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	05/08/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 This citation pertains to intake number MI00151925 Based on observations, interviews and record review, the facility failed to respond timely to resident concerns for 2 Residents (R3 and R4) of 3 residents reviewed for concerns. Findings include: R4 Review of R4's admission assessment dated [DATE], revealed he was admitted to the facility on [DATE] and had diagnoses that included: traumatic subdural hemorrhage (brain injury) with loss of consciousness status unknown, cognitive communication deficit, difficulty walking, weakness, malaise (general feeling of discomfort, illness, or lack of well-being) and prostate cancer. During an interview with R4 and his wife on 5/7/25 at 1:15 AM they were concerned about meals, safety and lack of encouragement of activities since admission. R4 said he could not eat the food. He said he would not eat ground meat, the facility told him they did not have bacon, and the eggs were too dry. R4's wife brought him a cheeseburger, french fries and ice cream from a restaurant. R4's wife was very concerned because R4 had been in the hospital for the last 3 months and he had lost 50 pounds in the last year because he had cancer. R4's wife had been bringing snacks and meals every day because he would not eat the meat or most of the meals. R4 and his wife reported they had been complaining about the meals almost daily since admission. They did not recall seeing anyone from the dietary department since admission. They did not know how to file a concern form with the facility. R4 and his wife agreed to bring their concerns to management at this time. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Dietary Manager (DM) E on 5/7/25 at 1:20 PM in R4's room, R4 and his wife reported the same concerns to DM E about the food and added that R4 wanted to be out of bed for breakfast and in the dining room for lunch and dinner. They added that R4 would not eat the food if it was cold. DM E explained that the food was served restaurant style in the dining room so the hot foods would be warmer than when he received them in his room. DM E said food preferences were to be completed on admission, and she did not have his food preferences. R4 and his wife said no one went over food preferences on admission. DM E found the food preferences paperwork on a table near the door in R4's room. When R4 complained about the ground meat she said she was following the Speech Therapist recommendations, and the Speech Therapist would have to evaluate him to change from ground meat to regular meat. During an interview with the Speech Therapist (ST) F on 5/7/25 at 1:50 PM in R4's room with R4 and his wife present, the ST F explained on admission she made his food orders as close to what she could do from his last hospitalization . ST F said the hospital had 7 different levels of diet and the facility only had 3. ST F saw R4 eat a french fry without any difficulty and saw that he had been eating a cheeseburger. She explained that based on his preferences she could change his diet. She saw the food preferences paperwork was still in his room and said normally she does complete that but for some reason she missed it. During an observation on 5/7/25 at 1:06 PM, R4 had lunch in his room on the bedside table. R4 was attempting to get into the bathroom and thought he had put the call light on, but the light was not on. The Surveyor assisted R4 with his call light. Certified Nurse Aide (CNA) G answered the call light. CNA G was asked if she had attempted to get R4 to the dining room for lunch and she said no he always ate in his room. (Request from 5/6/25 to eat in dining room for lunch and dinner was not communicated to the CNA). CNA G said R4 required the assistance of 2 people for transfers and left to get help. During an interview with the Director of Nursing (DON) on 5/8/25 at 11:00 AM, R4's food concerns, and desire for increased activity, food temperature, request to be up for meals and to the dining room were discussed. The DON said staff were aware of the need to complete concern forms and she was not aware of any concern forms for R4. She was not aware staff did not complete the food preferences or complete concern forms with R4 and his wife. R4 and his wife reported they had both made multiple complaints to staff about the food and wanted to be in the dining room for lunch and dinner. It was pointed out that after staff addressed the concerns on 5/7/25 they did not communicate to the Certified Nurse Aide that his preference was to eat in the dining room for lunch and dinner. No concern form was provided for the concerns made on 5/7/25 or previous complaints. R3 Review of R3's admission assessment dated [DATE] revealed she was admitted to the facility on [DATE] and had diagnoses that included: dementia, depression, and difficulty in walking. R3 was her own responsible party. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 5/8/25 at 10:28 AM, the surveyor asked the DON if she was aware of R3's requests to have family walk with her and have staff walk with her more. Record review revealed that R3 was discharged home with family on 4/11/25. The DON did not have personal knowledge of this request but was able to locate a care conference note dated 4/2/25 where the resident and family had requested to walk R3 to the bathroom daily instead of pushing her in the wheelchair. The note indicated the facility would not do this because they had determined it was not safe. The DON was not able to locate any reason why it was not safe for the Certified Nurse Aides (CNA's) to walk R3 to the bathroom as her care plan reflected. She only required 1 assist with a walker, family had been cleared to walk with her on 3/6/25 and the progress note dated 4/3/25 revealed she was able to walk 40 feet with