STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235608	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Pines Nursing and Rehabilitation Center	2121 Rockwell Dr Midland, MI 48642

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake # MI00148110 Based on interview and record review, the facility failed to provide increased supervision for 1 of 5 resident's (Resident #1) reviewed for falls, resulting in a fall with neck fractures and subsequent death. Findings: Resident #1 (R1) Review of an Admission Record revealed R1 was an [AGE] year-old male, admitted to the facility on [DATE], following a 13-day hospital stay for a left broken femur and multiple fractures of the pelvis. Other relevant diagnoses included highly impaired vision, hard of hearing, and chronic kidney disease. Review of R1's Hospital Discharge Summary dated [DATE] revealed, .Waxing and waning mentation, possible hospital delirium/sundowning: Issues with altered mental status possibly related to underlying dementia as well as need for pain medications with superimposed hospital delirium. Patient was alert and oriented x 3 upon evaluation during the day, difficulties happen at nighttime .Patient on day of discharge was doing very well. Alert and oriented x 3. Had no further issues with agitation at night. Pain was well controlled. Review of R1's Admission assessment dated [DATE] revealed R1 was alert and oriented to person, place, time, and situation .(R1) does have sundowners (confusion experienced in the evening through the night). Review of an Emar (electronic medication administration record) dated [DATE], revealed R1 was admitted to the facility and prescribed the following medications: Norco (an opiate pain reliever that causes sedation and confusion) ,d+[DATE] mg (milligrams) one tablet every 4 hours as needed, Robaxin (muscle relaxer that causes sedation) 500 mg one tablet by mouth four times a day, and Seroquel (an antipsychotic that causes sedation and confusion) 25 mg one tablet by mouth at night. The Seroquel had recently been prescribed and started while at the hospital due to possible hospital delirium/ sundowners. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a Provider Note dated [DATE] revealed, (R1) is at risk for falls due to medical condition and debility. Further review of the Emar, dated [DATE], reflected that R1 did not receive the prescribed pain medication Norco while at the facility until the morning of [DATE] at 7:49 AM. The last administered dose of Norco was given in the hospital, prior to R1's discharge to the facility, at 1:15 AM on [DATE], (R1 went greater than 2 days without prescribed pain medications). During an interview on [DATE] at 11:18 AM, Physical Therapist (PT) F reported that he assessed R1 on [DATE] following his admission. R1 was able to follow commands and stand but was unable to understand his weightbearing status and was made a hoyer lift transfer at that time. PT F reported that on [DATE] R1 was really confused and only bed mobility exercises were performed. During an interview on [DATE] at 9:42 AM, Nurse Practitioner (NP) D reported she had first assessed R1 on [DATE] and heard him moaning all day and visualized R1 throwing his legs over the bed and in constant motion which was likely indicative of pain. NP D reported that as she exited the facility on [DATE], she was notified by a licensed nurse that R1 was continuing to exhibit symptoms of pain and gave a verbal order to double the dose of Norco. NP D was not aware that the licensed nurses had not administered R1's Norco on [DATE] or [DATE]. During the same interview, NP D reported that she had ordered laboratory and diagnostic testing for R1 on [DATE] to ensure there was no other infectious process causing his agitation. NP D reported that she was not aware that when R1 admitted to the facility he was A&Ox,d+[DATE] and would have expected nursing staff to notify her of his change in mental status. NP D was not aware that the laboratory and diagnostic testing (chest x-ray) that were ordered on [DATE] had not been completed prior to R1's fall. Review of R1's Order Summary dated [DATE] revealed an increased order of Norco ,d+[DATE] mg two tablets by mouth every four hours as needed for pain. Review of R1's Care Conference Note dated [DATE] revealed, Resident was asleep and is currently in a mental state that prevents his participation .According to DPOA (durable power of attorney) A, resident was holding a conversation in the hospital and was very alert and oriented and had few memory issues .PT (physical therapist) F stated R1 had been unable to participate in therapy, and R1's decline has been very rapid . (There was no evidence that increased supervision/safety measures were implemented despite the Interdisciplinary Team noting a change in R1's cognitive status on [DATE]). Review of a Controlled Drug Receipt/Record/Disposition Form revealed that despite R1's acute change in cognition, R1 was given Norco ,d+[DATE] mg two tablets (the now ordered double dose) (a) on [DATE] at 7:49 AM and 4:00 PM, (b) on [DATE] at 3:12 AM, (c) on [DATE] at 3:37 AM and 7:55 PM, (d) on [DATE] at 1:04 AM, 7:10 AM, and 11:48 AM. Additionally on [DATE], R1 also received Robaxin 500 mg at 12:00 AM, 6:00 AM, and 12:00 PM. Both medications given during an acute change in condition, without increased supervision or safety measures put into place. Review of R1's Interdisciplinary Documentation dated [DATE] at 4:40 PM reflected that staff (a) heard a loud bang and entered R1's room, (b) found R1 laying on his left side on floor with feet still in the bed, (c) R1's face and head were reddened, (d) R1 had an abrasion to the top of the scalp, (e) moved R1 off the floor despite R1 not being able to answer any questions, and (f) received orders to send R1 to the emergency room . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R1's Hospital Documentation dated [DATE] revealed .Patient presenting as fall with multiple spinal fractures and with shock, suspect sepsis .It was reported that the patient was not at his typical neurologic (cognitive) baseline .septic shock, possibly secondary to sepsis due to pneumonia and urinary tract infection. Review of R1's Hospital Discharge Summary dated [DATE], revealed .Patient was noted to have injuries including C6 (sixth cervical vertebra) fracture, C7 fracture, possibly acute T1(first thoracic vertebra) and T2 compression fractures. Due to these injuries, the patient was admitted to the trauma service for admission . Discharge Condition: deceased . Review of R1's Death Certificate revealed the chain of events that directly caused the death .sudden death related to traumatic fall in adult resident facility. Spinal injuries include fractures, contusions, and compressions of the vertebral column, usually the result of trauma to the head or neck. The primary treatment after spinal injury is immediate immobilization to stabilize the spine and prevent cord damage. Stabilization of the head and neck is done prior to moving the victim to prevent secondary injuries such as paralysis from destabilization of a cervical vertebrae fracture . (Diseases: Causes and Diagnosis Current Therapy Nursing Management (4th ed.). Pennsylvania: Springhouse.).