

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Dimondale Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4000 N Michigan Road Dimondale, MI 48821	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0580 Level of Harm - Actual harm Residents Affected - Few	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705</p> <p>This citation refers to intake MI00145124.</p> <p>Based on observation, interview and record review, the facility failed to competently assess and monitor for changes in condition and notify the physician of pertinent findings in a timely manner for 2 residents (Resident #103 and Resident #104) resulting in the potential for and actual harm from unrecognized, clinically significant changes in condition and uncontrolled pain.</p> <p>Findings:</p> <p>Resident #103(R103)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R103 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included aftercare arthroplasty right hip removal prosthesis and insertion of antibiotic spacer post hip infection, muscle weakness, need for assistance with person care, cardiomyopathy, hypertension (high blood pressure), anemia, atrial fibrillation, and congestive heart disease. The MDS reflected R103 had a BIM (assessment tool) score of 15 which indicated his ability to make daily decisions was cognitively intact, and he required partial to moderate assist with transfers.</p> <p>During a telephone interview on 6/26/24 at 3:19 p.m. complainant C reported Certified Nurse Aid(CNA) D was very rough with R103 during a transfer on 5/9/24 around 7:30 p.m. and threw legs into bed followed by extreme pain. Complainant C reported R103 was post right hip reconstruction surgery on 4/25/24 and surgical follow up appointment on 5/8/24. Complainant C reported R103 was sent to the emergency room after X-ray showed right hip dislocation on 5/10/24 and returned to the facility on [DATE] around 2:00a.m. Complainant C reported facility ran out of pain medications and R103 went over 24 hours without. Complainant C reported R103 was seen by surgeon on 5/16/24 and sent to the hospital for emergency surgery related to damaged right hip and hardware was removed and unable to replace hardware for six months.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235256
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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Orthopedic Physician Consult, dated 5/8/24, reflected R103 was seen in the office for a two week post-operative right total hip arthroplasty revision removal prosthesis and insertion antibiotic spacer. The consult note reflected R103 had a current pain scale of 4/10 and indicated since the last office visit the pain had become better for the patient and decrease since surgery on 4/25/24. The note reflected the surgical incision demonstrated acceptable healing and no drainage. Continued review of Consult reflected X-ray of hip with Remedy long femoral stem hemiarthroplasty with was well aligned.</p> <p>Review of the Orthopedic Center X-Ray Report, dated 5/8/24, reflected R103 had X-Ray 73502-hip, unilat, 2-3 views Right completed. The report reflected, Hip/Pelvis X-ray: Remedy long femoral stem hemiarthroplasty. Well aligned.</p> <p>Review of R103's Physician Note, dated 5/10/24 at 2:44 p.m., reflected, Note Text: In today for an urgent visit on his request for pain in his right hip after he was transferred into the bed, and he fears that he might have dislocated his hip. He is a [AGE] year-old man with history of osteoarthritis, atrial fibrillation, and GERD. He is admitted for skilled care after he developed infection in his right hip prosthesis. The right hip was replaced initially in 2018. It was later replaced due to chromium toxicity two years ago. He had a fall recently and that required revision of the hip, but later developed prosthesis infection and was admitted for skilled care. He is currently receiving IV abx. He had a wound clinic follow up appointment and his wound back[vac] has been removed. He reports that last night, while being transferred into the bed nursing aid lift his leg to transfer him in the bed. He feels that right after the transfer, he developed significant pain in his right leg and his right leg appears externally rotated. His wife is also present and concerned if it has dislocated. Is it recent lab labs reviewed and currently his Vancomycin is being held based on his trough levels. He reports pain seven out of 10 currently, worse with slight movement. He requesting if a stronger pain medication can be given to him until the x-ray is done. Nursing staff, but also interviewed to complete this assessment .PLAN</p> <ul style="list-style-type: none"> - [AGE] year old man with infection of prosthetic right hip, IV antibiotics status I& D developed worsening pain with extra rotated right tip after transferring into the bed - X ray right to rule out dislocation - is