70 the unit, and floor nursing staff (aides) distributed the snacks. CDM "B" acknowledged in June (2022) during the transition from the former kitchen food vendor to their company there was a few days they were unable to obtain pudding, but did not recall any other snack shortages. CDM "B" confirmed there were snacks their company was unable to provide which residents have requested, such as cheese and crackers packets, however they provided appropriate substitutes such as peanut butter and crackers. CDM "B" reported they had not been able to get some of the same snacks as the other kitchen vendor had been, and understood the residents' concerns. They reported there should be evening snacks available on the units, as the kitchen stocked the unit kitchens daily. It was unclear to them why there would not be enough snacks available on the units. During an observation on 8/03/22 at 12:18 p.m., Certified Nurse Aide (CNA) "Y" showed surveyor the snack room on a nursing resident care unit, which contained a variety of dry snacks, breakfast bars, canned soups, yogurt, pudding, and beverages. There were no cheese snacks, cheese and crackers, eggs, or sandwiches; CNA "Y" reported they could make residents peanut butter and jelly. They reported the unit residents had preferences the other vendor provided, such as large [vendor name] specialty cookies, and other preferred snack brands. CNA "Y" reported they heard residents complaining they don't like the types of snacks provided. During an interview on 8/03/22 at 12:39 p.m., Resident C-1 reported she preferred a snack around 9:00 or 10:00 p.m., and was currently being told by the nursing staff, her aides, that there were no snacks available per her	F809		

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F809	Continued From page 71 preferences. She reported her aides told her they looked on other units, and found the same. Resident C-1 reported yesterday evening (8/02/22) she asked her aide to get her one of the dry bagged snacks (either tortilla chips or another type) and again was told none was available. Resident C-1 said this made her feel frustrated, and she would ask for snacks earlier in the day now, since none were consistently available at night. Resident C-1 reported she was diabetic and ate five times per day per her medical needs, and this was distressing to her. She reported when you send the aides to other units and they can't find these snacks anywhere, this was an issue. She stated, "Now I understand it is my right (to get an evening snack)." Review of the Resident Council Meeting minutes dated 7/27/22 for [resident care unit] revealed Confidential Resident #9 commented " ...No one has offered me snacks. I love popcorn. I will ask for popcorn; the staff leave the room and tell me they don't have popcorn..." Resident C-9 expressed this same concern in Resident Council meeting on 6/21/22, and the minutes reflected popcorn was available as a snack. Review of [name of unit] Resident Council minutes from 6/21/22 showed Resident C-10 reported, "With nighttime snacks, it depends on the CNA if they are offered." Review of the policy, "Nourishments", received on 8/04/22, revealed, "To provide supplements in addition to food at mealtimes. Replace nutrients not consumed at mealtimes. To provide nourishments at bedtime due to the length of time between evening meal and breakfast. To provide additional fluids other than at mealtime. Procedure: 1. Scheduled nourishments are delivered to the unit by Dietary	F809		

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	235088	A. BUILDING _____ B. WING _____	C 08/04/2022

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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F809	Continued From page 72 department at 9:30 am. (mid-morning), 2:30 p.m. (mid-afternoon), and 7:00 p.m. (H.S. [at night] and bulk snacks). 2. After delivery, CNA staff will distribute scheduled nourishments to specified residents (by nourishment label). CNA staff will also offer nourishments to all residents such as juice, water, cookies, etc ..."	F809		
F812 SS=L	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) 483.60(i) Food safety requirements. The facility must - 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 as evidenced by not sanitizing food contact	F812	Element 1: Department was provided immediate support staff comprised of: dietitians, executive chefs, vice president, and regional director of operations, general manager and project managers to carry out the functions of the food and nutrition department. The dish machine was put out of order and meal preparation and service was switched to disposables. A work order to Hobart was called 8-2-22 with service scheduled for 8-3-22. The department used disposables for all residents when the dish machine was placed out of order. HACCP (Hazzard Analysis Critical Control Point temperature and sanitation) logs were implemented immediately. All unlabeled and undated items were removed. Juice machines and ice machines have been cleaned and added to a cleaning schedule. Kitchen surfaces and equipment is being cleaned and sanitized daily. Identified refrigerators have been cleaned and sanitized. The CNA identified reheating food items was provided a 1 to 1 inservice at the time of occurrence. Element 2: Systemic changes for the following failures identified: a. All food and nutrition staff were re-educated per the abatement plan on: maintaining temperature logs of the dishwasher, proper procedures for testing,	8/30/22

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F812	Continued From page 73 surfaces, including plates, glasses, cups and flatware used among the entire resident population, and other food preparation equipment/utensils when using the high temperature mechanical dish washer and three compartment sink. This failure included: 1. Staff failing to identify the mechanical dish washer was not reaching a proper water temperature during the sanitizing cycle 2. F\ailing to demonstrate the dish machine had been tested and was properly sanitizing dishes for over a three month period. 3. Failing to operate the three compartment sink in a manner which sanitized food contact surfaces. 4. Failing to provide knowledgeable and competent staff conducting oversight and management of the kitchen functions. 5. Observation of expired and spoiled food was found in refrigerators. 6. Failing to ensure cooling processes were followed for potentially hazardous foods which had been cooked, cooled and stored to be re-heated at a later date. 7. Observations of floors, wall, ceilings and equipment soiled with grease, dust and grime. This deficient practice resulted in a high likelihood of a food borne illness among any or all the 132 highly susceptible resident population. Immediate Jeopardy (IJ) was identified on 8/02/22 at 11:11 AM, when the mechanical dish machine failed to demonstrate proper sanitizing of food contact surfaces and the facility having failed to show the machine had been properly sanitizing for over three months. The Immediate Jeopardy was identified to have	F812	and proper sanitation requirements for food surfaces. b. A plate simulating dish washer thermometer was put into use. i. The plate simulating dish washer thermometer is run through the dish machine 3 times per day and results are documented on the final rinse temperature at dish surface form. c. Quaternary sanitizer and dish machine temperature logs were put into place. The dining services director will retain the logs in the dining services directors office. d. All food and nutrition staff (hourly and management) will complete required education around safety and sanitation by 8/29/22. e. A deep cleaning company completed an assessment on 8/26/22 and has developed a regular deep cleaning schedule. f. Pest control services were in on 8/23/22. A monthly schedule has been added for additional service. g. Completed facility walk through with facilities leadership h. Training is being provided to dining services director, 1:1, ongoing until competency skills met. i. The cooks were educated on the proper use of HACCP controls and HACCP log documentation. j. Thermometers and reheating guides have been placed in the resident meal dining areas for staff who reheat food items. Nursing staff will be educated on the process and guide by 8/29/2022 Element 3: Dish machine temperature logs are being	

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F812	Continued From page 74 begun on 5/01/22, being the initiation of the contract with the current kitchen vendor, when monitoring of the mechanical dish machine ceased to occur and demonstrate proper sanitizing of food contact surfaces which were used among the entire resident population. The Nursing Home Administrator was notified of the Immediate Jeopardy on 8/2/22 at 2:30 PM, with an abatement plan requested at that same time. The abatement plan was submitted and received by the State Agency (SA) on 8/2/22 at 3:49 PM via email from the NHA and accepted at this time. The following observations, interviews and review of records are evidence of the immediate jeopardy: On 8/2/22 at 10:57 AM observations of the mechanical dish machine were made. The digital final rinse temperature gauge, on the top of the machine was observed during the placement of 10 racks being pushed through. On the tenth rack through, using this surveyor ' s tools, including a self-adhesive 160F Thermolable, heat sensitive irreversible strip was attached to a ceramic plate, and a Dish Temp irreversible maximum registering thermometer were placed on a rack and allowed to go through the wash, rinse and sanitize cycle of the machine. When the rack exited the conveyor of the machine, the strip had not turned black, indicating the plate surface had not reached the minimum temperature of 160F and the maximum registering thermometer read 154F. this temperature corresponded to the temperature read out on the top of the dish machine. When the temperature on the machine read out was pointed out to CDM "B" , she responded by stating "Oh, I think the	F812	monitored daily for proper temperatures and completeness by the dietary manager and/or designee. The general manager or designee will audit HACCP (quarternary, cooling food temps, etc)logs daily for completion. A sanitation audit will be conducted weekly to include sanitation, HACCP log compliance, and temperature log compliance, and cleanliness. The results will be presented to the administrator and the QA committee. The general manager is responsible for compliance.	

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F812	Continued From page 75 thermostat isn't working. " When CDM "B" was shown the irreversible thermometer matched the read out on the machine, CDM "B" stated "Oh." CDM "B" was then requested to conduct a test of the dish machine using the facility procedure. CDM "B" brought out a box of "T-sticks" , removed one, and placed it on a plastic caf tray and placed the tray on a dish machine rack. (T-Sticks are irreversible temperature monitors used to measure the internal temperature of food, and can be used to confirm water temperature. They are not approved as a device to demonstrate temperature compliance for a food contact surface.) CDM "B" stated " It ' s probably going to just get washed off." On the same rack, another plate with an irreversible thermolable and the maximum registering thermometer were placed to go through the machine cycle concurrently. The maximum temperature the final rinse gauge read was 158F during the cycle. When the rack exited the machine, the " T-Stick " was not present, the maximum registering thermometer read 158F and the thermolable had not turned black, indicating the food contact surface had not reached the minimum 160F. CDM "B" opened the dish machine and retrieved the " T-stick " and showed it had also not reached 160F. The container of "T-sticks " was then retrieved and the directions shown to CDM "B" for testing the water temperature of the machine. The container directions were clear as to place the cardboard part of the device within the tines of a fork to hold it in place. (this prevents it from being washed away). Further, the "T-sticks" are not approved for the demonstration of the food contact surface temperature compliance, rather, only indicates if the water temperature reached the temperature for which the " T-stick " is engineered to measure. CDM "B" stated,	F812		

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F812	Continued From page 76 following the reading of the directions, "I didn ' t know that. What do we do now?" CDM "B" was then asked to produce documentation the dish machine had been properly sanitizing food contact surfaces prior to this time. CDM "B" stated "We don ' t have any documentation for that." When asked when the dish machine was last documented properly sanitizing dishes, CDM "B" stated " That was before me. " When asked how long that was, CDM "B" stated " over three months. " On 8/01/22 at approximately 10:45 AM, it was observed that the three compartment sink was being used to wash, rinse and sanitize cooking equipment, including pans, pots, and utensils. The facility test strips were utilized to test the concentration of quaternary sanitizer in the sink, and determined it was between 100 and 150 ppm (parts per million). At 1:26 PM an observation of the three compartment sink was again made, with CDM "B" in attendance. The concentration of of quaternary sanitizer was again measured using the facility strips and found to be 100 ppm. An interview with CDM "B" was conducted at this time and asked what the concentration of the sanitizer should be, to which she answered " 50? 100? I'm not sure", then stated " that has probably been there all day." CDM "B" confirmed with Food service worker "D" that the sanitizing solution had not been changed all day. When asked if she knew what chemical was being used for sanitizing, she stated "I am not sure." A review of the sanitizing chemical bottle was conducted with CDM "B" and was noted it was a quaternary chemical and required a minimum concentration of 200 ppm. CDM "B" was asked if there was documentation of testing of the sanitizing solution, to which she replied "We don't keep that." On 8/02/22 at approximately 3:30 PM,	F812		

