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	05/07/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on interview and record review, the facility failed to notify the physician and PACE((Program of All-Inclusive Care for the Elderly) of a change in condition for 1 resident (R104) of three residents reviewed for change of condition, resulting in R104 being hospitalized . Findings included: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R104 [AGE] year-old female admitted to the facility on [DATE] from the hospital for respite care, with diagnoses that encephalopathy, seizure disorder, chronic obstructive pulmonary disease, respiratory failure, diabetes, kidney failure, anxiety, and depression. The MDS reflected R104 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for bed mobility, transfers, dressing, bathing and toileting. Review of the complaint received by the State Agency alleged the facility failed to prevent a significant medication error for R104. During a telephone interview on 5/5/25 at 3:23 p.m. Complainant C reported R104 was admitted to the facility, from the hospital, for respite care (temporary break for primary caregivers) on 4/18/25 as ongoing patient of PACE (Program of All-Inclusive Care for the Elderly). Complainant C reported PACE authorized R104 to be admitted to participating facility from 4/18/25 through 4/24/25 post hospitalization . Complainant C reported the facility had a contract with organization to coordinate care including to provide all medications and R104 had received narcotic medications on 4/23/25 that organization had not prescribed and was unaware R104 was taking. Complainant C reported R104 was transferred to the hospital on 4/23/25 related to unresponsive, acute respiratory failure and continued to be on life support in the Intensive Care Unit. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R104 Nursing Progress Note, dated 4/23/25 at 1:42 p.m., reflected, Resident was transferred to [named] Hospital at 1:00pm Via stretcher, doctor was called after resident was unresponsive, Respirations were 6, HR[heart rate] was 30 and o2[oxygen] stat[saturation] was 57. Doctor instructed Nurse and author of this note to send resident out. Nurse called 9-11 and EMT [emergency medical technician] came. While EMT was here Wrap[Licensed Practical Nurse D] nurse disclosed to nurse and author of this note that when she was given report before this resident was transferred over to this unit that the previous nurse stated that she had to sternum rub resident in order to give her medication. Nurse and author of this note then relayed that to the EMT, Resident was administered one round of Narcan, she became responsive but was taken to [named hospital] for observation. Review of R104 Service Authorization, received by facility from PACE provider 4/18/25 according to fax transmission located on top of page, reflected R104 was authorized to receive service from 4/18/25 through 4/24/25 by the facility. Continued review of the document revealed, Consultant Please Note: referral is authorized for this Visit, Procedure, and/or Tests indicated ONLY, unless otherwise noted. Call immediately for medication orders and/or changes in patient condition . Review of R104 Nurse Progress Note, dated 4/18/25 at 4:00 p.m., reflected, [named R104] arrived via ambulance on a stretcher. She was hospitalized for a Seizure . Review of R104 Social Service Note, dated 4/21/25 at 10:27 a.m., reflected, Resident is [AGE] years old, able to make eye contact when completing assessment. Resident scored a 15/15 BIMS, resident is cognitively intact and able to make her own decisions . Review of R104 Physician Progress Note, dated 4/21/25, reflected, She was seen today for admission assessment in a room .PLAN: [AGE] year-old female with history of morbid obesity, remote, seizure, disorder, atrial fibrillation, hypothyroid, sleep apnea and chronic respiratory failure who had multiple hospitalization in the past is admitted for skilled care after having ? hypoglycemic seizure, atrial fibrillation and acute/chronic respiratory failure. - Goal of rehabilitation is to return home where, she was helped by family for IADL[instrumental activities of daily living] and used a wheel chair at home. - Goal is to improve transfer with SBA[stand by assist] and min assist to transfer and monitor for progress - Pain control, morbid obesity and Pulmonary HTN[hypertension] are limiting factors and prognosis at this time is guarded - Pain control assessed and will schedule Oxy bid, which she has been taking in past with good results - Pain goal is reviewed with her, including side effects and interactions in detail - Will reassess pain control and titrate with goal to help improve transfer and keep pain at mild to tolerable - Keep O2 24 hours and inhalers as needed and use of CPAP[continuous positive airway pressure] and BIPAP[bilevel positive airway pressure] use and compliance discussed with her (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Keep anticoagulation and monitor heart rate and BP[blood pressure] - History of seizure with CT head not significant for any finding. Rule out hypoglycemia as likely trigger - Check blood sugar BID[two times daily] and sliding scale. Check A1c and follow up - Keep Keppra dose unchanged and reassess - kidney function monitoring and recheck BMP - Stop Statin for few weeks to avoid muscle side effects at this time - RD[registered dietician] consult for nutrition and caloric needs - Monitor bladder and bowel function - Keep Foley for now and reassess bladder function - Keep antidepressant and monitor sleep, mood and behaviors - Check TSH - Skin care as outlined in the care plan - Hospital records reviewed and medications reconciled - Care plan discussed with her and care team. Will follow up in few days to assess the progress. Review of R104 vitals signs, dated 4/21/25 through 4/23/25, reflected vitals that included: 4/21/25 at 7:44 p. m. -Pulse - 41 beats/minute (no evidence reported to physician). Blood pressure - 99/68 (no evidence reported to physician). Review of R104 Care Plan, dated 4/19/25, reflected, Observe for s/sx of respiratory distress and report to MD PRN: Abnormal respiratory rate, pulse ox, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, skin color . Review of R104 Change of Condition document, dated 4/23/25 and completed 4/24/25, reflected R104 had sudden change in responsiveness and physician notified at 12:00 on 4/23/25. The document included vitals from 8:54 a.m. as most recent. Review of R104 transfer form, dated 4/23/25, reflected R104 had unplanned transfer to the hospital related to unresponsive with vitals that included blood pressure of 89/56, heart rate 30 beats per minute, respirations of 6 per minute, and oxygen level of 57%. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R104 hospital documents, dated 4/23/25 through 5/5/25, reflected R104 continued to be on ventilator in the ICU. The documents included. This is a 67 y.o.[year old] female with PMHx[past medical history] of COPD, chronic hypercapnic respiratory failure on 4L O2[4 liters oxygen] at baseline, congestive heart failure, DM2[diabetes], Afib (Xarelto), HTN[hypertension], hypothyroidism, GERD[reflux], possible seizures (Keppra), anxiety, depression, OSA[osteoarthritis], opioid dependence (low back pain) who was admitted to [named hospital] on 4/23/2025 1339 due to decreased level of consciousness. As she was on Oxycontin, she was given Narcan in ED[emergency department], initially followed commands and answered questions appropriately but was on BiPAP, became more somnolent and required intubation. She was started on Bumex for acute on chronic HF[heart failure], treated with antibiotics for possible pneumonia. She required pressors. She was treated for shock, severe cardiomyopathy, AKI, EF is 20-25%. EEG showed moderate nonspecific encephalopathy. She required CRRT[continuous renal replacement therapy] starting 4/25. She was extubated on 4/29 to BiPAP. On 5/1 she was off CRRT and off pressors and transferred to floor. GI was consulted as she had marked transaminitis with cholestatic component, thrombocytopenia and echogenic liver. They recommended RUQ[right upper quad] ultrasound, liver panel in outpatient setting, trend labs and supportive care. They felt it was NAFLD/NASH with superimposed injury, drug induced liver injury or ischemic hepatitis. Cardiology recommended IV heparin for Afib. She was treated with metoprolol for idiopathic cardiomyopathy. They recommended to do a repeat ECHO in a week. Bumex was recommended for HFrEF[heart condition]. She uses a NG[nasal gastric] for feedings as she was NPO[nothing by mouth] status per SLP[thera[y]. On 5/3 she was transferred back to ICU for persistent and worsening hypoxemia, hypotension. She will not tolerate conventional HD[dialyisis] nor can tolerate any meaningful UF and she was started again on CRRT (5/3 nephrology note). She was re-intubated and palliative care was consulted . During a telephone interview on 5/6/25 at 10:50 a.m. Licensed Practical Nurse (LPN) D reported worked on 4/23/25 and assisted with R104 after transfer from 1 South unit to 1 North unit around 11:30 a.m. prior to lunch time. LPN D reported LPN E was R104's nurse on 4/23/25 prior to transfer to 1 north from 1 south. LPN D reported was assisting 1 North nurse and took report from LPN E who told her R104 needed sternal rub prior to giving morning medications on 4/23/25. LPN D reported had cared for R104 prior to 4/23/25 and reported significant change in