assessed. Increase PRN and Norco to every four hours - awaiting x-ray of hip, if this[dis] location is confirmed will transfer to emergency room for orthopedic intervention, if recommended - family, including wife and granddaughter was explained the care plan in detail and they agreed - nurse will call as soon as the stat x-ray report are available. Care plan is discussed with the nurse and nursing Director. <p>Review of of R103 Nurse Progress Notes, dated 5/10/2024 at 4:47 p.m., reflected, Received STAT x-ray results and reviewed with [named physician]. Noted dislocation of spacer/femur. Physician gave order to send resident to ED with hope he can be seen by ortho to have the hip reset. Daughter and wife updated on resident's status and notified of order to transfer resident. Will send to [named hospital], which is where resident was originally treated .</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Physician orders, dated 5/9/24 through 5/10/24 reflected no evidence of order for STAT X-ray for R103 on 5/10/24.</p> <p>Review of R103 Radiology Results Report, dated 5/10/24 at 3:06 p.m., reflected, Conclusion: 1. Post right hip with superior dislocation of the prosthetic femur. Suspected additional underlying malrotation. Correlate with prior imaging. 2. Questionable minute fracture deformities at the acetabular fossa versus expected postsurgical change .</p> <p>Review of the Hospital Records, date 5/10/24 through 5/11/24, reflected R103 was seen in the Emergency Department on 5/10 at 6:21 p.m. The record reflected, Chief Complaint: Pt comes from [named facility] after right hip sx[surgery] in April, last night staff threw his legs into bed and pt had significant pain, x-ray was obtained today showing R femur dislocation . Continued review of the ED Note Physician/Provider, dated 5/10/24 at 7:19 p.m., reflected, History of Present Illness: [named R103] a [AGE] year-old man with past history of right hip replacement complicated by infection presented to ED today wit complaint of right hip pain. The patient's wife and daughter were at bedside and provided additional history. The patient and his family state that nurses in the facility center were trying to put him in bed when they pulled his right leg out and the hip got dislocated .The patient and his wife did note that they are concerned that there was a caregiver abuse at the patients SAR that resulted in dislocation of the hip. They already spoke with the manager of the SAR and the nurse responsible has been placed on leave. They also made a police report.</p> <p>Review of R103 Nurse Progress Note, dated 5/11/2024 5:22 p.m., reflected, Resident has been pleasant and cooperative with cares. A/Ox4. VSS. Skin W/D. Takes medications as ordered. Has taken one PRN pain medication for pain in right hip. Has been resting in bed most of shift with call light in reach and safety maintained. Skin well approximated at S/P surgical site. No noted S/SX of infection present. Attends therapy per recommendations. Able to verbalize wants and needs. Needs met at this time.</p> <p>Review of R103 Nurse Progress Notes, dated 5/14/2024 at 7:55 a.m., reflected, spoke with resident's daughter who shared concerns about resident's pain management and hydration .Resident's daughter also expressed that she feels like his current rx for Oxycodone 5mg q4h prn is not enough to management resident's current pain level and requested that nurse asked the Dr for fentanyl patches for resident. Nurse spoke with resident and encouraged fluids through PM/midnight shift and offered OTC pain management which resident accepted. Dr notified .</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Physician Progress Note, dated 5/14/2024 at 11:10 a.m., reflected, Resident is a [AGE] year old male who was seen today for a follow-up of pain and need for fluids. He was admitted into the facility for rehab following a revision of his hip post fall. He was also treated for an infection of his prosthesis in the hospital. The attending visited with the resident on the 10th of May for pain and pain medications were increased. The notes reviewed and the daughter is concerned that the resident is not receiving adequate hydration and is requesting IV fluids. She also feels that the pain regimen is not covering his pain and she is requesting fentanyl patches. Spoke with the nurse and she reported that the resident does drink independently and does not feel he needs more fluids, but labs were ordered. Visited with the resident at bedside with the family present. The resident reported that he does have a lot of pain, but feels the oxycodone does provide him with relief. I spoke with him about the plan for the oxycodone and we also talked about adding a lidocaine patch in addition and both he and his family agreed. I spoke with the resident about his fluid intake. He said that he doesn ' t drink very much because he doesn ' t like the