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F812	Continued From page 77 dishwasher (DW) "E" was observed to take a pan from the middle rinse sink, of the three compartment sink, dip it into the third compartment containing the sanitizing solution, for less than two seconds, then place it on the drain board. CDM "B" was present during this observation and did not correct DW "E" . CDM "B" was then asked how long a food contact surface was supposed to be immersed in the sanitizing solution to be properly sanitized. CDM "B" stated "30 seconds? A minute?" A review of the container of sanitizing chemical revealed that a minimum of 60 seconds was required for proper sanitizing of food contact surfaces. A review of the policies provided by the dietary vendor included: "Policy #F019 Subject: Dishmachine temperatures; Date Issued 5/95; Date Revised: 1/18" This policy stated the following regarding the monitoring of the high temperature dish machine: "POLICIES: Dishmachine wash and rinse water should be maintained at temperatures that meet the guidelines established by the Food and Drug Administration.* state or local regulations will apply if more strict. PROCEDURES: Director Confirms the wash and rinse temperatures listed on the manufacturer's data plate on the dishmachine. Write these temperatures on the Dishmachine Temperature Record. Supervisor/Food and Nutrition Associate as assigned High Temperature Dishmachine - record on	F812		

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F812	Continued From page 78 Dishmachine Temperature Record form: Wash and final rinse temperatures during each period of use. Once a day,run a test strip (160"F strip) through the dishmachine to verify, the surface temperature of a dish. (The machine readings are the temperatures at the manifold of the machine, and not on the surface of the plate). Attach the used test strip to the Test Strips Results form. The test strip must verify that the surface temperature of the plate reached l60F. An alternative is to use an irreversible maximum registering thermometer. Write the sanitizing rinse temperature on the Irreversible Max Temperature form. Immediately brings any substandard temperatures to the attention of management. If documentation of the temperatures and test strips/max temps results has been assigned to a Food and Nutrition Associate, confirms that it is completed at each meal period. Director (In the event of inappropriate temperature) * Determines if reading is due to malfunctioning temperature gauge or inappropriate temperature. * Makes management decision concerning adequacy of sanitation of service ware. If due to inappropriate water temperature (high temperature machine), or inappropriate concentration of sanitizer solution (low temperature machine), implements disposable service ware. Contacts sources of repairs. . Documents action taken on back of form. Director/Designee Verifies completion of logs; initials form weekly. Retains Dishmachine Temperature Records for	F812		

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F812	Continued From page 79 one (1) year A review of Policy #F018: Sanitizing Food Contact Surfaces; Date Issued 5/95; Date revised: 1/18, was conducted and stated the following: Immerse items in sanitizing solution (third sink) for a minimum of 60 seconds. complete pot-sink Sanitizer Concentration Log daily at each meal period. the facility submitted the following abatement plan following the issuance of notice of Immediate Jeopardy: " Abatement Plan 1. Immediately transitioned to disposable products for meal service and food preparation. 2. Reeducation being provided to dietary staff regarding maintaining temperature logs of the dishwasher, proper procedures for testing, and temperature requirements for food surfaces. 3. Hobart (Dishwasher Maintenance Company) contacted and service call scheduled for 8/3/22. 4. Non-disposable cookware will be cleaned utilizing the three-compartment sink where sanitizer is used. 5. Reeducation will be provided to staff regarding use of the three-compartment sink and sanitization. 6. All residents have the potential to be affected however there have been no residents affected. Reeducation started on 8/2/2022 and will be conducted daily until all dietary staff have attended. Disposable products will be utilized until the dish machine meets the required temperatures and has been serviced by Hobart. Once the dish machine is working properly the temperature log will be completed daily.	F812		

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F812	Continued From page 80 The three compartment sink is being utilized and a sanitization (parts per million) log is being completed before use." The Immediate Jeopardy was removed on 8/3/22 at 11:11 AM following demonstration the mechanical dishwasher was operating correctly. Although the immediate jeopardy was removed on 8/3/22, the facility remained out of compliance at a scope and severity of no actual harm with potential for more than minimal harm that has the potential to affect a large portion of the facility's residents due to the inability to verify staff education, all policy updates, system changes, and sustained compliance. The FDA Food Code 2013 states: 4-703.11 Hot Water and Chemical. After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: (A) Hot water manual operations by immersion for at least 30 seconds and as specified under 4-501.111; (B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under 4-501.15, 4-501.112, and 4-501.113 and achieving a UTENSIL surface temperature of 71C (160F) as measured by an irreversible registering temperature indicator; On 8/01/22 at 10:30 AM, the initial tour of the kitchen was initiated. Observations of the walk in cooler included: 1. A large uncovered stainless steel pan containing scrambled eggs. The temperature was measured using a metal stem digital Thermapen, and found to have an internal	F812		

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F812	Continued From page 81 temperature ranging between 95F and 105F. An interview with Chef "A" was conducted at this time. Chef "A" was asked when the pan of cooked eggs had been placed in the refrigerator, to which he responded " Is there a problem? Right after breakfast, about a half hour ago. " When questioned further about the time Chef "A" revised the time to " maybe an hour or hour and a half " . When asked if an initial temperature had been taken to track the cooling process, Chef "A" stated " No. I'll throw them out. " 2. Six stainless steel pans containing a total of 24 beef roasts, covered with plastic wrap. There was no label indicating when the meat was cooked and placed in the refrigerator. The internal temperature of the whole intact roasts was measured using a metal stem digital Thermapen and found the temperatures to range between 41F and 44F. The ambient air temperature of the walk in cooler was 37F. An interview was conducted with Chef "A" concerning the cooking and cooling process of the meat. Chef "A" stated " They were probably cooked last night. " When asked about the cooling process and evidence of cooling logs, Chef "A" stated " I don ' t know anything about cooling logs. " 3. Four boxes of cucumbers with multiple rotting cucumbers in each box. 4. A tray containing 8 clear boxes of strawberries with 3 containers having multiple berries covered with mold. 5. A bag of cut Romaine lettuce with an expiration date of 7/26/22. Portions of the cut lettuce were turning brown and liquifying 6. One bag of carrot matchsticks with an expiration date of 7/23/22. 7. One open bag of chopped carrots, looking	F812		

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GRAND TRAVERSE PAVILIONS	1000 PAVILIONS CIRCLE TRAVERSE CITY, MI 49684

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F812	Continued From page 82 brown and withered and without a date indicating when it had been opened. 8. One bag of chopped celery with an expiration date of 7/29/22. Some pieces having turned brown. 9. Four stainless steel hotel pans with what appeared to be whole cooked turkey breasts, covered with plastic wrap. There was no label indicating when the turkey had been cooked and or placed in the refrigerator. At 1:45 PM it was observed a label had been attached to the plastic wrap which indicated the turkey had been cooked on 7/31/22, then had an expiration date of 8/14/22 for total of 14 days. The floors of the walk in cooler were dirty, covered with food debris with the junction of the walls and floor filled with dirt and grime. The wall/floor junction was not coved (rounded) to allow for proper cleaning. 10. The wall between the walk in refrigerator compartment and the freezer compartment, at the floor level, on the refrigerator side, had a build up of ice, on the right side of the door between the compartments. This indicates the wall and floor are not sealed and there was a constant leaking of air from the freezer compartment into the refrigerator compartment. 11. Four sealed packages of sliced cooked corn beef were observed in the walk in freezer. The package stated " Use by or freeze by 7/1/22. There was no date written on the package indicating when it had been placed in the freezer to allow for proper usage following future thawing. On 8/01/22 at approximately 1:45 PM, an interview with CDM "B" was conducted concerning the contents of the walk in refrigerator and freezer. When asked what the holding time for cooked food was, CDM "B" replied " Three Days. " CDM "B" was shown	F812		

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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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F812	Continued From page 83 the cooked turkey breasts with the 14 day time frame, to which she responded " I ' ll change that. " When shown the beef roasts and turkey breasts, CDM "B" was asked about documentation for the cooling process, CDM "B" stated " We don ' t have any cooling logs. " At this same time CDM "B" was shown the rotting cucumbers and containers with moldy strawberries. The following day on 8/02/22 at 8:48 AM the rotting cucumbers and strawberries were still on the shelves in the walk in cooler. During the initial tour a large plastic bin, labeled " Thickener " was observed to be uncovered and located partially under the food prep table near the three compartment sink.. No cover for the bin was observed in the vicinity or on the container, leading to potential contamination of the food inside. During the initial tour the only hand sink in the food preparation/three compartment sink area was observed to have a sign posted above stating: " NOT A HANDWASHING SINK. PLEASE DO NOT STORE ANYTHING IN THIS SINK. " This was observed throughout the survey during each visit to the kitchen. On 8/01/22 at 1:58 PM, an interview was conducted with CDM "B" and asked about the sink. CDM "B" replied " I don ' t know. We don ' t use it. " No other hand sink was readily available in the immediate area of the food preparation area. During all observations of the kitchen the plastic cover for the fluorescent light fixture in the cooking and serving area was observed to be covered with a layer of dust. During all observations of the kitchen the grease filters for the exhaust hood above the cooking equipment were observed to be covered and	F812		

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F812	Continued From page 84 caked with excessive grease. Non food contact surfaces, including the stand up mixer, the exterior of the ice machine, floors, walls, table legs and ceilings were observed to have excessive coverings of dirt, dust and grease. On 8/02/22 at approximately 8:45 AM CDM "B" was asked when the last deep cleaning of the kitchen had occurred. CDM "B" responded " Probably before I got here three months ago. " On 8/02/22 at approximately 8:30 AM, an open plastic garbage can, one third filled with rotten fruit was observed near the above mentioned hand sink and at the soiled end of the three compartment sink. Fruit flies were observed flying and landing throughout the kitchen, in the food preparation area, dish washing area and serving area. At this same time dirty pots, pans and cooking utensils were piled over three feet high, above the drain boards of the three compartment sink. The contents of the pans were not breakfast food, rather, dried on food from the previous day. During all observation opportunities on 8/01/22 and 8/02/22 in the kitchen, the floors under equipment were observed to be filled with days old debris, trash, food remnants and dust. Kitchen policies and procedures were requested from the Registered Dietitian " F " . The following policies were provided and reviewed and are sourced from the contracted Vendor providing dietary services to the Facility: FOOD HANDLING GUIDELINES (HACCP) Policy #B007; Date Issued 5/95; Date Revised 1/18 CLEANING OF FOOD AND NONFOOD CONTACT SURFACES; Policy #F013; Date	F812		

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F812	Continued From page 85 Issued 5/95; Date Revised 1/17. SANITIZING FOOD CONTACT SURFACES; Policy #F018; Date Issued 5/95; Date Revised 1/18. Included in the above policies were requirements for proper cooling of cooked food to be reheated later for service and included " Cooling Log " to track requirements for proper cooling of food. " Hot Holding Box " and " Cold Holding Log " were also included with policy #B007. Policy #F018 included forms for documenting the concentration and temperature of sanitizing solutions in the three compartment sink as well as buckets containing sanitizing solution for wiping cloths. These forms were identified as: " SANITIZER SOLUTION FROM DISPENSER " ; " POT SINK TEMPERATURE & SANITIZER CONCENTRATION LOG " (requiring documentation for each meal and a manager weekly review); " RED BUCKET LOG " (requiring two hour monitoring intervals and a manager review). On 8/01/22 between 12:00 PM and 12:30 PM, ice dispensers were observed to have black bio film accumulation in the discharge spouts in the following locations: Birch Unit Dining and pantry Cherry unit Dining and pantry Dogwood unit pantry Elm unit pantry On 8/01/22 between 12:00 PM and 12:30 PM juice dispensers in the individual unit pantries were observed to have coagulated juice residue in the discharge nozzles. This was observed in the Birch, Cherry and Dogwood unit pantries. During this time, a box of take out pizza and chicken bites were observed in the Dogwood	F812		