resident baseline including unresponsive and change in level of consciousness when first observed when R104 arrived on 1 North. LPN D reported as soon an R104 was transferred from 1 South unit to 1 north unit informed 1 North nurse they may need to send R104 to hospital related to change in condition including abnormal vital signs. LPN D reported assisted with R104 transfer to the hospital and Emergency Medical Team administered Narcan (medication that reverses effects of narcotics) and R104 became responsive and returned to the resident she recalled from baseline. LPN D reported did not recall R104 having order for Oxycodone 20mg when she had cared for R104 days prior and was surprised and stated, seemed like large dose. LPN D reported nurses are expected to monitor residents with new Narcotic orders for pain level, sleepiness, change in function, change in level of consciousness and should be reported to Physician related to change in condition immediately and documented. LPN D stated, When you have to sternal rub someone, something in wrong. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/6/25 at 11:34 a.m., LPN E reported was R104 on 4/23/25 day shift starting around 7:00 a.m. LPN E reported night shift did not report anything unusual for R104 and was told took medications whole in pudding, used oxygen and BIPAP with diagnosis of chronic obstructive pulmonary disease. LPN E reported first observed R104 around 7:30 a.m. and appeared to be resting comfortably and continued to pass medication on hall and reported usually passed medications to new residents like R104 at end of medication pass. LPN E reported got to R104 for morning medications late that day between 10:30 a. m. and 11:00 a.m. and reported R104 appeared groggy, tapped on chest and would open eyes, smile then fall back to sleep. LPN E told R104, Lets get medications down, we need to move you, and R104 swallowed medications in pudding. LPN E reported administered several medications including Metoprolol Tartrate (beta-blocker blood pressure medication), and Oxycodone 20 mg. LPN E reported did not check R104 blood pressure prior to administering medications and should have. LPN E reported Certified Nurse Aid had checked vitals at start of shift around 8:00 a.m. on 4/23/25 and reported R104 systolic blood pressure was under 90 and should not have administered Metoprolol and verified did not verify R104 blood pressure prior to administering medications. LPN E reported transferred R104 from 1 South unit to 1 North unit prior to lunch on 4/23/25 and told nurse during report had to really work to get R104 to take medication related to being lethargic an should be reported to physician. LPN E reported was approached by Director of Nursing (DON) B couple hours after and asked if LPN E had administered Metoprolol with low blood pressure and verified. LPN E reported received education related to verifying blood pressure prior to administering blood pressure medications and to hold if less than 100 systolic blood pressure (top number). LPN E reported all nurses received same education after R104 incident. LPN E reported should not have administered R104 medication and stated, they wanted her[R104] moved, and she was in a hurry. LPN E reported not aware of specific required documentation to monitor side effects of narcotics and reported was nursing judgement to report change in condition including increased lethargy. LPN E verified she did not notify physician related to R104 condition. During a telephone interview on 5/6/25 at 1:59 p.m., Registered Nurse (RN) G reported cared for R104 on 4/22/25 day shift and reported R104 was alert and slightly confused that with no change in baseline. RN G reported if resident had change in consciousness including lethargy nurse expected to obtain vitals, report to physician, follow orders and hold medication until verified with physician. During a telephone interview on 5/6/25 at 2:15 p.m. Certified Nurse Aid (CNA) H reported worked on 1 South unit the evening of 4/22/25 into 4/23/25. CNA H reported R104 oxygen level was below 60% when found without BIPAP in place sleeping and was reported to nurse. CNA H reported assisted another CNA I around 5:00 a.m. with R104 who was not acting like herself. CNA H reported R104 was not talking, appeared to have jerking movements that was not normal for R104 after oxygen levels had been reported to nurse earlier in shift. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/6/25 at 2:44 p.m. Licensed Practical Nurse (LPN) F reported was working 4/23/25 day shift on 1 North when R104 was transferred from 1 South and was on lunch. LPN F reported another nurse LPN D was also on the unit and received report from LPN E. LPN F reported returned from lunch about 12:25 p.m. was introduced to R104, who was slouched over in broda chair with BIPAP on, with no response from R104. LPN F reported was unsure what R104 baseline was but reported oxygen saturation was 57% and should be greater than 90% and heart rate was low. LPN F verified R104 was a full code and requested assistance to transfer to bed and R104 vitals improved, and LPN F remained at bedside to monitor. LPN F reported R104 never woke up, opened eyes or responded to staff during transfer from chair to bed. LPN F reported R104 heartrate went down to 30 beats per minute with respirations 6 to 8 per minute and low oxygen and physician was notified and orders given to transfer to hospital. LPN F verified was told that morning nurse had reported R104 was administered morning medications after sternal rub require to wake R104. LPN F reported R104's documented blood pressure was 89/56 on 4/23/25 morning prior to receiving blood pressure medication and oxycodone at 11:00 a.m. LPN F reported EMS staff administered Narcan to R104 and R104 immediately woke up and was responsive and verified had been non-responsive entire time on 1 North unit. LPN F reported facility provided education to nurse staff related to monitoring blood pressure prior to administering blood pressure medications or narcotics after R104 incident. During a telephone interview on 5/6/25 at 3:30 p.m., CNA J reported worked on 4/23/25 starting at 7:00 a.m. on 1 South. CNA J reported had cared for R104 prior to 4/23/25 and reported significant change in R104 baseline noticed at 7:00 a.m. CNA J reported R104 did not look right and was having trouble breathing. CNA J R104 BIPAP machine was alarming when she had arrived to shift and night shift nurse RN K entered R104 room and adjusted machine and alarm stopped. CNA J informed LPN E about R104 including concerns with breathing, less responsive and overall did not look good. CNA J reported by the time they transferred R104 to 1 North R104 CNA J was really concerned and reported to LPN D. CNA J reported R104 BIPAP was making noise again during transfer around 12:00 p.m. During a telephone interview on 5/6/25 at 3:59 p.m., CNA I reported was familiar with R104 and had cared for R104 on 4/22/25 night shift into 4/23/25. CNA I reported had reposition R104 in bed at start of shift between about 11:00 p.m. and 12:00 a.m. and R104 was talking and making jokes. CNA I reported during next rounds observed R104 who appeared less responsive, weak, and out of it that was a change for R104. CNA I reported informed RN K something was wrong with R104 and RN K asked if CNA I had obtained vitals. CNA I then obtained R104 vitals, including low oxygen, and reported back to RN K. CNA I reported RN K did not go to R104 until CNA I returned with vitals to observe R104. CNA I stated, nothing going on unless vitals say according to that nurse. CNA I reported R104 was completely different on second and third rounds during that night and stated, she was not ok. CNA I reported did not feel like nurse responded to reported changes for R104, however, advised to report concerns to immediate supervisor, who was 1 South nurse and that was done. CNA I reported had cared for R104 the evening prior and had similar incident with low oxygen levels and reported to nurse who immediately assessed R104 and adjusted BIPAP and encouraged R104 with breathing and improved. CNA I reported R104 never improved from second and third rounds on 4/22/25 night shift. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/6/25 at 4:44 p.m., CNA L reported cared for R104 on 4/23/25 morning shift starting about 7:00 a.m. CNA L reported did not receive report from night shift and entered R104 room to obtained vitals around 7:00 a.m. and R104 appeared to be in really bad shape with oxygen saturation of 54% and encouraged R104 to take deep breaths for about seven minutes and came up to 90% on BIPAP machine. CNA L reported R104 blood pressure was low as well. CNA L reported R104 was lethargic, eyes would open and close, skin had poor color and was twitching and struggled with breathing. CNA L reported both RN K and LPN E entered R104 room and RN K reported R104 needed sternal on and off during shift to awaken. CNA L reported asked RN K, how could you not notice her[R104] in this shape? CNA L reported assisted R104 to transfer from 1 South to 1 North between 10:30 a.m. and 11:00 a.m. on 4/23/25 and refused to transfer R104 in wheel chair and requested broda chair because was not safe related to R104 was non-responsive at the time. CNA L reported Physician entered R104 room at time of transfer to 1 North and advised staff to transfer R104 to hospital and appeared was not aware of R104's change in condition until that moment. CNA L reported would report to Unit Manager if nurse did not respond to staff