water, but has been drinking Gatorade. I let him know because of his history, we will check his labs first and go from there. I also let him know that I had the nurse to consult dietary for additional fluids with his IV ABX and to continue to drink what he likes. The resident does see ortho tomorrow. He has not been working with PT because he had to go back to the hospital because his hip popped out and he has been in a lot of pain .Plan:</p> <ol style="list-style-type: none"> 1. Right hip pain 2. Dehydration <p>Receiving oxycodone 5mg QID and PRN q 6 hours. Had the nurse split up order and new C2 completed</p> <p>Has ibuprofen as needed for breakthrough pain, will continued</p> <p>Added lidocaine patch to right hip q 24 hours</p> <p>BMP ordered to check hydration status.</p> <p>Consult dietary for possibly fluids with ABX, continue to encourage fluids</p> <p>Plans discussed with the nurse .</p> <p>Review of the Medication Administration Note, dated 5/15/2024 at 12:36 p.m., reflected R103 was sent to hospital from doctors appointment.</p> <p>Review of the Hospital Discharge Summary, dated 5/22/2, reflected R103 was admitted [DATE] and taken to the Operating Room for an open irrigation and debridement of his right hip and removal of antibiotic spacer. Patient has no hip prosthesis in. The Summary included, Discharge Diagnosis and Plan: 1. Infection of right prosthetic hip joint .Pt is to remain nonweightbearing on his rt lower extremity as he has no hip joint currently. PT Must work with patient today to at least stand and transfer and get him off his pack so as not to develop bed sores .Will leave incisional drain on for another 10 days and DC sutures in 3 weeks post op .cefepine 2g and vacomycin .for total of 4 weeks .end date at 6/17/24 .Dislocated hip .heart failure .cardiomyopathy .atrial fibrillation .anemia .</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of the FRI investigation notes reflected, 5/10/24(no time): [named R103] and [named R103 wife]Second interview with [named DON B]. This writer notified wife and daughter that resident hip was dislocated per the x-ray, the physician was notified, and was ordering [named R103] to be transferred to the hospital .</p> <p>Continued Review of the FRI investigation notes reflected, 5/10/24(no time): [Named CNA D] .I entered the room as the call light was on and I went to check on the resident. The resident requested to be put in bed, after I transferred him to the bed, he requested that I put his legs up. I counted to three and then picked his legs up to transfer them onto the bed. After the transfer, the resident made a grunting noise and stated that his leg hurt, I then notified the nurse that he was in pain .5/14/24: [named CNA F] Sometimes I think that she needs to slow down to show the residents more empathy .The family member reported the situation to me, I then notified the nurse .5/17/24: [named Registered Nurse(RN) H] I do feel that she should slow down at times when providing care .</p> <p>During an interview on 6/27/24 at 12:25 p.m., Physical Therapy staff(PT) I reported had worked at the facility for about five months and was not involved in training staff including hip precautions. PT I reported post hip precautions included no hip flexion over 90 degrees, no abduction and need for careful staff assist with transfers if residents request with support of both ankles at same time to keep body alignment. PT I reported had worked with R103 prior to 5/9/24 incident and reported had been progressing well with therapy including short ambulation with use of walker. PT I reported after 5/9/24 R103 was unable to get out of bed related to uncontrolled pain so only able to perform limited range of motion exercises until discharged [DATE]. PT I reported completed one on one education with CNA D post incident with R103 that included safe transfer with hip precautions on 5/21/24.</p> <p>Review of the Physical Therapy Treatment Encounter, dated 5/6/24 through 5/14/24, reflected R103 was progressing toward goals and compliant with treatment 5/6/24 through 5/9/24 with noted ambulation with 2 wheel walker 5 feet on 5/9/24 at 12:48 p.m Review of therapy on 5/13 and 5/14 reflected pain with leg immobilize in place with sessions in bed.</p> <p>During an interview on 6/27/24 at 12:48 p.m., Licensed Practical Nurse(LPN) G reported nurse expected to report assess resident if staff report change of condition to nurse and report to physician in document on change of conditions documents or progress notes. LPN G reported if CNA staff report resident with increased pain, nurse expected to assess resident first then determine what options available for pain control and if no medication or treatments available or pain not controlled to contact physician and document. LPN G reported expect that pain medications should be available within no more than 4 hours from pharmacy if narcotics orders. LPN G reported worked day shift on 5/9/24 and was giving report to RN H about 7:00 p.m. when CNA staff reported R103 had requested pain medications. LPN G reported during day shift R103 pain was controlled and was able to go outside with family and participate in therapy. LPN G reported worked next on 5/11/24 and 5/12/24 and R103 did not get out of bed related to increased pain. LPN G reported investigation was completed. LPN G reported if residents have increased uncontrolled pain nurse should assess and notify physician and document.