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F812	Continued From page 86 pantry refrigerator. No identification indicating the date it was placed in the refrigerator or to whom it belonged was on the boxes. The refrigerator walls and fan grates, in the Dogwood pantry, were observed to be covered with food debris and dust. On 8/02/22 at 10:05 AM the refrigerator in the Maple unit pantry was observed. The interior panel for the door was observed to have a black mold-like covering and the gasket was torn at the bottom of the door allowing air and moisture to escape.. On 8/03/22 at approximately 11:30 AM, an interview was conducted with Sr. Culinary Director (SCD) "G", representing the kitchen vendor company hired by the Facility. SCD "G" confirmed the conditions of the kitchen when he arrived the previous evening were unacceptable, and acknowledged there was still rotten food in the walk in cooler, unlabeled food, and an unclean environment to be serving food from. REFERENCES TO THE FDA FOOD CODE 2013 INCLUDE: 3-101.11 Safe, Unadulterated, and Honestly Presented. FOOD shall be safe, unADULTERATED, and, as specified under 3-601.12, honestly presented. 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57C (135F) to 21C (70F); and (2) Within a total of 6 hours from 57C (135F) to 5C (41F) or less.	F812		

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F812	Continued From page 87 3-701.11 Discarding or Reconditioning Unsafe, Adulterated, or Contaminated Food. (A) A FOOD that is unsafe, ADULTERATED, or not honestly presented as specified under 3-101.11 shall be discarded or reconditioned according to an APPROVED procedure. 4-601.11 Equipment, Food-Contact Surfaces, NonfoodContact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris 4-602.11 Equipment Food-Contact Surfaces and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: (1) Except as specified in (B) of this section, before each use with a different type of raw animal FOOD such as beef, FISH, lamb, pork, or POULTRY; (2) Each time there is a change from working with raw FOODS to working with READY-TO-EAT FOODS; (3) Between uses with raw fruits and vegetables and with TIME/TEMPERATURE CONTROL FOR SAFETY FOOD; (4) Before using or storing a FOOD TEMPERATURE MEASURING DEVICE; and (5) At any time during the operation when contamination may have occurred 4-602.13 Nonfood-Contact Surfaces.	F812		

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F812	Continued From page 88 NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues 6-201.13 Floor and Wall Junctures, Coved, and Enclosed or Sealed. (A) In FOOD ESTABLISHMENTS in which cleaning methods other than water flushing are used for cleaning floors, the floor and wall junctures shall be coved and closed to no larger than 1 mm (one thirty-second inch). (B) The floors in FOOD ESTABLISHMENTS in which water flush cleaning methods are used shall be provided with drains and be graded to drain, and the floor and wall junctures shall be coved and SEALED. 6-501.111 Controlling Pests. The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: (A) Routinely inspecting incoming shipments of FOOD and supplies; (B) Routinely inspecting the PREMISES for evidence of pests; (C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under 7-202.12, 7-206.12, and 7-206.13; and (D) Eliminating harborage conditions. On 8/1/22 at approximately 1:30 p.m., an observation was made of Certified Nurse Aide (CNA) "S" in the Dogwood main dining room using the microwave to reheat sausage and sauerkraut. When asked why CNA "S" was reheating the food, she stated, "The food has	F812		

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F812	Continued From page 89 been sitting out so long and it got cold." CNA "S" was observed taking the temperature of the sausage and while removing the thermometer, used her bare hands to touch the sausage in order to remove the thermometer. When asked what temperature the food needed to be reheated, CNA "S" stated, "It's either 145 (degrees Fahrenheit) or 165. I'm not sure so I try to get the food in between there." When asked if staff have to consistently reheat foods for residents because it gets cold, CNA "S" stated, "It depends on the day and who is in the kitchen."	F812		
F814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) 483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of garbage and refuse in a sanitary manner, leading to an infestation of fruit flies in the food preparation and dish washing area of the kitchen, potentially resulting in food borne illness among any or all 132 residents. Findings include: On 8/1/22 at 10:45 AM a garbage can adjacent to the three compartment sink, at the soiled end, was observed to be uncovered and approximately full of vegetable waste. Fruit flies were observed throughout the area including on the food preparation tables and clean end of the three compartment sink. This same observation was made at 11:30 AM and 2:30 PM. On 8/2/22 at approximately 8:30 AM, observations of the kitchen were made with CDM (Certified Dietary Manager) "B" as the	F814	F814: Dispose Garbage and Refuse Properly Element 1: The garbage was immediately removed. Lids were placed on all trash. Element 2: Lids for all refuse containers in the kitchen have been placed on trash cans. A new garbage disposal has been ordered on 8/11/22 and will be installed upon receipt. Staff will be educated on the use of the garbage disposal upon install. The pest control management vendor conducted a walk established a plan for monthly preventive drain maintenance. Element 3: A sanitation audit will be completed twice weekly. Results will be presented to the administrator and the QA committee for review. The dietary manager is responsible for compliance.	8/30/22

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F814	Continued From page 90 morning meal was in progress of being served. The same garbage can mentioned above, was observed to be approximately half full of fruit remnants, open and with fruit flies too numerous to count. An interview with CDM "B" was conducted at this time and it was learned the kitchen staff were not using the garbage disposal at the direction of the facility staff. When asked to identify the facility staff this directive originated from, CDM "B" stated " Maintenance." They said it leaks onto the first floor below the kitchen (located on the second floor). On 8/3/22 at 11:30 AM, an interview with the Nursing Home Administrator was conducted related to the directive to kitchen staff to not use the garbage disposal. The NHA stated "I've haven't heard that before. " ..	F814		
F880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) 483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: 483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services	F880	1. Both Resident #61 and Resident #117 have completed their quarantine and returned back to their room with no adverse effects. Residents #401, 402, 403, 404, 405 and 406 on the maple unit (non-COVID) did not develop any signs or symptoms of COVID-19 nor did they test positive. A root cause analysis (RCA) will be conducted by the QA committee as required by the DPOC. Results will be used to develop any further education, policies or procedures or other corrective actions as warranted. These materials will be provided to the governing body as directed. 2. Residents on the non-COVID unit have the potential to be affected. Education for clinical and any staff that enter residents rooms on standard infection control	8/30/22

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F880	Continued From page 91 under a contractual arrangement based upon the facility assessment conducted according to 483.70(e) and following accepted national standards; 483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. 483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. 483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F880	practices, hand hygiene, disinfecting shared medical equipment, COVID prevention, and appropriate use of PPE will be completed by 8/29/22 including a post-test for competency. Additional education will be provided based on the outcomes of the root cause analysis as warranted. All relevant facility infection control policies and procedures will be reviewed and recommendations for any needed revisions will be made based on the RCA. 3. CQI, staff development, the ICP and the nursing administration team will observe the use of PPE by staff on all shifts 3-5 times weekly until otherwise directed by the QA committee. Results of these audits will be directed to the QA Committee for review. 4. DON responsible for compliance.	

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F880	Continued From page 92 infection. 483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent infection control breaches during meal service for the COVID-19 isolation unit and rehabilitation unit. This deficient practice resulted in the potential spread of COVID-19 to the remainder of the residents (#401, #402, #403, #404, #405, #406) located in the non-isolation area of the rehabilitation unit. Findings include: On 8/1/22 at 5:10 p.m., meal trays were observed being delivered to Residents on the COVID-19 isolation unit. Registered Nurse (RN) "P" began by donning required Personal Protective Equipment (PPE) for entering a Coronavirus Disease 2019 (COVID-19) isolation room. RN "P" proceeded to retrieve the meal tray for Resident #117 from a kitchenette used for both non-isolation rehabilitation residents and residents in the COVID-19 isolation area. RN "P" delivered the meal tray to Resident #117 and touched various surfaces within the isolation room, including a bedside table where the meal tray was placed. RN "P" then exited the room and did not remove any PPE before going to retrieve the meal tray for Resident #61 from the shared kitchenette. On 8/1/22 at 5:15 p.m., RN "P" proceeded to the shared kitchenette to retrieve the meal tray for Resident #61 and contaminated the shared kitchenette surfaces with gloves worn in the	F880		

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F880	Continued From page 93 room of Resident #117. RN "P" then proceeded to deliver the meal tray to Resident #61. On 8/1/22 at 5:20 p.m., RN "P" was observed doffing PPE. RN "P" failed to remove gloves before removal of the isolation gown and contaminated their uniform with the gloved hands. A total of six other residents (#401, #402, #403, #404, #405, #406) in the non-isolation area who also utilized the shared kitchenette had the potential to be exposed to COVID-19 as a result of the infection control breach. On 8/4/22 at 2:08 p.m., during an interview, Infection Preventionist (IP) RN "R" was asked if PPE worn in a COVID-19 isolation area should be doffed before coming into contact with a shared kitchenette also being utilized for non-isolation residents. RN "R" confirmed PPE should be removed prior to touching the environment of a common area used for non-infectious residents.	F880		

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WATKINS ROSS

200 Ottawa Ave NW Suite 600
Grand Rapids MI 49503
WatkinsRoss.com
616.456.9696

February 6, 2023

PERSONAL & CONFIDENTIAL

Lindsey Dood
Grand Traverse Pavilions
1000 Pavilions Circle
Traverse City, MI 49684

RE: Grand Traverse Pavilions Other Post-Employment Benefit (OPEB) Plan

Dear Lindsey:

Transmitted via email, this is a copy of your OPEB accounting report for the fiscal year ending December 31, 2022. This information is intended to assist you in complying with Governmental Accounting Standards Board Statement No. 74 (GASB 74) Financial Reporting for Postemployment Benefit Plans Other than Pension Plans, and Statement No. 75 (GASB 75) Accounting and Financial Reporting for Postemployment Benefits Other than Pensions.

The State of Michigan under Public Act (PA) 202 requires that Other Post-Employment Benefit (OPEB) Plans covering 100 or more members have a peer review or change of actuaries once every 8 years. In addition, the Act requires an actuarial study be performed once every 5 years. Watkins Ross satisfies those requirements by virtue of having three credentialed OPEB actuaries on staff providing peer review for each other and, when necessary, rotating certification of our OPEB actuarial valuations. Additionally, Watkins Ross completes full actuarial valuations for all our OPEB Plan clients once every two years including an analysis of the sources of actuarial gains and losses (actuarial experience study) and evaluates whether changes in assumptions are warranted (see Comments section of this report for more detail).

If you have any questions about this report, please call me at (616) 742-9244.