contact guard assistance. The DON was not able to locate any risk/benefit information related to her request to be walked to the bathroom. Upon exit no information was located as to why the facility felt it was not safe for R3 to walk to the bathroom with the CNA's or any concern forms to address R3's concerns were provided. Review of R3's Activities of Daily Living (ADL) care plan dated 2/5/25 revealed, Ambulation: Therapy only resolved 2/14/25, 2/14/25 revealed, ambulation: one Assist with 2WW (two wheeled walker) follow with wheelchair. Review of R3's Interdisciplinary Documentation note dated 4/2/25 at 13:41 (1:41 PM) revealed, Resident and daughters state that Resident should be walked to the bathroom vs (verses) wheeled in wheelchair, and despite explanation as to why that would be unsafe daughter was talking over staff and was argumentative. Review of R3's Interdisciplinary Documentation note dated 4/3/25 at 10:56 AM revealed, Note Text: UR; (utilization review) PT/OT (Physical Therapy/Occupational Therapy), 1 PA (physical assistance with transfer with 2 WW (wheeled walker). Minimal assist with transfers. Ambulating max 40 ft (feet) CGA (contact guard assistance) with UB (upper body) ADL's (activities of daily living) Moderate assist with LB (lower body) ADL's.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 28101 This citation pertains to intake number MI00151925 Falls Based on observation, interview and record review, the facility failed to provide adequate supervision, assistance and meaningful interventions to prevent falls for 2 residents (R1 & R6) of 4 residents reviewed for falls. Findings include: R1 Review of R1's admission record dated 5/8/25 revealed she was [AGE] years old, admitted to the facility on [DATE] and had diagnoses that included: Dementia, depression, difficulty in walking, and weaknesses. She was not her own responsible party. Review of R1's incident and accident report dated 1/21/25 at 23:00 (11:00 PM) revealed she had an unwitnessed fall. The description revealed, Called to room by CNA (Certified Nurse Aide), I observed R1 sitting on her bottom with her legs straight out in front of her. Her back was towards her bathroom door and her legs were facing her bed. R1 stated that she went to the bathroom and was trying to get back to her bed and she fell on her bottom. After Immediate Action Taken was Encourage resident to attend activities and come to common area for increased visibility. Staff interview revealed that R1 had been observed walking in her room at 10:30 PM and she was assisted to a chair, R1 refused assistance to the restroom. When that CNA returned, she found R1 scooting across the floor on her bottom. The root cause was increased confusion, self-ambulating from restroom to bed, without using call light or asking for staff assistance. No new intervention to prevent falls was located. Review of R1's incident and accident report dated 1/31/25 at 23:45 (11:45 PM) revealed she had an unwitnessed fall. The description revealed, Nurse made aware that resident had fall in room. Upon arrival, resident laying on floor by bed. When asked resident states I was seeing if I could walk. Interviews did not reveal any information about prior care or condition. It was unclear if she had been in bed, if she had slept or when she had last used the restroom. The immediate action taken revealed, touch pad call light added. The root cause was the resident room relocated x 3 over the last 2 weeks due to structural damage to facility, resulting in increased confusion to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R1's incident and accident report dated 2/5/25 at 6:15 AM, revealed she had an unwitnessed fall. The description revealed, Notified by CNA that R1 was observed on the floor in her room. Upon entering the room, observed R1 laying on her left side facing her bed with her lap blanket underneath her and her bed blanket on top of her. Her walker was to the left of her. I don't know what I was doing. I must have fallen from my bed. Immediate Action Taken revealed, Care plan reviewed and updated with pad alarm for immediate intervention as R1 does not use her call light and does not understand her limitations. The conclusion revealed, R1 was observed 15 minutes prior to the fall resting in her recliner, reading a book. She had been toileted less than 2 hours prior to the incident. The root cause was, R1 continues to be self-determined to transfer and ambulate. She is non-compliant with using call light for assistance. Resident was attempting to make her bed and her feet got caught in her blanket and she fell . The immediate intervention was the same as the fall on 1/31/25 which was to add a touch pad alarm. Review of R1's incident and accident report dated 2/6/25 at 9:20 AM revealed, Staff witnessed the resident tipping out of her wheelchair and yelled for help and ran to catch her. Staff managed to get a hand under her head but was not successful in preventing her head for striking the floor. The immediate action was to send R1 to the emergency room . The root cause was R1 was non-compliant with medication acceptance causing her to become hypotensive. No new intervention to prevent injury was located. Review of R1's incident and accident report dated 2/19/25 at 11:45 AM revealed, Resident was seated in the dining room as lunch was being served. This staff member was preparing meds (medications) at the med cart and heard a thunk sound and when I turned around, I observed this resident sitting on the floor next to her wheelchair in the dining room by the wall. Immediate action was to add a pad alarm to her wheelchair, bed and recliner. The root cause was R1 is self-determined. Review of R1's incident and accident report dated 3/14/25 at 19:15 (7:15 PM) revealed, Nurse was called to room R1's room where resident was observed laying on floor next to recliner head facing