</p> <p>During an interview on 6/27/24 at 1:30 p.m., CNA J reported had worked at the facility over three years. CNA J reported if change in resident baseline with either oral intake of resident reports of pain expected to report to nurse and reported not able to document that information as CNA. CNA J reported knows how to care for residents by following the Kardex.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Physician orders, dated 5/9/24 through 5/10/24, reflected R103 had orders that included Oxycodone 5mg every 6 hours as needed for pain and Tylenol 1000mg every 6 hours as needed for pain.</p> <p>Review of the Electronic Medical Record(EMR), dated 5/9/24 through 5/10/24, reflected R103 requested as needed Oxycodone 5mg on 5/19/24 at 4:06 pm for pain 5/10 on pain scale and with effective pain control at 6:55 p.m. of 2/10 on pain scale. R103 was given as needed dose of Tylenol for patient complaint of 8/10 on pain scale at 7:38 p.m. R103 was given as needed dose of Oxycodone 5mg for R103 complaint of severe pain. R103 was given additional dose of Tylenol 1000mg on 5/10/24 at 1:17 a.m. related to prior Tylenol and Oxycodone dose ineffective with pain 7/10 on pain scale. R103 was administered as needed dose of Oxycodone 5mg 5/10/24 at 4:10 a.m. related to R103 report of pain 7/10 on pain scale. R103 requested additional as needed dose of Oxycodone 5mg on 5/10/24 at 10:32 for pain of 6/10 on pain scale and requested increased pain medication when seen by physician.(order changed from Oxycodone 5mg every 6 hours to every 4 hours on 5/10/24 at 11:45 a.m.). Continued review of the EMR reflected no mention of nursing assessment of R103 post reported incident at 7:00 p.m.(including right hip physical assessment/positioning) or no evidence of physician notification of change in pain level.(prior to reported incident R103 pain level documented between 0 to 6 on pain assessment).</p> <p>During an telephone interview on 6/27/24 at 4:09 p.m., LPN K reported R103 was a pleasant man with a pleasant family. LPN K reported worked on 5/10/24 with R103 after family reported concerns about R103 right hip pain. LPN K stated, Resident was in excruciating pain. LPN K reported R103 was assessed by physician on 5/10/24 who suspected R103's right hip was dislocated. LPN K reported R103's wife did not want to wait for X-ray to arrive and DON B was notified and shortly after mobile X-ray arrived. LPN K reported even with changes in R103 pain medications pain was no controlled and X-ray came back positive for dislocation and R103 was transferred to the hospital.</p> <p>During an interview on 6/27/24 at 4:51 p.m., CNA L reported had worked at the facility for about one year and worked with R103 on the evening on 5/9/24 from 11:00 p.m. through 6:30 a.m. CNA L reported R103 told her was transferred into bed with staff assist and transfer did not go right. CNA L reported later that night attempted to change R103 and he refused care because hip was, in bad condition and hurting really bad. CNA L reported R103 reported did not want to end up in hospital with worse injury. CNA L reported to Registered Nurse(RN) H.</p> <p>During an interview on 6/27/24 at 5:10 p.m. LPN M reported was not present for at time of R103 incident on 5/9/24. LPN M reported R103 was alert and oriented and able to make needs known. LPN M reported worked 5/14/24 when R103 daughter reported concerns that R103 pain medications were not controlling pain and reported had notified physician. LPN M reported R103 did not return after orthopedic appointment the next day. LPN M reported if CNA staff reported to her that resident with recent post hip replacement complained of increased pain with transfer would assess resident, notify NHA and Physician because possible allegation of abuse.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/27/24 at 5:20 a.m., CNA D reported worked with R103 on second shift on 5/9/24. CNA D reported R103 used call light and report she answered call light on 5/9/24 around 7:00 p.m. CNA D reported R103 was sitting in a wheelchair with left side against the bed and stood up with use of walker and pivoted to turn and sit on edge of bed without assist. CNA D reported R103 requested assistance to get legs into bed. CNA D reported she lifted R103 ankles after counting to 3 to the bed and R103 made a noise that made her think he was in pain.