Sincerely,

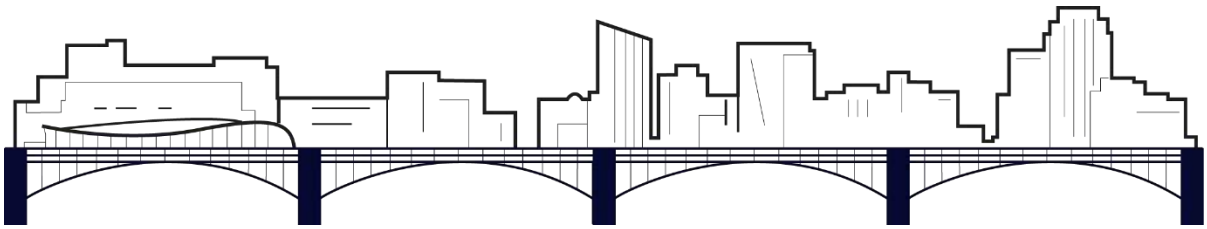
Christian R. Veenstra, FCA, ASA, MAAA
President / Enrolled Actuary

Enclosure

Grand Traverse Pavilions Post-Retirement Medical Plan

Accounting Report

for the Period Ending December 31, 2022
under GASB Statements 74 & 75



CONTENTS

INTRODUCTION AND CERTIFICATION

The schedules included in this report have been prepared in order to provide the information necessary to comply with Governmental Accounting Standards Board (GASB) Statement Nos. 74 and 75. This information may, at the discretion of management of the plan sponsor and its auditor, be used for the preparation of its financial statements. The calculations herein have been made based on our understanding of GASB 74 and 75, and may be inappropriate for other purposes.

The calculations summarized in this report involve actuarial calculations that require assumptions about future events. We believe that the assumptions used in the report are within the range of possible assumptions that are reasonable and appropriate for the purposes for which they have been used. However, other assumptions are also reasonable and appropriate and their use would produce different results.

This report contains additional information and details related to plan provisions and recommended contribution calculations.

This report was prepared on the basis of participant data and asset values as reported to us by the plan sponsor. Watkins Ross relied upon the data as submitted, and has no reason to believe that any information, which would have a material effect on the results of this valuation, was not considered in the preparation of the report.

The enrolled actuary certifying this report represents himself as meeting the Qualification Standards of the American Academy of Actuaries to render actuarial opinions contained in the report.

Prepared and certified by:

Christian R. Veenstra, FCA, ASA, MAAA
Enrolled Actuary #20-05668

COMMENTS

Purpose of Governmental Accounting Standards Board (GASB) Reporting

The objective of GASB is to provide guidelines and requirements for accounting and financial reporting by state and local governments for postemployment benefits other than pensions (OPEB). This statement establishes standards for recognizing and measuring liabilities, deferred inflows and outflows of resources and methods and assumptions that are required to be used to project benefit payments and discount those payments to their actuarial present value.

State of Michigan Public Act 202

Public Act 202 (PA 202) was drafted to address the underfunded status of pension and retiree healthcare plans of local governments in Michigan. Accordingly, PA 202 included transparency and funding requirements. In addition, in order that the plans' funded status be reported on a consistent basis, Uniform Assumptions were published. While all of the Uniform Assumptions have a sound and reasonable basis, some might not be appropriate for each plan and therefore may be different than what is used for funding. Additionally, some of the assumptions may differ from what is required for reporting under GASB.

PA 202 further requires that plans covering 100 or more Plan Members – active and inactive:

1. **At least every 5 years, the local unit of government (city, village, township, county, county road commission or other districts, authorities created by the state or 1 or more these entities) shall have an actuarial experience study conducted by the plan actuary for each retirement system of the local unit of government and**
2. **At least every 8 years, the local unit of government shall do at least 1 of the following:**
    a. **Have a peer actuarial audit conducted by an actuary that is not the plan actuary**
    b. **Replace the plan actuary**

Actuarial Experience Study last performed: December 31, 2022

1. Turnover - experience continues to support the assumption of high, low-service based turnover
2. Retirement – in light of changing retirement patterns, this assumption was re-evaluated and modified to better reflect recent experience

Peer review/change in actuary: December 31, 2018

Next peer review/change in actuary by: December 31, 2026

Changes in Actuarial Assumptions, Plan Changes and Expected Actuarial Experience

There was a 7% actuarial gain (decrease in liability) of $114,000 due primarily to a 25% more than expected decrease in the number of active, covered, low service lives since the last full valuation. The combination of actuarial assumption changes, described in the "Assumptions and Methods for Calculation of Actuarially Determined Contribution" section of this report, generated an actuarial increase of $30,000 – most significant of which was the discount rate decreasing from 7.35% to 7.0%.

PLAN DESCRIPTION

Plan Description

Grand Traverse Pavilions Post-Retirement Medical Plan (Plan) is a single employer plan established and administered by ***Grand Traverse Pavilions*** (Employer) and can be amended at its discretion.

Benefits Provided

A summary of plan provisions is available on page 17.

Summary of Plan Participants

As of December 31, 2022, Plan membership (counts on which the valuation was performed) consisted of the following:

	Total	Ave age	Ave svc
Inactive participants receiving benefits	30	71.8	
Active participants	97	47.6	17.8
Total participants	127		

Contributions

The Plan was established and is being funded under the authority of the Employer's governing body and under agreements with the unions representing various classes of employees. The Plan's funding policy is that the employer will continue to pay benefits from general operating funds until the OPEB trust is sufficient to pay benefits. Active participants do not make contributions to the Plan. There are no long term contracts for contributions to the plan. The plan has no legally required reserves.

Summary of Significant Accounting Policies

For purposes of measuring the net Other Post-Employment Benefits (OPEB) liability, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expenses, information about the fiduciary net position of the Plan and additions to/deductions from the Employer's fiduciary net position have been determined on the same basis as they are reported by the Employer. For this purpose, benefits payments are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

ASSUMPTIONS AND METHODS

The Employer's OPEB liability was measured as of as of December 31, 2022.

Actuarial Assumptions

The Total OPEB Liability was determined by an actuarial valuation as of December 31, 2022 using the following actuarial assumptions:

Inflation	2.5%
Salary increases	3.0% (for purposes of allocating liability)
Investment rate of return	7.0% (net of investment expense, including inflation)
Mortality	2010 Headcount weighted Public General Employees and Healthy Retirees with MP-2021 mortality improvement scale

The long-term expected rate of return on Plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of Plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. Best estimates of arithmetic real rates of return for each major asset class included in the Plan's target asset allocation as of December 31, 2022 are summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Rate of Return
Global equity	60.0%	4.5%
Global fixed income	20.0	2.0
Private investments	20.0	7.0

The sum of each target allocation times its long-term expected real rate is **4.5**%.
Together with 2.50% inflation, the long-term expected rate of return is 7.0%.

Discount Rate

The discount rate used to measure the total OPEB liability was **7.0%.** The projection of cash flows used to determine the discount rate assumed that benefit payments will continue to be paid from general operating funds until the OPEB trust is sufficient to pay benefits. Based on those assumptions, the Plan's fiduciary net position was projected to be sufficient to make all projected future benefit payments of current Plan participants. For projected benefits that are covered by projected assets, the long-term expected rate was used to discount the projected benefits. From the year that benefit payments were not projected to be covered by the projected assets (the "depletion date"), projected benefits were discounted at a discount rate reflecting a 20-year AA/Aa tax-exempt municipal bond yield. A single equivalent discount rate that yields the same present value of benefits is calculated. This discount rate is used to determine the Total OPEB Liability. The discount rate used for December 31, 2021 was 7.35%.

RECONCILIATION AND RECOGNITION OF NET OPEB LIABILITY

Changes in the Net OPEB Liability

	Total OPEB Liability (a)	Plan Fiduciary Net Position (b)	Net OPEB Liability (Asset) (a) - (b)
Balance at December 31, 2021	**1,482,043**	**1,386,685**	**95,358**
Changes during the Year			
Service Cost	12,714	-	12,714
Interest	106,658	-	106,658
Experience (Gains)/Losses	(113,745)	-	(113,745)
Changes in benefit terms	-		-
Change in actuarial assumptions	30,378	-	30,378
Contributions to OPEB trust	-	-	-
Contributions/benefit paid from general operating funds	-	87,245	(87,245)
Net Investment Income	-	(144,401)	144,401
Benefit Payments	(87,245)	(87,245)	-
Administrative Expenses	-	(2,279)	2,279
Other Changes	-	-	-
Total Changes	(51,240)	(146,680)	95,440
Balance at December 31, 2022	**1,430,803**	**1,240,005**	**190,798**
Plan Fiduciary Net Position as a percentage of total OPEB Liability			86.7%

Net OPEB Liability – Discount and Trend Rate Sensitivities

The following presents the Net OPEB Liability (NOL) of the Employer, calculated using trend and discount rates 1% higher and lower than base assumptions:

	1% Decrease	Current rate	1% Increase
Discount			
Total OPEB Liability	$1,578,765	$1,430,803	$1,304,490
Plan Fiduciary Net Position	1,240,005	1,240,005	1,240,005
Net OPEB Liability	338,760	190,798	64,485

	1% Decrease	Current trend	1% Increase
Trend			
Plan benefits are fixed and not subject to healthcare trend rates			

RECONCILIATION AND RECOGNITION OF NET OPEB LIABILITY

OPEB Expense

Below are the components of the OPEB Expense:

	Fiscal Year Ending December 31, 2022
Service Cost	$12,714
Interest on Total OPEB Liability	106,658
Experience (Gains)/Losses	(20,208)
Changes of benefits terms	-
Changes of Assumptions	(106,671)
Employee Contributions	-
Projected Earnings on OPEB Plan Investments	(101,837)
Investment Earnings (Gains)/Losses	12,270
Administrative Expenses	2,279
Other Changes in Fiduciary Net Position	-
OPEB Expense	**$(94,795)**

OPEB Plan Fiduciary Net Position

The OPEB Plan Fiduciary Net Position as of December 31, 2022 is $1,240,005.

Deferred Inflows and Outflows of Resources Related to OPEB Plan

	Deferred Outflows Of Resources	Deferred Inflows Of Resources
Experience (Gains)/Losses	-	169,514
Changes of Assumptions	118,170	846,144
Investment Earnings (Gains)/Losses	114,450	-
Total	**$ 232,620**	**$1,015,658**

Amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEBs will be recognized in OPEB Expense as follows:

Year Ended December 31,	Amount Recognized
2023	$(114,609)
2024	(106,793)
2025	(94,032)
2026	(77,633)
2027	(126,879)
Thereafter	$(263,093)

RECONCILIATION AND RECOGNITION OF NET OPEB LIABILITY

Reconciliation of Net OPEB Liability

Net OPEB Liability (Asset) December 31, 2021	95,358
Total OPEB expense	(94,795)
Contributions	(87,245)
Change in deferred outflows of resources	128,530
Change in deferred inflows of resources	148,950
Net OPEB Liability (Asset) December 31, 2022	**$190,798**

Total OPEB Liability at December 31, 2022

	Total
Active participants	675,833
Inactive participants receiving benefits	754,970
Total	**$1,430,803**

SCHEDULES OF REQUIRED SUPPLEMENTARY INFORMATION

Description of Actuarially Determined Contributions

Recommended Funding Contribution

Previously, under Governmental Accounting Standards Board (GASB) Statement Nos. 43 and 45, an Annual Required Contribution (ARC) was provided in order that an OPEB plan sponsor could either contribute such amount to an OPEB trust or book the balance on the employer's financial pages as an OPEB Obligation.