reports of resident change in condition. During a second interview on 5/7/25 at 8:27 a.m., LPN E reported no knowledge of low oxygen reading for R104 on 4/23/25 at start of shift with exception of providing CNA staff personal oximeter to use and re-check post bad reading. During an interview on 5/7/25 at 8:34 a.m., Director of Nursing (DON) B reported R104 was admitted [DATE] for PACE respite care. DON B reported recent collaboration team meeting with PACE within past two weeks and learned that residents admitted with PACE services require all changes in care including medications or change of conditions should be communicated with PACE. DON B verified was not aware prior to meeting that facility had to communicate and changes and was unsure if facility had contract with PACE. DON B reported R104 change of conditions was not communicated to PACE and they were not informed of medication changes made on 4/21/25 when Oxycodone was added and should have been. DON B reported PACE basically manages whole person and everything goes through them. DON B reported would expect CNA staff to report anything abnormal to nurse, nurse to assess, complete Change of Condition(COC) documentation if needed or at least Nurse Progress Note. DON B reported would expect abnormal vitals to be documented as well as normal after adjustments/assessments and COC would include physician notification. DON B reported would expect nurse staff to use nurse judgement or follow blood pressure parameters prior to medication administration including use of [NAME] blockers. DON B reported would have expected nurse to hold R104 Metoprolol dose on 4/23/25 morning with blood pressure of 89/56 and notify physician. DON B reported the facility completed a Past Non-Compliance for R104 incident and all nurse staff were educated related to blood pressure parameters and facility was in compliance by 4/26/25. During a telephone interview on 5/7/25 at 9:34 a.m., Medical Director (MD) M reported would expect to be notified by facility staff of change in resident condition including systolic blood pressure less than 100, and definitely oxygen less than 70%, and increase lethargy. MD M reported did not receive call from facility for R104 for change of condition prior to order to transfer to hospital. MD M reported blood pressure perimeters are nursing judgement but wound expect to be notified if systolic blood pressure less than 100 prior to administration of blood pressure medications or Oxycodone (Narcotic). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 5/7/25 at 10:01 a.m., RN K reported had worked at facility for about two years and typically work on south hall. RN K reported cared for R104 7p to 7a night shift 4/22/25 into 3/23/25. RN K reported R104 had COPD and used BIPAP while sleeping. RN K reported R104 was awake and alert at start of shift and around 5am CNA I did rounds and reported something was wrong with R104 and asked if nurse could come check. RN K asked CNA K, what is problem? RN K reported had asked if CNA I had obtained full vitals and instructed to do so. RN K reported CNA staff should have knowledge to obtain vitals before telling informing nurse something is wrong. RN K reported CNA I returned to nurse with vitals including low oxygen level and stated, this was a teaching moment for CNA I. RN K reported entered R104 with CNA I around 5:00 a.m. and R104 was sleeping and woke her up by shaking and opened eyes for moment and closed and reported taught CNA I to assess capillary refill prior to monitoring oxygen level. RN K reported would expect CNA staff to first obtain accurate data prior to asking nurse to assess residents. RN K was asked where to locate vitals, and RN K reported should be documented in Electronic Medical Record(EMR) and verified was unable to locate full set of vitals for R104 including no blood pressure or heart rate for 12 hour shift and stated did not document them. RN K reported was unsure why R104 vitals were not documented and reported maybe CNA staff add vitals. This surveyor asked RN K why R104 6:00 a.m. medications were not given and marked with, SL. RN K verified Medication Administration Record(MAR) reflected R104 Levothyroxine Sodium(thyroid medication) was marked as SL(sleeping according to codes on MAR) because resident was sleeping and medications not given. This surveyor asked RN K if nurse notified physician thyroid medication was not administered and RN K reported was unsure and reported Physician was not notified of missed dose. RN K reported did not notice change in R104 baseline mostly because was not familiar with R104. RN K reported was unable to recall if he had reported to oncoming staff on 4/23/25 that sternal rub was required to wake R104. RN K reported staff were educated recently related