STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235256	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dimondale Nursing Care Center	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review, the facility failed to assess, monitor, document, and provide appropriate and timely treatment per professional standards of practice for one (#9) of one Residents reviewed for management of known Congestive Heart Failure (CHF-inability of the heart to pump blood efficiently, causing shortness of breath, fatigue, leg and foot swelling, and weakness), resulting in a 44 pound weight gain, shortness of breath, acute respiratory failure with hypoxia, acute pulmonary edema and acute re-hospitalization for acute exacerbation of CHF. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R9 was a [AGE] year old female admitted to the facility on [DATE] with re-admission post hospital stay 1/24/25 related to exacerbation of Congestive Heart Failure(CHF), with diagnoses that included hypertension (HTN, high blood pressure), chronic CHF, chronic kidney disease, diabetes mellitus and depression. The MDS reflected R9 had a Brief Interview of Mental Status (BIMS assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for toileting, bathing, dressing, hygiene, bed mobility, and transfers. The MDS reflected no behaviors including refusal of care. During an observation and interview on 2/12/25 at 1:10 p.m., R9 door laying in bed with very strong odor of urine in room with (a brand name external urinary catheter system) in place on floor at the bedside. R9 was observed with noted edema in bilateral hands and legs. R9 reported they were admitted to facility at the end of November 2024 after hospital admission and readmitted to the hospital in January 2025 related to increased swelling. R9 reported does not refuse care or weights. Review of R9 Electronic Medical Record, dated 11/26/24 through 2/12/25, reflected R9 admission weight on 11/27/24 was 356 pounds(lbs). Continued review of R9's weight summary reflected R9 weight was consistently measured by mechanical lift and reflected the following weights: 12/9/24 = 362.2 lbs.(6.2 lbs gain in 12 days) 12/27/24 = 389.5 lbs.(33.5 lbs gain in 30 days)(no documented weight between 12/9/24 and 12/27/24). 1/3/25 = 386.3 lbs. 1/8/25 = 396.1 lbs.(40.1 lbs gain in 42 days) (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 0684 Level of Harm - Actual harm Residents Affected - Few	1/14/25 = 400.4 lbs(44.4 lbs gain in 48 days) 1/25/25 = 329 lbs(re-admission post hospital stay related to exacerbation of CHF) 1/28/25 = 357.7 lbs 2/2/25 = 364.1(35 lbs gain in 8 days) Review of R9 Hospital Discharge Summary, date printed 11/26/24, reflected, R9 had a hospital admitted [DATE] for Hyperkalemia (elevated potassium) and Acute Kidney Injury (AKI). The Discharge Summary reflected, AKI/hyperkalemia, baseline creatinine 1. On presentation 3.43. -Likely etiology prerenal with component of ATN[acute tubular necrosis]. Nephrology was consulted. -Lisinopril 10mg daily discontinued, Lasix 20 mg p.o.[by mouth] daily discontinued Resume Lasix after BMP check in 1 week. -Amlodipine can be added for blood pressure control if needed outpatient .NP[Nurse Practitioner] Follow up in 1 week[contact details included] . Review of R9 Hospital After Visit Summary, dated 1/26/24, reflected the following: If admitted for Heart Condition: I understand .Weighing myself daily and reporting a gain of 2-3 pounds a day/or 5-6 pounds a week to my physician is important . Review of R9 Nurse Progress, dated 11/26/2024 at 9:48 p.m., reflected, Resident arrived at the facility about 1706[5:06 p.m.] on a stretcher and staff assisted the paramedics with transfer to bed. Resident has history of HTN, diabetes type 2, acute kidney failure, CHF, Morbid Obesity, Vitamin D and B12 deficiency. Resident alert and oriented. Review of R9 Social Service Note, dated 11/27/2024 at 3:47 p.m., reflected, Patient is a [AGE] year old female, who admitted to (facility) with an admitting dx of ACUTE KIDNEY FAILURE, UNSPECIFIED and she plans to return to her group home upon discharge. Patient made eye contact with writer and had answered all questions appropriately. Patient had scored 15/15 on the BIMS assessment, indicating her cognition remains intact. Patient is their own responsible party and is able to make decisions in their own day to day care. Review of R9 Physician Note, dated 12/10/2024 at 4:43 p.m., reflected, She was seen today for a follow up visit on nursing request for a lump in her right breast and edema of hands .No SOB [short of breath], cough, dyspnea, chest pain or other associated symptoms reported. She has been keeping her hands on pillow to raise it, which has been helping the swelling a lot. She still has the catheter to prevent her sacral area and continues to be NWB[non-weight bearing]. EXAMINATION She was comfortable in her bed, resting BP[blood pressure]:: 