GASB Nos. 74 and 75, however, eliminate the ARC as a component of the financial statement and, instead, separately identify an accounting expense that must be recorded on the financial pages - whether a contribution was actually made to an OPEB trust. Although a recommended contribution is no longer part of GASB reporting, we have included one along with the accounting entries in this report to provide information for funding. This recommended contribution is designed to eventually fund your plan enough that you can pay retiree benefits directly from that trust instead of general operating funds. The amortization period is based on average future working years for active employees.

Actuarially Determined Contribution (ADC)	Fiscal Year Ending December 31,	
	2023	2022
Discount rate	7.0%	7.35%
Amortization period	12 years	13 years
Amortization method	Level dollar	Level dollar
Normal cost	11,404	12,714
Amortization of Net OPEB Liability	22,450	10,840
Interest to end of year	2,370	1,731
Total recommended employer contribution	36,224	25,285

State of Michigan Public Act 202 (PA 202) Contributions

PA 202 was issued by the State of Michigan and requires the calculation of other "contribution" amounts. These are

1. The Actuarially Determined Contribution (ADC) using Assumptions for financial reporting and
2. The minimum required amount to be deposited into an OPEB trust

The first of these contributions as shown in the first table on the following page of this report, $25,285 – and matching the 2022 ADC above, is an amount required to be reported to the State of Michigan to be measured against annual revenue to determine whether or not a Corrective Action Plan (CAP) must be adopted. It is not a *required* contribution.

The second of these numbers is the actual minimum amount the State of Michigan requires to be deposited into a trust and it is based on the normal cost (actuarially calculated) for those covered by your plan and hired after June 30, 2018. Because this plan is closed to new hires, there is no contribution requirement other than any Corrective Action Plan that might have been determined to improve the funded status of this plan.

SCHEDULES OF REQUIRED SUPPLEMENTARY INFORMATION

State of Michigan Public Acts 530 and 202 Information

Net OPEB Liability and Actuarially Determined Contribution

Financial information	2022
Assets (Fiduciary net position)	1,240,005
Liabilities (Total OPEB Liability)	1,430,803
Funded ratio for the Plan Year	86.7%
Actuarially Determined Contribution	$25,285
Is ADC calculated in compliance with No. Letter 2018-3?	Yes

Membership as of the valuation date	
Number of active members	97
Number of inactive members	-
Number of retirees and beneficiaries	30
Premiums paid on behalf of the retirants	$87,245

Investment Performance
This information is available from the Investment Manager

Actuarial Assumptions	2022
Actuarially assumed rate of investment return	7.0%
Discount rate	7.0%
Amortization method used for funding unfunded liability	Level dollar
Amortization period used for funding unfunded liability	13 years
Is each division closed to new employees	Yes
Healthcare inflation assumption next year	N/A
Healthcare inflation assumption - long term	N/A

Uniform Assumptions	2022
Actuarial value of assets using uniform assumptions	1,240,005
Actuarial accrued liability using uniform assumptions	1,448,325
Funded ratio using uniform assumptions	85.6%
Actuarially Determined Contribution (ADC) using uniform assumptions	$31,957

SCHEDULES OF REQUIRED SUPPLEMENTARY INFORMATION

Changes in Net OPEB Liability and Related Ratios

Fiscal Year Ending December 31	2022	2021	2020
Total OPEB Liability			
Service Cost	12,714	15,002	19,102
Interest	106,658	121,605	122,861
Changes of Benefit Terms	-	(231,933)	-
Difference between Expected and Actual Experience	(113,745)	(21,977)	(63,103)
Change of Assumptions	30,378	3,065	(8,070)
Benefit Payments	(87,245)	(86,413)	(81,156)
Net Change in Total OPEB Liability	(51,240)	(200,651)	(10,366)
Total OPEB Liability – Beginning	1,482,043	1,682,694	1,693,060
Total OPEB Liability – Ending (a)	1,430,803	1,482,043	1,682,694
Plan Fiduciary Net Position			
Contributions to OPEB trust	-	-	-
Contributions/benefit payments made from general operating funds	87,245	86,413	81,156
Net Investment Income	(144,401)	171,419	142,863
Benefit Payments (Including Refunds of Employee Contributions)	(87,245)	(86,413)	(81,156)
Administrative Expenses	(2,279)	(2,376)	(1,932)
Other	-	-	-
Net Change in Fiduciary Net Position	(146,680)	169,043	140,931
Plan Fiduciary Net Position – Beginning	1,386,685	1,217,642	1,076,711
Plan Fiduciary Net Position – Ending (b)	1,240,005	1,386,685	1,217,642
Net OPEB Liability – Ending (a)-(b)	**190,798**	**95,358**	**465,052**
Plan Fiduciary Net Position as a Percentage of Total OPEB Liability	86.7%	93.6%	72.4%
Covered Employee Payroll	5,394,906	5,393,752	7,201,258
Net OPEB Liability as Percentage of Payroll	3.5%%	1.8%%	6.5%%

Schedule of Employer Contributions

Actuarially Determined Employer Contribution (ADC)	Fiscal Year Ending December 31,		
	2022	2021	2020
Normal cost	12,714	15,002	19,102
Amortization of Net OPEB Liability[1]	10,840	50,581	64,439
Interest to end of year	1,731	4,820	6,140
Total ADC	25,285	70,403	89,681
Contribution/benefit payment	(87,245)	(86,413)	(81,156)
Contribution Deficiency/(Excess)	(61,960)	(16,010)	8,525
Covered Employee Payroll	5,394,906	5,393,752	7,201,258
ADC as Percentage of Payroll	0.5%%	1.3%%	1.2%%

[1] Based on EAN, 13, 14 and 15 year amortization respectively of unfunded liability; alternative scenarios can be considered

SCHEDULES OF REQUIRED SUPPLEMENTARY INFORMATION

Changes in Net OPEB Liability and Related Ratios

Fiscal Year Ending December 31		
	2019	**2018**
Total OPEB Liability		
Service Cost	17,028	231,153
Interest	114,539	213,488
Changes of Benefit Terms	-	(4,383,381)
Difference between Expected and Actual Experience	(4,874)	-
Change of Assumptions	139,387	(1,451,552)
Benefit Payments	(67,804)	(82,575)
Net Change in Total OPEB Liability	198,276	(5,472,867)
Total OPEB Liability – Beginning	1,494,784	6,967,651
Total OPEB Liability – Ending (a)	1,693,060	1,494,784
Plan Fiduciary Net Position		
Contributions to OPEB trust	500,000	500,000
Contributions/benefit payments made from general operating funds	67,804	82,575
Net Investment Income	77,793	-
Benefit Payments (Including Refunds of Employee Contributions)	(67,804)	(82,575)
Administrative Expenses	(1,082)	-
Other	-	-
Net Change in Fiduciary Net Position	576,711	500,000
Plan Fiduciary Net Position – Beginning	500,000	-
Plan Fiduciary Net Position – Ending (b)	1,076,711	500,000
Net OPEB Liability – Ending (a)-(b)	**616,349**	**994,784**
Plan Fiduciary Net Position as a Percentage of Total OPEB Liability	63.6%	33.45%
Covered Employee Payroll	7,762,001	__
Net OPEB Liability as Percentage of Payroll	7.9%%	___%

Schedule of Employer Contributions

Actuarially Determined Employer Contribution (ADC)	Fiscal Year Ending December 31,	
	2019	**2018**
Normal cost	17,028	231,153
Amortization of Net OPEB Liability[1]	102,643	442,628
Interest to end of year	9,274	20,213
Total ADC	128,945	693,994
Contribution/benefit payment	(567,804)	(582,575)
Contribution Deficiency/(Excess)	(438,859)	111,419
Covered Employee Payroll	7,762,001	__
ADC as Percentage of Payroll	1.7%%	___%

[1] Based on EAN, 16 and 17 year amortization respectively of unfunded liability; alternative scenarios can be considered

SCHEDULES OF REQUIRED SUPPLEMENTARY INFORMATION

Assumptions used to determine the actuarially determined contribution:

Valuation Date December 31, 2022

Actuarial Methods

Cost method Entry Age Normal (level percent)

Asset valuation method Market value

Actuarial Assumptions

Discount rate – 7.35% for 2022 contribution; 7.0% for 2022 disclosure and 2023 contribution
Rationale –20-year Aa Municipal bond rate for beginning of year and average effective rate produced by the prescribed method under GASB accounting rules

Payroll inflation – 2.0%
Rationale –Per employer input

Return on plan assets – 7.35% for 2022; 7.0% for disclosure and 2023 contribution
Rationale – Developed using method required under GASB accounting

Mortality rates – 2010 Headcount weighted Public General Employees and Healthy Retirees with MP-2021 mortality improvement scale
Rationale – Contemporary tables

Utilization – 100% of employees eligible for stipend will elect coverage at retirement; Actual coverage used for non-active
Rationale – Stipend towards coverage comes at no cost to retirees

Turnover rates

Service	Rate	Service	Rate	Service	Rate
0	0.2200	12	0.0493	24	0.0304
1	0.1870	13	0.0464	25	0.0297
2	0.1540	14	0.0436	26	0.0295
3	0.1210	15	0.0407	27	0.0293
4	0.0990	16	0.0392	28	0.0290
5	0.0715	17	0.0376	29	0.0288
6	0.0682	18	0.0361	30	0.0286
7	0.0649	19	0.0345	31	0.0281
8	0.0616	20	0.0330	32	0.0275
9	0.0583	21	0.0323	33	0.0270
10	0.0550	22	0.0317	34+	0.0264
11	0.0521	23	0.0310		

Rationale – Experience based

SCHEDULES OF REQUIRED SUPPLEMENTARY INFORMATION

Retirement rates

Age	Rate	Age	Rate
50-55	0.0100	65-66	0.1500
56-61	0.0200	67-68	0.2000
62	0.3000	69	0.7500
63	0.2000	70	1.0000
64	0.1000		

Rationale –Experience based

Disability rates

Age	Rate	Age	Rate
30	0.0002	46	0.0014
31	0.0003	47	0.0016
32-33	0.0004	48	0.0019
34	0.0005	49	0.0021
35-40	0.0006	50	0.0024
41	0.0007	51	0.0027
42	0.0008	52	0.0031
43	0.0009	53	0.0034
44	0.0010	54	0.0038
45	0.0011	55	0.0041

Rationale –Experience based

Marital assumption – spouses are not eligible for employer stipend
Rationale – Plan provision based

Stipend
Pre-65 - $500 per retiree per month
Medicare eligible - $210 per retiree per month

Healthcare trend - None
Rationale – Stipend provided by employer is not subject to increases

Data Collection

Date and form of data - All personnel and asset data was prepared by the Plan sponsor or a representative and was generally relied upon as being correct and complete without audit by Watkins Ross

Changes since prior valuation

- Salary scale increase from 2.0% to 3.0%
- Retirement rates updated to reflect changing experience
- Discount rate lowered from 7.35% to 7.0% consistent with return on investment expectations