to blood pressure parameters and was unable to report when to report to physician. After review of provided staff education reported recalled did get education that included to notify physician if systolic blood pressure under 100. During a second interview on 5/7/25 at 12:15 a.m., LPN D verified facility management provided education for blood pressure parameters within past 2 week and verified did not receive education related to narcotic side effect monitoring. LPN D reported nursing judgement to monitor for sleepiness, lethargic, and change of condition, follow policy and procedures. LPN D reported would wake resident for 6:00 a.m. thyroid medication and would not document on MAR as sleeping. LPN D reported if thyroid medication not given would notify physician dose not given. LPN D reported would not administer narcotic to resident if sleeping or lethargic. During a interview and record review on 5/7/25 at 12:26 p.m., Unit Manager (UM) N reported did not observe R104 on 4/23/25 but was notified by telephone that R104 was nonresponsive that was not R104 baseline. UM N reported was familiar with R104 when resident was on 1 west for short while but moved related to roommate issues and reported was very talkative and alert. UM N reported would expect nurse staff to check blood pressure prior to administration of beta blocker because if too low can bottom out resident and they will end up in ICU on ventilator. UM N reported facility staff not required to document monitoring for narcotic use side effects and reported was nursing judgement. UM N reported would not expect nursing staff to administer beta blocker and/or narcotic with low blood pressure or sleep/lethargic. UM N reported completed R104 Change of Condition document on 4/24/25 by review of records because identified staff had not completed and should have. UM N reported would not expect nurse to document sleeping as reason for missed dose thyroid medication and would expect physician to notified of missed dose. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During second interview on 5/7/25 at 1:35 p.m., DON B verified Plan of Correction was 4/26/25 and focused on staff failed to monitor blood pressure prior to administration of blood pressure medication and verified no education was provided for monitoring of side effects of narcotics. DON B reported R104's blood pressure medication and narcotic should have been held and physician notified as well as staff should have completed Change of Condition documentation prior to administering R104 morning medications.

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	05/07/2025

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.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on interview and record review the facility failed prevent a significant medication error as evidenced by administration of Metoprolol (beta-blocker blood pressure medications) without monitoring blood pressure prior to administration for resident (R104), resulting in hospitalization . Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R104 [AGE] year-old female admitted to the facility on [DATE] from the hospital for respite care, with diagnoses that encephalopathy, seizure disorder, chronic obstructive pulmonary disease, respiratory failure, diabetes, kidney failure, anxiety, and depression. The MDS reflected R104 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for bed mobility, transfers, dressing, bathing and toileting. Review of the complaint received by the State Agency alleged the facility failed to prevent a significant medication error for R104. During a telephone interview on 5/5/25 at 3:23 p.m. Complainant C reported R104 was admitted to the facility, from the hospital, for respite care (temporary break for primary caregivers) on 4/18/25 as ongoing patient of PACE (Program of All-Inclusive Care for the Elderly). Complainant C reported PACE authorized R104 to be admitted to participating facility from 4/18/25 through 4/24/25 post hospitalization . Complainant C reported the facility had a contract with organization to coordinate care including to provide all medications and R104 had received narcotic medications on 4/23/25 that organization had not prescribed and was unaware R104 was taking. Complainant C reported R104 was transferred to the hospital on 4/23/25 related to unresponsive, acute respiratory failure and continued to be on life support in the Intensive Care Unit. Review of R104 Nursing Progress Note, dated 4/23/25 at 1:42 p.m., reflected, Resident was transferred to [named] Hospital at 1:00pm Via stretcher, doctor was called after resident was unresponsive, Respirations were 6, HR[heart rate] was 30 and o2[oxygen] stat[saturation] was 57. Doctor instructed Nurse and author of this note to