130/81 12/10/2024 Temp: 97.3 Pulse: 69 bpm[beats per minute] Weight: 362.9 Lbs [6.9 lbs gain since admission] (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resp: 18 Breaths/minute BS[blood sugar]: 132 O2[oxygen]: 95 % . Hand edema is dependent. ACE wrap if needed, keep moving hands and keep it elevated. Check albumin with CMP[comprehensive metabolic panel] . Review of R9 Nursing Progress Notes, dated 12/30/2024 at 5:23 a.m., Resident had her call light and responded she complained of SOB asking Staff for an inhaler and she does have any order. She was reassessed after giving her 02 on 2L[liter]. V/S[vital signs] were WNL[within normal limits] BS was 95 she was given milk to help sustain BS before breakfast. Resident stated that she can breath better with the O2. The on call Dr[doctor] was tiger text and phone call was tried with no answer up this morning. But resident is filling better. Review of the Nursing Progress Notes, dated 1/5/2025 at 3:46 p.m., reflected, Resident now noted to have coarse rhonchi throughout lungs and persistent non productive cough. Current VS BP 94/65, T-98.0, Pulse-74, Resp-18 and Oxygen at 95% with 2L of oxygen in place via NC[nasal cannual]. I have administered her PRN albuterol inhaler x 2 so far today with little effect. Denies chest pain or discomfort, respirations are even and unlabored. On call provider notified of clinical condition. Awaiting direction. (No mention of R9's 30 pound weight gain in past 39 days). Review of R9 Nursing Progress Note, dated 1/5/2025 at 7:07 p.m., reflected, New orders from provider for Duo nebs via nebulizer every 6 hours x 5 days. LN[licensed nurse] notified [named family] of clinical condition. Orders entered and oncoming nurse to be notified. (No mention of R9's 30 pound weight gain in past 39 days). Review of R9's Weight Change Note, dated 1/8/2025 at 2:19 p.m., reflected, DATA: WEIGHT WARNING: Value: 396.1 Vital Date: 2025-01-08 10:14:00.0 MDS: +5.0% change over 30 day(s) [9.1% , 33.0] +3.0% change over 30 day(s) [9.1% , 33.2] +5.0% change [9.1% , 33.2] +7.5% change [11.3% , 40.1] +10.0% change [11.3% , 40.1] NOTES: Nutrition follow up: Current weight 1/8 396.1#[pounds], 1/3 386.3#, 12/27 389.5# up from 12/9 362. 9#. Resident is not receiving any diuretics. She was eating very well then had SOB and was positive for covid with a cough and had a decline in oral intakes and has since recovered some and eating better. She is being treated for unstageable wound to left heel which is improving and typically she accepts liquacel well for additional protein. Will review resident in complex for weight gain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R9 Weight Change Note, dated 1/15/2025 3:00 p.m., reflected, DATA: WEIGHT WARNING: Value: 400.4 Vital Date: 2025-01-14 14:23:00.0 MDS: +5.0% change over 30 day(s) [10.2% , 37.0] +3.0% change over 30 day(s) [10.3% , 37.5] +5.0% change [10.3% , 37.5] +7.5% change [12.5% , 44.4] +10.0% change [12.5% , 44.4] NOTES: Nutrition follow up: Current weight is 400.4# 1/14, 391.3# 1/13, 1/8 396.1#, 1/3 389.5#. Weights are up from 362.9# 12/9. Resident has been eating excellent at meals. Wound to her heel is healed. Will recommend to d/c liquacel supplement. MD[medical director] wanted to watch the weights when discussed at complex. (R9 had documented 44.4 pound weight gain(12.5%) in past 48 days since admission with orders for continue to monitor). Review of R9 Nursing Progress Note, dated 1/15/2025 7:27 p.m., reflected, Resident voiced c/o[complaint of] weight gain and feeling SOB O2 at 95% and v/s wnl. Edema is noted. MD made and awaiting response. Note completed by Licensed Practical Nurse (LPN) S. Review of the facility Change of Condition assessment, dated 1/15/25, reflected R9 had increased or worsening edema and shortness of breath. The assessment indicated R9 had CHF and diabetes as pertinent diagnoses and was marked for, Recently progressive or persistent minor SOB without other symptoms, OR with progressive leg edema. and, Persistent unilateral or bilateral edema. The assessment included notes that reflected, Resident voiced c/o weight gain and feeling SOB O2 at 95% and v/s wnl. Edema is noted. Review of R9 Nurse Progress Note, dated 1/16/2025 at 7:07 p.m., reflected, Resident voiced concerns r/t[related to] ring being stuck on left index finger. Resident would like ring removed if possible, discussed possibility of using ring cutter to remove. Will continue to monitor. The record had no mention of communication with physician related to continued edema or follow up from 1/15/25 Change in Condition with no documented response from Provider. Review of R9 Nurse Progress Note, dated 1/17/2025 at 7:02 p.m., reflected, Resident noted to have significant edema and weight gain. Resident's daughter in to visit and discussed with nurse and resident current clinical condition. Provider notified and all above in agreement to send resident to ED [emergency department] for eval/tx[evaluation/treatment] . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/12/25 at about 5:00 p.m., LPN S reported did complete Nurse Progress note on 1/15/15 about R9 edema and weight gain and completed Change in Condition Assessment and sent tiger text to physician with note waiting response at end of shift. LPN S verified did not speak with physician or receive response back prior to end of shift and reported was unsure if physician responded and verified no new orders added 1/15/25. LPN S reported facility new admission weight policy was usually to obtain weight on admission then weekly times four weeks and follow physician orders. LPN S reported would be the same for residents with CHF. LPN S reported had been off for past five days and was currently R9's nurse. LPN S verified R9 had documented refusal of physician ordered weight on 2/11/25 and verified was not aware. LPN S verified R9 primary diagnosis was CHF and verified re-admission to facility 1/24/25 post hospital admission for exacerbation of CHF. LPN S reported R9 had physician orders for weekly weights with last documented weight 2/2/25(10 days prior) of 264 pounds and verified re-admission weight was 329 lbs which indicated significant weight gain. LPN S reported if resident with CHF has over five pound gain physician should notified and documented in medical record. During an interview on 2/12/25 at 5:15 p.m., Clinical Care Coordinator Registered Nurse (CCC) R reported had worked at the facility for about two months with prior work experience on acute care hospital setting. CCC R reported was facility policy to perform admission weight on all residents then weekly to monthly depending on physician orders. CCC R reported would expect nurse to notify physician of weight gain of more than five pound for resident with diagnosis of CHF. CCC R reported nursing best practice would be to monitor resident with diagnosis of CHF weight daily especially with recent re-hospitalization for exacerbation of CHF. CCC R reported was R9's Clinical Care Coordinator and reported was not aware of R9 prior weight gain and not aware of current weight gain. CCC R reported would expect nurse to follow physician orders and verified R9 had physician order for weight on 1/10/25 that was not completed and indicated refused on 1/11/25. CCC R reported would expect nurse to continue to reapproach resident, document in medical record and report to CCC. CCC R verified was not notified of R9 weight refusal. CCC R reported would expect nursing staff to continue to reach out to physician if no response and document in medical record and inform CCC and verified was not aware physician did not respond to R9 change of condition notification. CCC R verified was unable to locate physician response in R9 EMR for 1/15/25 change in condition. CCC R verified R9 admission weight was 356 lbs on 11/27/24 with physician orders for weekly weights. CCC R reported was unsure why R9's weight was not obtained weekly but should have been. CCC R verified R9 weight on 12/27/24 was 389 lbs and verified 33 lbs weight gain in one month should have been reported to physician and documented in EMR. CCC R reported was unable to locate that R9's significant weight gain had been reported to physician. During an interview on 2/12/25 at 5:27 p.m., Director of Nursing (DON) B reported would expect new admission residents to be weighted on admission then evaluated by Registered Dietician who would decide frequency. DON B reported would expect the same with resident with diagnosis of CHF unless physician ordered otherwise including if resident had recent hospital re-admission for exacerbation of CHF. DON B reported would expect nurse to notify physician of resident weight gain of over five pounds and document in medical record. DON B reported would expect nurse to follow physician orders. Review of R9 Weight Change Note, dated 1/27/2025 at 6:58 a.m., reflected, Readmit Nutrition Assessment Diagnosis: CHF, resp failure, morbid obesity, DM, UTI, depression, CKD, HTN, hypothyroidism,GERD (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Medication trt for dx :novolog,senokot, duloxetine, pantprazole,levothyroxine, Lasix (40mg BID) Ht:67 Current weight: 329 # BMI:51 Usual/Desired Wt: Weight at initial admission was 356# and this increased to 400# 1/14 .Nutrition Diagnosis/Assessment:Resident was sent to the hospital with significant edema. She was noted to have chest pain,hyperkalemia, CHF exacerbation,UTI. Cardiology seen resident and noted borderline cardiomegaly with acute pulmonary edema. She was noted to have CKD stage 3B (follow potassium and fluids). She was not previously on Lasix but was started on IV Lasix and transitioned to oral. This most likely resulted in her weight loss as edema has improved. She was also started on a CPAP and UTI was treated with antibiotics. Nutrition Interventions: 