(CNA D acted out wheelchair position and had reported did not move wheelchair to place legs in bed, however wheelchair would have been in the way to pivot legs in bed with smooth motion. CNA D changed story and reported maybe she did move wheelchair prior to assisting R103 position legs in the bed.) CNA D reported R103 requested pain medication, CNA D reported to LPN G and RN H during shift report at around 7:00pm that after transferring R103 to bed R103 complained on increased right hip pain(surgical hip) and requested pain medications. CNA D reported R103 pressed his call light three additional times in next 45 minutes to ask for pain medications related to elevated pain. CNA D reported to RN H again that R103 requested pain medication. CNA D reported after R103 got pain medications did not hear from him again during the shift that ended at 11:00 p.m. CNA D reported R103 was a one person assist with transfers and had not received specific teaching related to post hip precautions but now after incident they have a binder at the nurse station with post hip precautions. CNA D reported hip precautions were not on R103 kardex at the time but now have been added after incident. CNA D reported worked 5/10/24 first shift 7:00 a.m. to 3:00 p.m. and was questioned at the end of the shift about R103 transfer on 5/9/24 evening. CNA D reported was later called by Human Resources and informed she would be on suspension pending investigation and was off for about two weeks. CNA D reported received education from PT I prior to return to work.</p> <p>During an observation on 6/28/24 at 9:45 a.m. observed transfer precautions binder located at the south nurse station included post hip precautions.</p> <p>During a telephone interview on 6/28/24 at 11:01 a.m., CNA F reported had worked second shift on 5/9/24 at the time of the incident around 7:00 p.m. with R103. CNA F reported R103 was very upset and dis-[NAME], R103 wife was upset because R103 had requested assistance from another CNA to transfer into bed. CNA F reported wife was angry because she asked CNA D to be genital because of recent hip surgery and CNA D quickly transferred legs on bed and caused R103 immediate pain in right hip. CNA F reported consoled R103 and wife and reported to RN H that R103 complained of immediate right hip pain after CNA D transferred him. CNA F reported R103 was a pleasant man who was alert and oriented and was clearly in severe pain after incident related to reported pain, significant facial grimacing, and stated, looked like he was in pain because he was board stiff. CNA F reported worked with R103 in the past and pain was controlled and would go outside in wheelchair with family or to Dining Room but not after incident, he remained in bed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Dimondale Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4000 N Michigan Road Dimondale, MI 48821	
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)		
<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 6/28/24 at 11:30 a.m., RN H reported had worked with R103 on 5/9/24. RN H reported was told by CNA D had pain after transfer from wheelchair to bed. RN H reported R103 had recently received as needed Oxycodone for pain so was not due at that time so gave as needed dose of Tylenol. RH H spoke with R103 who reported pain was, pretty high and reported CNA D staff was rough and moved little too fast when assisting with transfer. RN I reported he then spoke with CNA D about R103 complaint. RN I verified did not document in the medical record about the reports from staff of R103 increased pain during transfer. RN I later learned from someone else that R103 right hip was dislocated and had to be transferred to the hospital. RN I reported did not contact physician or assess R103 right hip including palpation or observe for external rotation. RN I continued to administer as needed pain medication through out night shift. RN I reported did not report incident as allegation of abuse because did not think CNA D intended to hurt R103.</p> <p>During an interview on 6/28/24 at 12:08 p.m., Physician Medical Director(MD) N reported had been the Medical Director at the facility for several years. MD N reported did not receive call from the facility on 5/9/24 related to R103 pain post staff assisted transfer around 7:00 p.m. MD N reported staff requested R103 to be seen on 5/10/24 and reported was unsure when. MD N reported ordered x-ray to rule out dislocation. MD N reported x-ray came back positive for dislocation and order to send R103 to the hospital. MD N reported did not feel staff deliberately caused injury. MD N reported would expect nurse to give ordered medication. MD N was queried if he would expect nurse to call if aware of knowledge that R103 reported rough transfer followed by increased pain. MD N reported was not able to answer that question. MD N reported assessed R103 on 5/10/24 and wife and daughter were upset after increased pain related to transfer night prior.