PA 202 if different from GASB assumptions

- Discount rate – 6.85%
- Mortality improvement scale – MP-2020

SCHEDULES OF REQUIRED SUPPLEMENTARY INFORMATION

Schedule of Difference between Actual and Expected Experience

Year Ended December 31,	Difference Between Expected and Actual Experience	Recognition Period (Years)	Amount Recognized in Year Ended December 31,						Deferred Outflow of Resources	Deferred Inflow of Resources
			2022	2023	2024	2025	2026	2027+		
2018	-	11.87	-	-	-	-	-	-	-	-
2019	(4,874)	10.98	(444)	(444)	(444)	(444)	(444)	(1,322)	-	(3,098)
2020	(63,103)	11.85	(5,325)	(5,325)	(5,325)	(5,325)	(5,325)	(25,828)	-	(47,128)
2021	(21,977)	11.02	(1,994)	(1,994)	(1,994)	(1,994)	(1,994)	(10,013)	-	(17,989)
2022	(113,745)	11.02	(12,445)	(12,445)	(12,445)	(12,445)	(12,445)	(51,520)	-	(101,300)
Net Recognized in OPEB Expense			(20,208)	(20,208)	(20,208)	(20,208)	(20,208)	(88,682)	-	(169,514)

Schedule of Changes in Assumptions

Year Ended December 31,	Changes in Assumptions	Recognition Period (Years)	Amount Recognized in Year Ended December 31,						Deferred Outflow of Resources	Deferred Inflow of Resources
			2022	2023	2024	2025	2026	2027+		
2018	(1,451,552)	11.87	(122,287)	(122,287)	(122,287)	(122,287)	(122,287)	(350,969)	-	(840,117)
2019	139,387	10.98	12,695	12,695	12,695	12,695	12,695	37,827	88,607	-
2020	(8,070)	11.85	(681)	(681)	(681)	(681)	(681)	(3,303)	-	(6,027)
2021	3,065	11.02	278	278	278	278	278	1,397	2,509	-
2022	30,378	11.02	3,324	3,324	3,324	3,324	3,324	13,758	27,054	-
Net Recognized in OPEB Expense			(106,671)	(106,671)	(106,671)	(106,671)	(106,671)	(301,290)	118,170	(846,144)

SCHEDULES OF REQUIRED SUPPLEMENTARY INFORMATION

Schedule of Differences between Projected and Actual Earnings on Plan Investments

Year Ended December 31	Difference Between Expected and Actual Earnings on OPEB Assets	Recognition Period (Years)	Amount Recognized in Year Ended December 31,						Deferred Outflow of Resources	Deferred Inflow of Resources
			2022	2023	2024	2025	2026	2027+		
2018	-	5.0	-	-	-	-	-		-	-
2019	(39,085)	5.0	(7,817)	(7,817)			-		-	(7,817)
2020	(63,796)	5.0	(12,759)	(12,759)	(12,760)				-	(25,519)
2021	(82,009)	5.0	(16,402)	(16,402)	(16,402)	(16,401)			-	(49,205)
2022	246,238	5.0	49,248	49,248	49,248	49,248	49,246		196,990	-
Net Recognized in OPEB Expense			12,270	12,270	20,086	32,847	49,246		196,990	(82,541)

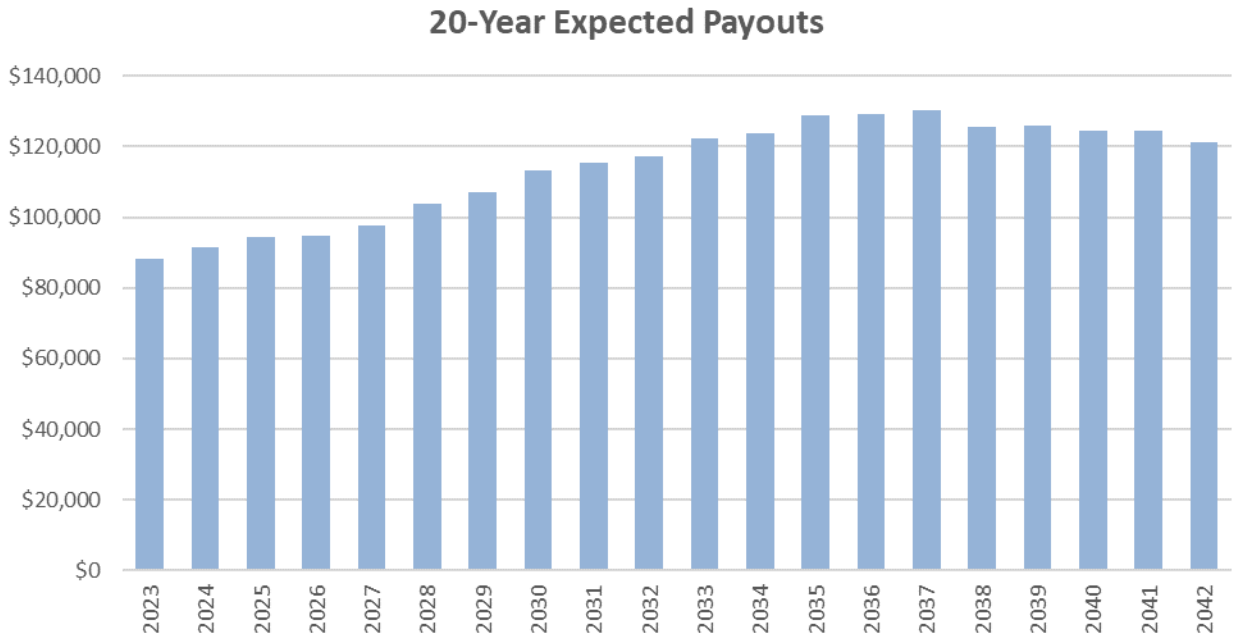
Total Deferred Outflow (Inflow) of Resources

	Amount Recognized in Year Ended December 31,				
	2023	2024	2025	2026	2027+
Total Deferred Outflow/(Inflow) of Resources	(114,609)	(106,793)	(94,032)	(77,633)	(389,972)

Projected benefit payments and contributions

A graphic illustration of 20 years of projected benefit payments for the current group of covered lives is shown below. Plans open to new participants could see higher than expected payments if new members are hired and are eligible to retire during the projection period.

The chart below reflects expected cash flows to pay benefits for current plan participants.



SUMMARY OF PLAN PROVISIONS

Plan name - Grand Traverse Pavilions Other Post-Employment Benefit (OPEB) Plan

Eligibility and Benefits

Non-Union and RN Bargaining Unit employees hired prior to January 1, 2011 and LPN and General Bargaining Units hired prior to January 1, 2016 who have worked at least twenty (20) continuous years for the Organization and who have reached at least age sixty-two (62) at the time of retirement will be provided a payment of up to $500.00 per month (or the single subscriber premium cost to the organization, whichever is lower) up to age 65 to be used for the purchase of health insurance benefits; After reaching age 65 the retiree will be provided a payment of up to $210.00 per month to be used for the purchased of Medicare supplemental coverage; This payment shall cease upon the retiree's death

All other employees may retire at age 60 with 6 years of service and participation in the plan by paying 100% of premium

Retiree contribution – Portion of premium not paid by employer

Changes since prior valuation – None

GLOSSARY

A number of special terms and concepts are used in connection with OPEB plans and the OPEB accounting report. The following list reviews a number of these terms and provides a brief discussion of their meaning.

Actuarially Determined Contribution (ADC) – A target or recommended contribution for the reporting period, determined in conformity with Actuarial Standards of Practice based on the most recent measurement available when the contribution for the reporting period was adopted.

Actuarial Cost Method – This is a mathematical formula which is used to allocate the present value of projected benefits to past and future plan years.

Amortization – The difference between actual and expected investment returns, the difference between actual and expected experience, and the impact of any plan or assumption changes will be amortized and paid over future years.

Annual Recommended Contribution (ARC) – the sum of the normal cost payment and the annual amortization payment for past service costs to fund the net OPEB liability.

Depletion Date (Cross-over Point) – The projected date (if any) where plan assets, including future contributions, are no longer sufficient to pay Projected Benefit Payments to current members.

Long-term expected rate of return – The rate of return based on the nature and mix of current and expected plan investments and over the time period from when an employee is hired to when all benefits to the employee have been paid.

Market Value of Assets – The market value of all assets in the fund including any accrued contribution for the previous plan year, which was not paid by the end of the year.

Measurement Date – The date the Total OPEB Liability, Fiduciary Net Position, and Net OPEB Liability are determined.

Net OPEB Liability (NOL) – The Total OPEB Liability less the Plan Fiduciary Net Position.

Normal Cost – For GASB 74/75 purposes, normal cost is the equivalent of service cost (see definition of service cost).

Other Post-Employment Benefits (OPEB) – Benefits (such as death benefits, life insurance, disability, and long-term care) that are paid in the period after employment and that are provided separately from a pension plan, as well as healthcare benefits paid in the period after employment, regardless of the manner in which they are provided. OPEB does not include termination benefits or termination payments for sick leave.

GLOSSARY

OPEB Expense (OE) – The change in the Net OPEB Liability (NOL) recognized in the current measurement period. Changes to the NOL not fully recognized in a given year's OPEB expense will be maintained as deferred inflows and deferred outflows. These will be recognized incrementally in the OPEB expense over time.

Plan assets – Stocks, bonds and other investments that have been segregated and restricted (usually in a trust) to provide for post-retirement benefits. Assets not segregated in a trust, or otherwise effectively restricted so that they cannot be used by the employer for other purposes, are not plan assets, even though it may be intended that those assets be used to provide post-retirement benefits.

Plan Fiduciary Net Position – The market value of plan assets as of the measurement date.

Present Value – The present value of a future payment or a series of payments is the amount of each payment, discounted to recognize the time value of money, and further reduced for the probability that the payment might not be made because of death, disability or termination of employment.

Projected Benefit Payments – All benefits projected to be payable to current active and inactive participants as a result of their past service and their expected future service.

Real Rate of Return – The rate of return on an investment after the adjustment to eliminate inflation.

Reporting Date – The date that represents the fiscal year end for the plan or employer.

Service Cost – The value of portion of Total OPEB Liability earned during the current year computed in accordance with GAAP accounting rules.

Single Equivalent Discount Rate – The single rate that gives the same total present value as discounting the Projected Benefit Payments with the long-term expected rate of return until the Depletion Date and discounting any remaining Projected Benefit Payments with the yield on a 20-year AA/Aa tax-exempt municipal bond index.

Total OPEB Liability (TOL) – The actuarial present value of the accrued benefit determined under the Entry Age actuarial cost method calculated using the blended Single Equivalent Discount Rate.

Valuation Date – The date as of which an actuarial valuation is performed.

Grand Traverse Pavilions
A COMMUNITY CARING FOR GENERATIONS

February 13, 2023,

TO: Grand Traverse County Department of Health and Human Services Board

FROM: Rose Coleman
CEO/Administrator

RE: January Report

On January 4, Coleman and Lindsey Dood, Financial Director met remotely with Rob Long and Jon Lanczak with Plante Moran to review and discuss their draft strategic planning and the logistics of presentation to internal team members.

On January 5, 11 and 20 Coleman, Dood and Holly Kazim, Dirctor of Clinical Services met with representatives of Unidine to discuss their status on improving services at the Pavilions.

On January 2, Dood met with a third party valuation specialist and Scott Voss of Voss Insurance Services, Inc. to review the damage to Hawthorn Cottage.

On January 13 Dood met with Chris Kuhn to discuss the upcoming hearing regarding two cost report issues being appealed.

On January 17 and 18 Dood represented the Pavilions at the ALJ hearing to contest the Medicaid cost report audit findings.

Throughout the month of January we had 17 admissions/re-admissions and 16 discharges. Three residents were transferred from short to long term care.