1. Diet as ordered by physician-Regular (follow for need to restrict sodium or fluids) 2. Follow weights- new diuretic in place 3. Follow for TSH improvement 4. Will honor food preference 5. Monitor weight/labs/physical parameters to evaluate that diet and intake meet actual nutrition needs and resident goals . Review of R9 Physician Note, dated 2/3/2025 at 7:05 p.m., reflected, Resident was seen today for a readmission back into the facility. She was sent to the ER [emergency room] for significant edema and weight gain. The resident was complaining of chest pain and SOB. Chest X-ray revealed cardiomegaly and right side pleural effusion. She was diagnosed with HF[heart failure] exacerbation .Resident's weight has increased significantly, Check weight in 1 week[2/10/25] . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R9 Hospital Physician Discharge Summary, dated 1/24/25, reflected, Admission Diagnosis: Hyperkalemia, Chest Pain, Acute UTI[urinary tract infection], Acute exacerbation of CHF .CHF exacerbation, AKI(acute kidney injury), Supratherapeutic INR .Discharge Diagnoses: Principal Problem: CHF exacerbation, Active Problems: Hypoxia, Current long-term us of anticoagulant medications with history of deep vein thrombosis, HFrEF (heart failure with reduced ejection fracture), Acute pulmonary edema, Acute respiratory failure with hypoxia and hypercapnia, Acute on chronic respiratory failure wit hypoxia and hypercapnia, Mood disorder due to known physiological condition .Hospital Course .Chest pain of 1 week duration, central, gripping, 7/10, worse with leaning forward .CXR[chest X-ray significant for cardiomegaly with central vascular prominence and right-sided pleural effusion. admitted for AHRF[acute hypoxemic respiratory failure] 2/2[secondary to] HFrEF exacerbation .Rapid response called on 1/18 for hypoxia and chest pain . ABG[arterial blood gas] suggestive of respiratory acidosis. Bedside echo suggesting IVC[inferior vena cava] dilation >2; noted small pericardial effusion. Patient was started on bipap[bilevel positive airway pressure] with Lasix IV 40 mg with improvement .Due to respiratory acidosis, and acute hypoxic hypercapnic respiratory failure, patient was started on nightly CPAP[continuous positive airway pressure]. Previously on CPAP, but pt was not using at facility. Case manager spoke with facility and facility stated they will re-order CPAP. Recommend to continue nightly CPAP. Cardiology recommended lasix IV[intravenous] 40 mg BID[twice] daily until patient reached dry weight. On day of discharge transitioned to PO[by mouth] lasix 40 mg BID. Continue on hydralazine 10 mg three times daily and Toprol XL 50 mg . Review of R9 Hospital After Visit Summary, dated 1/24/25, If admitted for Heart Condition: I understand . Weighing myself daily and reporting a gain of 2-3 pounds a day/or 5-6 pounds a week to my physician is important . Review of R9 Care Plan, dated 11/27/24, reflected, CHF: Assess/Document/Report to MD PRN for any s/sx dependent edema of legs/feet, perioribtal edema, SOB upon exertion, cool skin, dry cough, distended neck veins, weakness, wt. gain unrelated to intake, wheezes upon auscultation, increased heart rate, leathargy, disorientation. During a telephone interview on 2/13/25 at 9:59 a.m., R9's family member T reported R9 was her own responsible party and R9 family member T was listed as emergency contact and Care Conference person. R9's family T reported had alerted nurse staff two weeks prior to Christmas of concern with R9's increased edema with no response and was present on 1/17/25 when R9 was transferred from the facility to the hospital. R9's family T reported other family member U had reported concerns of R9 increased edema to nurse staff on 1/15/25 with no follow up response. R9's family T reported on 1/17/25 had insisted R9 be sent to the hospital. R9's family T reported staff tried to tell her that 40 lbs weight gain was related to poor food intake. R9's family reported R9 had prior history of CHF with history of exacerbation requiring hospitalization prior to admission to facility with recent hospital stay between 11/16/24 and 11/26/24 diuretics placed on hold related to kidney function. During an interview on 2/13/25 at 11:18 a.m., DON B reported reviewed R9 medical record and reported completed time line. DON B reported located email communication between Registered Dietician and physician about R9 dated 1/15/25 through 1/17/25 related to possible weight gain related to poor food choices.(40 lbs in 48 days since admission). DON B was asked if information was documented in R9 medical record and DON B responded, no, staff could do better about documentation. DON B reported was unsure if weight alerts existed and reported was unsure why staff did not receive weight alert for R9 33 pound gain from admission to 12/27/24. (continued on next page)

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