</p> <p>During a telephone interview on 6/28/24 at 1:07 p.m., R103 wife O reported was present on 5/9/24 and observed CNA D assist R103 transfer to bed around 7:00 p.m. that caused R103 immediate pain. R103 wife O reported she had been outside with R103 for about one hours prior to both returning to R103 room and used the call light to assist R103 into bed. R103 wife O reported CNA D entered the room alone. R103 wife O reported told CNA D R103 needed two people to transfer and CNA D responded, they were busy, and R103 reported he would try. R103 wife O reported took several minutes but R103 stood from wheelchair and sat on bed slowly. R103 wife reported told CNA D needed to be very careful and CNA D asked if R103 needed help with legs and R103 reported yes. CNA D grabbed both legs near heels and threw R103's legs on the bed and R103 screamed in pain. R103 wife O told CNA D she could not believe she just did that and told R103 wife O she would tell the nurse what had happened. R103 wife O reported did not see CNA D prior to leaving for the evening. R103 wife O reported also went to nurse desk and reported to nurse what had happened to R103 and need for pain medications prior to leaving on 5/9/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Dimondale Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4000 N Michigan Road Dimondale, MI 48821	
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)		
<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 6/28/24 at 1:28 p.m., R103 reported recalled very clearly what happened on 5/9/24. R103 reported had reconstructive surgery on right hip after complications including infection on 4/24/25. R103 reported admitted to facility on 5/3/24 and had been working with therapy and progressing well with good pain control around 4/10 on pain scale. R103 reported on 5/9/24 CNA D assisted him into bed. R103 reported was sitting on side of bed and stated, she tossed my legs onto bed. R103 reported it cause him so much pain at 10/10 he could not even say what happened next. R103 stated, I was trying to keep it together. R103 reported RN H asked about pain several times during the night and reported told RN H CNA D threw R103 legs in bed. R103 reported CNA D came in room after R103 told RN H what had happened and CNA D apologized and asked, how should I have done that? R103 reported did not assess R103 right after the incident or move the covers to observe right leg. R103 reported told everyone he could what happened because he was in so much pain and worst pain he had ever been in and reported everyone knew what had happened. R103 reported no relieve from pain medications and remained 10/10 on pain scale through the night and next day. R103 reported daughter called the physician who came right in and ordered an X-ray that took about four hours to arrive and was later sent to the hospital.</p> <p>During a telephone interview on 6/28/24 at 1:48 p.m., R103 daughter C reported she called Physician Medical Director N on 5/10/24 at about 10:30 a.m. and informed him of transfer on 5/9/24 evening that caused uncontrolled pain to R103 post operative right hip. R103 daughter C reported MD N came to assess R103 right away and was mad and suspected hip was dislocated. R103 daughter C reported at least four hours before mobile X-ray arrived and results came back about one hour later and R103 was sent to the hospital. R103 daughter C reported R103 had additional right hip surgery on 5/15/24 to remove hardware and R103 currently does not have hip and was told by surgeon could not re-attempt prosthesis for 6 months which means no weight to right leg.</p> <p>During an interview on 6/28/24 at 4:30 p.m., DON B reported was first made aware of R103 incident on 5/9/24 on 5/10/24 at around 10:00 a.m. DON B reported CNA J reported R103 family was upset related to interaction from prior day. DON B reported R103 room and R103 on in bed and R103 wife and daughter were present when she got there. DON B reported R103 was assisted into bed by CNA D on 5/9/24 evening and R103 yelled out when legs assisted into bed. DON B reported R103 family had already called MD N and verified. DON B reported would expect nursing staff to assess residents if staff reported acute pain during transfer. DON B reported MD N ordered stat X-ray after assessed on 5/10/24 and verified was unable to located order. DON B reported verified mobile X-ray order was called in on 5/10/24 at 11:40a.m., mobile X-ray arrived at 3:06 p.m. and notified facility at 3:52 p.m. of R103 right hip dislocation. DON B reported STAT X-rays are obtained within 4 hours and reported R103 should have had an order for STAT X-ray in the EMR.</p> <p>During an interview on 6/28/24 at 5:26 p.m., NHA A reported was first aware of R103 allegation of abuse on 5/10/24 at 4:45 p.m. wh [TRUNCATED]</p>		