The Wellness Center saw the following patients this month: Medicare A: 8; Medicare Advantage Skilled: 8; Medicare B: Outpatient: 58; Medicare B: Inpatient: 44; Private Insurance: Outpatient: 12; Private Insurance: Inpatient: 0; Work compensation: Outpatient: 1; Private pay: Outpatient: 0; Private pay: Inpatient: 0. Auto: Outpatient: 4; Auto: Inpatient:0.

For the cottages, in the month of January there were 3 admission, 1 respite stays, 3 discharge, 1 death and 3 in house transfers.

Kazim continued to lead the Dining Improvement project meeting with Steve P and the team to work toward our improvement project goals. Communal dining project started 12/5/22, this should be completed 2/6/23.

Kazim continues to have weekly communication with Unidine to review issues.

During the month of January, Kari Belanger and Linda Burton, Recreational Therapists, completed a total of 59 video chats over FaceTime, Google Duo or Zoom. Kazim completed 4 on Elm.

In January, 4 family members have registered their dog to come in and visit their loved one.

Burton worked with a Birch family member to help their resident celebrate her 100th birthday on January 12.

Burton attended the MAAP (Michigan Association of Activity Professionals) board retreat on January 12-13; also attended the Senior Companion Advisory Council meeting on January 24.

Belanger worked with a Cherry family member to help her and her husband who resides with us, in celebrating their 50th wedding anniversary on January 14, here at the Pavilions with family and close friends.

Activities and special events that occurred in January included: hot cocoa & sweet treats, trivia (all about birds and Michigan trivia), crafts (bookmark making and Valentine's making), card & dice games (Skip-Bo, UNO, Yahtzee, Bunco), cooking (make & enjoy breakfast pizza, make & enjoy chocolate covered cherry dump cake), bingo, noodle ball & balloon ball exercise, Catholic Rosary and Catholic Mass, Happy Hour, What A Crock featuring queso blanco dip & chips, Soup's On Luncheon, and Coffee & Croissants.

Resident Council meetings were held on January 25 and 26 respectively.

Recruitment is underway for the following open positions: CNAs; Universal Workers; Environmental Services and Licensed Nurses.

Ten employees were hired in January – 1 SNF Universal Worker; 1 Cottage Universal Worker; 6 CNA; and 2 Licensed Nurse. We received 60 applications in January.

In January, there were 2 resignations; 2 retirements; and 3 terminations.

In January, 10 employee referrals were received.

In January, there no new or renewed unemployment claims filed.

There were zero (0) new and zero (0) renewed unemployment claims filed in January. Holibaugh protested zero (0) claims in January. So far, no charges have been applied to our account for the first quarter of 2023.

The cabling project that started in late September was should have been complete in December 2022, is still going on. Butler has had several phone call and emails with the vendor about the progress of the job being less than expected. The new ESI phone system was installed while some areas did not have new cabling down yet. Gannon Killeen, Information Systems Intern, Wild, Willett, Butler and Curt Keiser, Keiser Services, worked to get phones staged. Willett and Killeen installed a temporary connection for those areas that did not have cable job completed. Minor tweaks continue with the new system as staff learn how to use it.

Chris Willett, Information Systems Technician, and Butler met with PaceNorth management staff on moving PaceNorth Administration to a new office location. Willett continues to work with Pace North staff on duo authentication. Willett, Killeen, and Butler worked with Keiser on getting the new office location for PaceNorth ready. This involved troubleshooting the current cabling in the building and verifying locations. Butler worked on getting high speed Internet, firewall, wifi connections and up-grading Pace North's phone system to ESI cloud based.

On January 4, Tim Coggins, Environmental Services Director, and Cati Kujawski, Environmental Services Manager, met the residents of Hawthorn cottage to discuss the flooding that occurred on December 26. We covered the topic of what to do in the event of an actual fire, and the safe place to be. We also discussed the rebuilding of the northeast end of Hawthorn cottage, and that it would be completed by the contractor that originally remodeled the cottages.

On January 6, Graham Motor and Generator Service discovered a bad contactor on the backup generator block heater. Without the block heater, the generator would get too cold to start. Coggins rented a forced air heater, purchased some flexible ducting, and supplied enough heat to the generator cabinet to keep the engine warm enough to start. In the event of a power outage, if the generator would not start, we would be required to relocate all the residents.

On January 10, Coggins and Kujawski toured the damage at Hawthorn cottage with Casey Comstock of Comstock Construction (general contractor) and Bob Myers of Chess Construction (drywall contractor). Comstock and Chess were two of the contractors that worked on the original remodel of the cottages.

On January 12, Coggins, Kujawski and Clayton Wagatha, Community Relations and Volunteer Assistant, Met with Mary Panek of Arya Pure to discuss the upcoming installation of the Active Pure air purification system at our facility. We also discussed holding a reception at the Grand Traverse Pavilions as well as one at the Haggerty Center to showcase to installation.

On January 20, Graham Motor and Generator repaired the block heater in the backup generator, eliminating the need to heat the cabinet and run the generator. They also supplied an extra heating element, in the event of future failures, there would be no wait time for this part.

On January 26, Coggins and Kujawski met with Doug Bonnell of TruNorth Landscaping to discuss work on the courtyards. They will get started on cutting back plants, composting and getting the courtyards ready for planting in the spring.

On January 29, Coggins posted a request for public bids to replace the aging transformer that serves the main building. This transformer is original to the building, and is reaching the end of its life.

On January 31, Coggins, Kujawski, and Luke Johnson, Skilled Maintenance Tech, attended an on line demonstration of The WorxHub work order system. This system, if implemented, would send work orders directly to the maintenance tech or custodian, eliminating wait time for work orders submitted after hours, allow better tracking and reporting of work orders, eliminate manual inputting of work order history, allow for tracking of equipment maintenance costs, and allow trend analysis of work orders to allow the Environmental Services department to be more proactive in troubleshooting and avoiding maintenance issues.

Added Business (1)

GRAND TRAVERSE PAVILIONS
MEMORANDUM

Financial Operations Report
January 2023

Grand Traverse Pavilions Combined

REVENUE:

The overall revenue for the Pavilions in January was $2,229,719 resulting in an unfavorable budget variance of $381,807. Revenue for January included estimated Medicaid reimbursement for the Medical Care facility from the rate reconciliation and the Certified Public Expenditures programs of $375,000 which represents 75 percent of budget due to having only 75% of budgeted Medicaid census. This estimate will be updated for actual costs and occupancy before the financial statements are audited.

EXPENSES:

The total overall operating expenses for the Pavilions in January were $2,284,292 resulting in a favorable variance to budget of $247,411.

NET INCOME/LOSS:

There was net loss of $138,407 from the combined programs of the Pavilions in January resulting in an unfavorable budget variance of $134,396.

OPERATING CASH:

Total unassigned operating cash on hand at month-end was $913,103. This was an operational decrease of $1,295,778. This was due to several reasons. There was no QMI and QAS payments (MDHHS prepaid January, February and March in December for a net $95,000 shortfall in January), lower collections from nursing home operations of $51,000, payments totaling $519,582 made to Unidine (approximately $320,000 more than a typical month), $93,720 payment for the ActivePure system, $19,240 to Plante Moran, $31,500 in annual insurance premiums, $190,126 for the retention bonus for 2022, a union pension bond payment of $304,676, the ongoing loss from operations and the $375,000 of revenue that won't be paid until the cost report is settled. No further update on the Employee Retention Credit refunds. No update on the payment of the ARPA grant. **Request a temporary transfer of the $1M in the Capital Expenditure Fund until that can be replenished by the Employee Retention Credit.**

VOUCHERS:

Purchase orders, invoices, checks written, and supporting documentation reviewed for voucher numbers 5411-5418 for the month of January and were in order without exception.

Grand Traverse Medical Care

REVENUE:

The census for January averaged 131 residents which was twenty four below the budgeted census and the same as the prior month. Private pay census was two below budget, Medicare was equal to budget and Medicaid/Hospice was twenty-two below budgeted census. Total resident revenue was $1,389,444 (excluding the rate adjustments) resulting in a $196,387 unfavorable budget variance. The occupancy percent for January was 55% of licensed beds and 83% of available beds.

Other revenue equaled $623,637, which produced a negative budget variance of $178,744. Miscellaneous income included payments received and accrued revenue for reimbursement for COVID-related expenses that included wage premiums for direct care workers (estimated) and COVID testing administration totaling $46,652. It also included total interim payments from the insurance claims related to the cottage pipe break of $65,211. Total revenue for January was $2,005,581 which produced an unfavorable budget variance of $375,131.

EXPENSES:

Operating Expenses for the month equaled $2,050,235 which was a favorable budget variance of $243,513.

NET INCOME/LOSS:

Grand Traverse Medical Care produced a net loss of $105,166 for the month, which resulted in a $131,756 unfavorable budget variance.

RECEIVABLES:

Total cash collected on accounts receivable in January for Grand Traverse Medical Care was $1,299,429, a decrease of $59,580 from the prior month and represented 96.2% of the prior month SNF resident revenue.

WELLNESS CENTER

Total revenue for the Wellness Center in January was $128,241 (up $22,787 or 22% from the prior month) while total expenses equaled $113,673. This produced net income from the Wellness Center operations of $14,568. Grand Traverse Medical Care's financial report incorporates these amounts.

The Cottages

REVENUE:

Total revenue of $224,138 generated an unfavorable variance to budget of $6,676. The average census for the Cottages-Assisted Living was 51 residents during the month (one less than the prior month and eleven below budget),

representing 66% occupancy. There were 8 days of overnight respite provided during the month. Hawthorn Lofts-Independent Living average census was 3 residents per day for 100% occupancy (one vacant but in another unit due to the flood).

EXPENSES:

Expenses for January (before depreciation) were $234,057, which was below the budgeted amount by $3,898 for a favorable variance.

NET INCOME/LOSS:

The program had net loss for the month of $33,241 resulting in an unfavorable variance of $2,778.

RECEIVABLES:

There are $25,585 in problematic private accounts receivable (two tenants). There are $55,057 outstanding from the waiver program (up from the prior month). This is due to the AAA waiver program deciding not to pay its bills without agreement on contract terms. This was resolved in February. There is also $30,560 outstanding from Pace North, which represents two months of services, up from the prior month but the billing issue has been resolved.