doorway, legs straight out towards the bed. The alarm pad was not in chair. Call light not on. Immediate action taken was reminders to put the alarm pad in place. The root cause was increased confusion related to UTI (urinary tract infection). Review of R1's incident and accident report dated 3/22/25 at 8:45 AM revealed, Resident was observed on the floor in front of her wheelchair in the dining room today. Staff heard a thud and turned to observe this resident on the floor. The resident appeared to be asleep in her wheelchair before the incident and could not tell us what had happened. The immediate action with to provide a different style wheelchair and having therapy evaluate positioning. The root cause was the resident was sleeping in her wheelchair, leaning forward and fell to the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 5/7/25 at 3:15 PM, R1's fall incident and accident reports were reviewed. The policy did not include doing an investigation or how to do a root cause. The DON was not always able to determine from the investigations what R1's behaviors were, or care was prior to her falls. Review of the falls and care plan revealed that R1 lacked safety awareness and required supervision during waking hours and needed to be in a supportive chair to prevent falling. The review of these records revealed some of the interventions were repeated at times, no new interventions were implemented at times and on one occasion an intervention that had been implemented was not in use. The DON did not know R1's wake or sleep patterns and was unaware of any structured activities or tolerance to being in areas where she could be observed when she was awake. When asked about meaningful interventions for each incident and how to prevent another fall, the DON could not elaborate the root cause and did not locate any interventions in R1's care plans to ensure R1 would be supervised when awake and anticipate her needs. R6 Review of R6's admission assessment dated [DATE] revealed she was [AGE] year-old, admitted to the facility on [DATE] and had diagnoses that included: epilepsy, dementia, depression, difficulty walking and weakness. R6 was not her own responsible party. R6 was observed in her nursing unit dining room on 5/6/25 at 12:00 noon. At approximately 12:20 PM, R6 wheeled herself out of the dining room to a restroom around the corner from the dining room. Four staff were in the dining room at that time assisting other residents eat at the far end of the dining room (they were not in eyesight when R6 left the dining room). R6 attempted to open the bathroom door and when she was not able to open it, she asked the housekeeper standing there with her cleaning cart for help to get into the bathroom. The housekeeper told her everyone is eating right now, and the housekeeper left the area without getting any staff to assist her. A few minutes later R1 asked the office staff sitting at the desk to help her get into the bathroom and that person said she could not help and left the area without getting R6 any help. R6 went back to her table to finish eating without getting any assistance to use the toilet. At approximately 12:30 PM, R6 wheeled herself over to the day room across from the dining room and transferred herself into a comfortable chair. R6 did not lock her wheelchair brakes and landed hard enough to make a thud when she landed in the chair. R6 had a strong urine smell that the Surveyor smelled from over 5 feet away when she was sitting in a comfortable chair. Review of R6's Activities of daily living (ADL) care plan dated revision on 12/18/24 revealed, R1 has altered functional mobility and ADL's related to advanced age with multiple comorbidities, decreased mobility and strength, recent illness, impaired cognition, high risk for falls and the need of staff assistance with transfers, mobility and toileting. It included the following interventions 1) initiated 6/22/22 able to leave on toilet: NO, 2) initiated 6/22/22 non-ambulatory, 3) transfer: Two assist (resident self-determines throughout the day; goals are to prevent injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 5/7/25 at 3:30 PM the observations of R6 not being within eyesight of staff while eating, leaving the dining room and attempting to get help to use the toilet were shared along with the unsafe transfer that was also unobserved by facility staff. R1 and R6 were both on the same nursing unit and the majority of the residents on that unit have dementia and lack safety awareness. The DON was disappointed that the staff R6 approached did not follow through with getting R6 help. The DON did not have any other information to add as to how the facility planned to ensure the residents on the Dementia unit would be provided with adequate supervision and assistance moving forward.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 This citation pertains to intake MI00151925 Based on observations, interviews and record review the facility failed to ensure that 1 Resident (R4) of 4 residents reviewed for accident hazards met the required bed rail and mattress hazards entrapment assessments. Findings include: Review of R4's admission assessment dated [DATE], revealed he was admitted to the facility on [DATE] had diagnoses that included: traumatic subdural hemorrhage (brain injury) with loss of consciousness status unknown, cognitive communication deficit, difficulty walking, weakness and malaise (general feeling of discomfort, illness, or lack of well-being. Review of the Michigan Department of Consumer and Industry Services Guidelines for Use of Bed Rails in Long Term Care Facilities, dated March 1, 2001, revealed, II. Properly Fitted Mattresses and Initial Bed Rail Installation. A. Since the size of the resident varies, a long-term care facility must document that the equipment chosen was assessed in relation to the specific resident for whom it is used to avoid the possibility of serious injury or death from entrapment or slipping through gaps created by body weight, body size, or bed, rail, mattress configurations. The maximum acceptable gap of the resident must be recorded in the medical record at the time the bed rail is installed for that resident. B. In an occupied bed, the space between bed rail and mattress and between the mattress and head or foot board can be no greater than 2.5 inches on any side. If the medical record indicates a smaller gap is required, the Department will require the long-term care facility to comply with the smaller measurement. C. Foam edges are acceptable to reduce gaps if they meet the fire safety standards and are not worn or otherwise rendered ineffective. D. The long-term care facility may consider placing Velcro or other anti-skid material between the mattress and mattress deck to reduce mattress movement. III. Proper Maintenance of Bed Rails. When bed rails are used, the long care facility must document that it has monitored and maintained the mattress and bed rails as follows: A. On each of the first 5 days following initial use, the resident, bed frame, bed rails and mattress must be monitored by each shift to document proper fit of and to ensure that the maximum distance between components for that resident, as recorded in the medical record, is not exceeded. The monitoring must ensure that the resident's weight, movement, or bed position is not exceeded. The monitoring must ensure that the resident's weight, movement, or bed position is not creating gaps that could potentially entrap the resident's head or other body parts. If gaps in excess of the maximums acceptable for the residents are being created, the record must document corrective actions taken. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 8:40 AM, R4 was observed sitting at the edge of his bed eating. The mattress at the foot of the bed had shifted and 6 inches of the metal bed frame was exposed. The mattress was a specialty mattress for pressure relief that was plugged into the wall which controlled air pressure. The bed had half rails on the top portion of the bed that covered most of the top section of the bed. R4 had a dressing over his left anterior lower leg and bruises on his right leg. R4 did not know where he got the bruises and injuries and reported he had short term memory loss after suffering a head injury from falling. The back of R4's thighs were resting on the metal bed frame. The gap between side rail and mattress with R4 in a sitting position was 5 inches. The mattress was compressed significantly. R4 said he could not stand without help. No staff were in the room at that time. During an interview with the Unit Manager (UM) C on 5/7/25 at 9:10 AM, the surveyor expressed concern about the R4's mattress sliding and concern that the gap between the mattress and rail could cause an entrapment issue. A request for the facility bed safety policy was requested along with all documents related to R4's assessments for bed safety. During an interview with the Maintenance Director (MD) D and the Nursing Home Administrator (NHA) on 5/7/25 at 11:25 AM, the Surveyor expressed concern for R4's bed safety and again requested the facility policy for bed safety. MD D had a form that he completes on residents with bedrails that indicated maximum gaps for residents' beds with rails. MD D keeps the forms in a book in his office. We went to R4's room, R4 was not in bed at that time. The mattress on the bed easily slid with light touch and when it was slid to the far-right position at the top it had a 2 3/4 inches gap and MD D reported his form allows for 2 3/8 inches (Michigan regulation is 2.5 inches). The resident was not in bed so the compressed measurement could not be accurately measured. However, the mattress was easily compressed with one hand to measure 3.5 inches at that same point. Review of R4's, Assessment/evaluation for conformance to FDA's bed system entrapment zones revealed the assessment was only evaluated on one day 4/29 (no year) or time of day. There was no indication if R4 was in bed at the time of the assessment. The form indicated the type of bed. For rail type Assist and Mattress/Overlay Type Air. All boxes were checked except the Zone 5 which did not apply to this bed. Zone 4 was the space/gap that forms between the mattress compressed by the patient, and the lowest portion of the rail, at the end of the rail. A dimensional limit of less than 2 3/8 inches measured between that mattress support platform and the lowest portion of the rail at the end to prevent neck entrapment. In addition, the V-shaped opening under the rails may present a risk of entrapment due to wedging. Nursing homes are to report entrapment events at this zone to the FDA. This form did not include the distance between the mattress and the rail as required by the State of Michigan. The maximum acceptable gap of the resident must be recorded in the medical record at the time the bed rail is installed for that resident. B. In an occupied bed, the space between bed rail and mattress and between the mattress and head or foot board can be no greater than 2.5 inches on any side. If the medical record indicates a smaller gap is required, the Department will require the long-term care facility to comply with the smaller measurement. Review of R4's medical record revealed one Restraint/Enabler assessment dated [DATE] at 9:23 AM (after the surveyor identified bed concerns). The Assessment revealed that R4 had bilateral assist rails to promote independent mobility. These are an assistive device. They do not restrict movement or his field of view. The assessment did not include any measurements or discussion of entrapment concerns. No other assessments, measurements or orders were located to assess R4's bed rail entrapment risk.