Unassigned Fund Balance

Approved 2023 Operating Budget	$ 30.8M
Unassigned Fund Balance Target Percentage	20%
Unassigned Fund Balance Target Amount	$6.2M
Current Unassigned Fund Balance* ** ***	$.5M
Current Fund Balance as a percentage of Operating Budget	2%
Amount Available Above/ (Below) Target	($5.7) M

***Excludes Medicare Advance Payment (loan) of $734,999 less cumulative repayments of $354,279.58, a net of $380,719.42 ($16,790.12 in Medicare withholdings in January).**

****Fund balance is different from a cash balance as it includes other assets and is net of current liabilities. Those items do not generally change significantly so we are reporting here on the cash balance amount. The policy requires a review of the actual fund balance annually.**

*****Excludes $6.118M receivable (plus interest) from the Internal Revenue Service for the Employee Retention Credit expected anytime.**

*****Also excludes for the year ending 12/31/22 $2.851M estimated receivable from the Medicaid rate settlement process and $999K estimated receivable from the Medicaid Certified Public Expenditures program (total of $3.850M due from the State of Michigan expected in the fall of 2023). That estimate is in the process of being refined by Plante Moran.**

*****Also excludes $375k estimated receivable from Medicaid rates and CPE for 2023.**

GRAND TRAVERSE PAVILIONS
COMBINED STATEMENTS
MONTHLY FINANCIAL REPORT

January 2023

PROGRAM REVENUE	ACTUAL	BUDGET	VARIANCE	Y-T-D ACTUAL	Y-T-D BUDGET	Y-T-D VARIANCE
G.T. Medical Care	$ 2,005,581	$ 2,380,712	$ (375,131)	$ 2,005,581	$ 2,380,712	$ (375,131)
Cottages	224,138	230,814	(6,676)	224,138	230,814	(6,676)
TOTAL REVENUE	$ 2,229,719	$ 2,611,526	$ (381,807)	$ 2,229,719	$ 2,611,526	$ (381,807)
PROGRAM EXPENSES						
G.T. Medical Care	$ 2,050,235	$ 2,293,748	$ 243,513	$ 2,050,235	$ 2,293,748	$ 243,513
Cottages	234,057	237,955	3,898	234,057	237,955	3,898
TOTAL EXPENSES	$ 2,284,292	$ 2,531,703	$ 247,411	$ 2,284,292	$ 2,531,703	$ 247,411
DEPRECIATION						
G.T. Medical Care	$ 60,512	$ 60,650	$ 138	$ 60,512	$ 60,650	$ 138
Cottages	23,322	23,450	128	$ 23,322	$ 23,450	$ 128
Total Depreciation	$ 83,834	$ 84,100	$ 266	$ 83,834	$ 84,100	$ 266
NET INCOME/(LOSS)						
G.T. Medical Care	$ (105,166)	$ 26,314	$ (131,618)	$ (105,166)	$ 26,314	$ (131,480)
Cottages	(33,241)	(30,591)	(2,778)	(33,241)	(30,591)	(2,650)
OVERALL NET INCOME/(LOSS)	$ (138,407)	$ (4,277)	$ (134,396)	$ (138,407)	$ (4,277)	$ (134,130)

GRAND TRAVERSE PAVILIONS

GRAND TRAVERSE MEDICAL CARE

MONTHLY FINANCIAL REPORT

January 2023

RESIDENT REVENUE	ACTUAL	BUDGET	VARIANCE	Y-T-D ACTUAL	Y-T-D BUDGET	Y-T-D VARIANCE
Private	$ 291,673	$ 316,660	$ (24,987)	$ 291,673	$ 316,660	$ (24,987)
Medicare	196,289	183,310	12,979	196,289	183,310	12,979
Medicaid	901,482	1,085,861	(184,379)	901,482	1,085,861	(184,379)
Total Resident	$ 1,389,444	$ 1,585,831	$ (196,387)	$ 1,389,444	$ 1,585,831	$ (196,387)
OTHER REVENUE & (EXPENSES)						
Donations	$ -	$ 20,833	$ (20,833)	$ -	$ 20,833	$ (20,833)
Pace North	7,500	36,648	(29,148)	7,500	36,648	(29,148)
Child Day Care	8,553	7,750	803	8,553	7,750	803
Miscellaneous	510,178	634,381	(124,203)	510,178	634,381	(124,203)
QAS / QAAP/QMI - Net	97,406	102,769	(5,363)	97,406	102,769	(5,363)
Total Other Revenue	$ 623,637	$ 802,381	$ (178,744)	$ 623,637	$ 802,381	$ (178,744)
LESS:						
Bad Debts	7,500	7,500	-	7,500	7,500	-
TOTAL REVENUE	$ 2,005,581	$ 2,380,712	$ (375,131)	$ 2,005,581	$ 2,380,712	$ (375,131)
OPERATING EXPENSES						
Administration	$ 124,605	$ 95,572	$ (29,033)	$ 124,605	$ 95,572	$ (29,033)
Financial Mgmt.	142,540	148,803	6,263	142,540	148,803	6,263
Human Resources	30,650	40,272	9,622	30,650	40,272	9,622
Environmental Services	194,644	150,787	(43,857)	194,644	150,787	(43,857)
Housekeeping	83,664	91,762	8,098	83,664	91,762	8,098
Laundry	35,816	44,629	8,813	35,816	44,629	8,813
Food Services	215,894	250,000	34,106	215,894	250,000	34,106
Resident Care	1,025,919	1,198,111	172,192	1,025,919	1,198,111	172,192
Therapy	101,673	124,310	22,637	101,673	124,310	22,637
Ancillaries	15,120	18,800	3,680	15,120	18,800	3,680
Diversional Therapy	24,911	43,438	18,527	24,911	43,438	18,527
Human Services	20,185	30,806	10,621	20,185	30,806	10,621
Child Care	22,678	26,187	3,509	22,678	26,187	3,509
Volunteer Services	747	6,123	5,376	747	6,123	5,376
Pace North	-	11,648	11,648	-	11,648	11,648
Depreciation-Equip	11,189	12,500	1,311	11,189	12,500	1,311
OPERATING EXPENSES	$ 2,050,235	$ 2,293,748	$ 243,513	$ 2,050,235	$ 2,293,748	$ 243,513
Income/(Loss) before Bldg Depreciation	$ (44,654)	$ 86,964	$ (131,618)	$ (44,654)	$ 86,964	$ (131,618)
Less Building Depreciation	60,512	60,650	138	$60,512	$60,650	138
Net Income(Loss)	$ (105,166)	$ 26,314	$ (131,756)	$ (105,166)	$ 26,314	$ (131,756)

GRAND TRAVERSE PAVILIONS
COTTAGES
MONTHLY FINANCIAL REPORTS

January 2023

REVENUE	ACTUAL	BUDGET	VARIANCE	Y-T-D ACTUAL	Y-T-D BUDGET	Y-T-D VARIANCE
Cottages Revenue	$ 223,336	$ 229,914	$ (6,578)	$ 223,336	$ 229,914	$ (6,578)
Sub-Total	$ 223,336	$ 229,914	$ (6,578)	$ 223,336	$ 229,914	$ (6,578)
OPERATING EXPENSES						
Operating Expenses	$ 234,057	$ 237,955	$ 3,898	$ 234,057	$ 237,955	$ 3,898
Sub-Total	$ 234,057	$ 237,955	$ 3,898	$ 234,057	$ 237,955	$ 3,898
Operating Income/(Loss)	$ (10,721)	$ (8,041)	$ (2,680)	$ (10,721)	$ (8,041)	$ (2,680)
OTHER INCOME / EXP.						
Miscellaneous Income	$ 802	$ 900	$ (98)	$ 802	$ 900	$ (98)
Donation Income			-			-
Bad Debt Expense	-	-	-	-	-	-
Total Other Inc./(Exp.)	$ 802	$ 900	$ (98)	$ 802	$ 900	$ (98)
Income/(Loss) before Bldg Depreciation	$ (9,919)	$ (7,141)	$ (2,778)	$ (9,919)	$ (7,141)	$ (2,778)
Less Building Depreciation	23,322	23,450	128	23,322	23,450	128
NET INCOME(LOSS)	-$33,241	-$30,591	$ (2,650)	-$33,241	-$30,591	-$2,906

GRAND TRAVERSE PAVILIONS
CHILD DAY CARE
MONTHLY FINANCIAL REPORTS

January 2023

REVENUE	ACTUAL	BUDGET	VARIANCE	Y-T-D ACTUAL	Y-T-D BUDGET	Y-T-D VARIANCE
Day Care Revenue	$ 8,553	$ 7,750	$ 803	$ 8,553	$ 7,750	$ 803
Sub-Total	$ 8,553	$ 7,750	$ 803	$ 8,553	$ 7,750	$ 803
OPERATING EXPENSES						
Operating Expenses	$ 22,678	$ 26,187	$ 3,509	$ 22,678	$ 26,187	$ 3,509
Sub-Total	$ 22,678	$ 26,187	$ 3,509	$ 22,678	$ 26,187	$ 3,509
Operating Income/(Loss)	$ (14,125)	$ (18,437)	$ 4,312	$ (14,125)	$ (18,437)	$ 4,312
OTHER INCOME / EXP.						
Donation/Misc Income	$ -	$ -	$ -	$ -		$ -
Grant Income	-	-	-	-	-	-
Bad Debt Expense	-	-	-	-	-	-
Total Other Inc./(Exp.)	$ -	$ -	$ -	$ -	$ -	$ -
Net Income/(Loss)	$ (14,125)	$ (18,437)	$ 4,312	$ (14,125)	$ (18,437)	$ 4,312

GRAND TRAVERSE PAVILIONS

Service Excellence Award Program

January 2023

Date:	01/02/2023
Employee:	Michol Popp
Awarded for:	Thanks for assisting staff in doing a thorough fall investigation!
Position:	Campus Manager
Nominated by:	Chrissy Wagatha

Date:	01/02/2023
Employee:	Amanda Prance
Awarded for:	Amanda thank you for staying late today to cover the CM role. You are great and it is very much appreciated.
Position:	Scheduling Coordinator
Nominated by:	Kristen Packard

Date:	01/09/2023
Employee:	Vladimir Silkovskiy
Awarded for:	For coming in during the alarm at Hawthorn. He responded in the middle of the night and worked hard to remove water, keep tenants and staff safe and then later in the day move the tenants that were affected. We are so lucky to have such an amazing ES team
Position:	Maintenance
Nominated by:	Holly Kazim

Date:	01/09/2023
Employee:	Rick Harner
Awarded for:	For coming in during the alarm at Hawthorn. He responded in the middle of the night and worked hard to remove water, keep tenants and staff safe and then later in the day move the tenants that were affected. We are so lucky to have such an amazing ES team
Position:	Maintenance
Nominated by:	Holly Kazim

Date:	01/16/2023
Employee:	Chrissy Wagatha
Awarded for:	Thank you for presenting fall information to all shifts and for putting it all together so nicely. You do a great job reviewing falls and are always so organized.
Position:	Rehab ADON
Nominated by:	Kristen Packard

Date:	01/16/2023
Employee:	Ashley Parks
Awarded for:	Ashley is recognized for her awesome team work and dedication to all of our lovely residents!
Position:	CNA
Nominated by:	Jeanie Hickman

Date:	01/23/2023
Employee:	Adrian Reed
Awarded for:	Taking excellent care of me and being very attentive to my needs.
Position:	CNA
Nominated by:	Melinda Reid

Date:	01/23/2023
Employee:	Nicole Graham
Awarded for:	Always being there to help! Very appreciated.
Position:	CNA
Nominated by:	Ashley Parks

Date:	01/30/2023
Employee:	Mattie Ponder
Awarded for:	Helping keep up on resident’s laundry by folding and putting away for the next shift! Thank you so much for the extra help.
Position:	Launderer
Nominated by:	Heather Burgess

Date:	01/30/2023
Employee:	Philip Coumans
Awarded for:	Great addition to the Team, thanks doing a great job daily, and working through Hawthorns water crisis.
Position:	Universal Worker
Nominated by:	Jeff Valentine

Date:	01/30/2023
Employee:	Levi Harner
Awarded for:	Levi took the time out of his busy day to shave a resident's growing beard that wasn't part of his CNA assignment. His thoughtfulness, extra effort and care is appreciated!
Position:	CNA
Nominated by:	Michelle Godin