send resident out. Nurse called 9-11 and EMT[emergency medical technician] came. While EMT was here Wrap nurse disclosed to nurse and author of this note that when she was given report before this resident was transferred over to this unit that the previous nurse stated that she had to sternum rub resident in order to give her medication. Nurse and author of this note then relayed that to the EMT, Resident was administered one round of Narcan, she became responsive but was taken to [named hospital] for observation. Review of R104 transfer form, dated 4/23/25, reflected R104 had unplanned transfer to the hospital related to unresponsive with vitals that included blood pressure of 89/56, heart rate 30 beats per minute, respirations of 6 per minute, and oxygen level of 57%. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/6/25 at 11:34 a.m., LPN E reported was R104 on 4/23/25 day shift starting around 7:00 a.m. LPN E reported night shift did not report anything unusual for R104 and was told took medications whole in pudding, used oxygen and BIPAP with diagnosis of chronic obstructive pulmonary disease. LPN E reported first observed R104 around 7:30 a.m. and appeared to be resting comfortably and continued to pass medication on hall and reported usually passed medications to new residents like R104 at end of medication pass. LPN E reported got to R104 for morning medications late that day between 10:30 a. m. and 11:00 a.m. and reported R104 appeared groggy, tapped on chest and would open eyes, smile then fall back to sleep. LPN E told R104, Lets get medications down, we need to move you, and R104 swallowed medications in pudding. LPN E reported administered several medications including Metoprolol Tartrate (beta-blocker blood pressure medication), and Oxycodone 20 mg. LPN E reported did not check R104 blood pressure prior to administering medications and should have. LPN E reported Certified Nurse Aid had checked vitals at start of shift around 8:00 a.m. on 4/23/25 and reported R104 systolic blood pressure was under 90 and should not have administered Metoprolol and verified did not verify R104 blood pressure prior to administering medications. LPN E reported transferred R104 from 1 South unit to 1 North unit prior to lunch on 4/23/25 and told nurse during report had to really work to get R104 to take medication related to being lethargic an should be reported to physician. LPN E reported was approached by Director of Nursing (DON) B couple hours after and asked if LPN E had administered Metoprolol with low blood pressure and verified. LPN E reported received education related to verifying blood pressure prior to administering blood pressure medications and to hold if less than 100 systolic blood pressure (top number). LPN E reported all nurses received same education after R104 incident. LPN E reported should not have administered R104 medication and stated, they wanted her[R104] moved, and she was in a hurry. LPN E reported not aware of specific required documentation to monitor side effects of narcotics and reported was nursing judgement to report change in condition including increased lethargy. LPN E verified she did not notify physician related to R104 condition. During a telephone interview on 5/6/25 at 2:44 p.m. Licensed Practical Nurse (LPN) F reported was working 4/23/25 day shift on 1 North when R104 was transferred from 1 South and was on lunch. LPN F reported another nurse LPN D was also on the unit and received report from LPN E. LPN F reported returned from lunch about 12:25 p.m. was introduced to R104, who was slouched over in broda chair with BIPAP on, with no response from R104. LPN F reported was unsure what R104 baseline was but reported oxygen saturation was 57% and should be greater than 90% and heart rate was low. LPN F verified R104 was a full code and requested assistance to transfer to bed and R104 vitals improved, and LPN F remained at bedside to monitor. LPN F reported R104 never woke up, opened eyes or responded to staff during transfer from chair to bed. LPN F reported R104 heartrate went down to 30 beats per minute with respirations 6 to 8 per minute and low oxygen and physician was notified and orders given to transfer to hospital. LPN F verified was told that morning nurse had reported R104 was administered morning medications after sternal rub require to wake R104. LPN F reported R104's documented blood pressure was 89/56 on 4/23/25 morning prior to receiving blood pressure medication and oxycodone at 11:00 a.m. LPN F reported EMS staff administered Narcan to R104 and R104 immediately woke up and was responsive and verified had been non-responsive entire time on 1 North unit. LPN F reported facility provided education to nurse staff related to monitoring blood pressure prior to administering blood pressure medications or narcotics after R104 incident. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/6/25 at 4:44 p.m., CNA L reported cared for R104 on 4/23/25 morning shift starting about 7:00 a.m. CNA L reported did not receive report from night shift and entered R104 room to obtained vitals around 7:00 a.m. and R104 appeared to be in really bad shape with oxygen saturation of 54% and encouraged R104 to take deep breaths for about seven minutes and came up to 90% on BIPAP machine. CNA L reported R104 blood pressure was low as well. CNA L reported R104 was lethargic, eyes would open and close, skin had poor color and was twitching and struggled with breathing. CNA L reported both RN K and LPN E entered R104 room and RN K reported R104 needed sternal on and off during shift to awaken. CNA L reported asked RN K, how could you not notice her[R104] in this shape? CNA L reported assisted R104 to transfer from 1 South to 1 North between 10:30 a.m. and 11:00 a.m. on 4/23/25 and refused to transfer R104 in wheelchair and requested broda chair because was not safe related to R104 was non-responsive at the time. CNA L reported Physician entered R104 room at time of transfer to 1 North and advised staff to transfer R104 to hospital and appeared was not aware of R104's change in condition until that moment. CNA L reported would report to Unit Manager if nurse did not respond to staff reports of resident change in condition. During an interview on 5/7/25 at 8:34 a.m., Director of Nursing (DON) B reported R104 was admitted [DATE] for PACE respite care. DON B reported recent collaboration team meeting with PACE within past two weeks and learned that residents admitted with PACE services require all changes in care including medications or change of conditions should be communicated with PACE. DON B verified was not aware prior to meeting that facility had to communicate and changes and was unsure if facility had contract with PACE. DON B reported R104 change of conditions was not communicated to PACE and they were not informed of medication changes made on 4/21/25 when Oxycodone was added and should have been. DON B reported PACE basically manages whole person and everything goes through them. DON B reported would expect CNA staff to report anything abnormal to nurse, nurse to assess, complete Change of Condition (COC) documentation if needed or at least Nurse Progress Note. DON B reported would expect abnormal vitals to be documented as well as normal after adjustments/assessments and COC would include physician notification. DON B reported would expect nurse staff to use nurse judgement or follow blood pressure parameters prior to medication administration including use of [NAME] blockers. DON B reported would have expected nurse to hold R104 Metoprolol dose on 4/23/25 morning with blood pressure of 89/56 and notify physician. DON B reported the facility completed a Past Non-Compliance for R104 incident and all nurse staff were educated related to blood pressure parameters and facility was in compliance by 4/26/25. During a telephone interview on 5/7/25 at 9:34 a.m., Medical Director (MD) M reported would expect to be notified by facility staff of change in resident condition including systolic blood pressure less than 100, and definitely oxygen less than 70%, and increase lethargy. MD M reported did not received call from facility for R104 for change of condition prior to order to transfer to hospital. MD M reported blood pressure perimeters are nursing judgement but wound expect to be notified if systolic blood pressure less than 100 prior to administration of blood pressure medications or Oxycodone (Narcotic). During an interview and record review on 5/7/25 at 10:01 a.m., RN K reported had worked at facility for about two years and typically work on south hall. RN K reported staff were educated recently related to blood pressure parameters and was unable to report when to report to physician. After review of provided staff education reported recalled did get education that included to notify physician if systolic blood pressure under 100. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second interview on 5/7/25 at 12:15 p.m., LPN D verified facility management provided education for blood pressure parameters within past 2 week and verified did not receive education related to narcotic side effect monitoring. LPN D reported nursing judgement to monitor for sleepiness, lethargic, and change of condition, follow policy and procedures. LPN D reported would wake resident for 6:00 a.m. thyroid medication and would not document on MAR as sleeping. LPN D reported if thyroid medication not given would notify physician dose not given. LPN D reported would not administer narcotic to resident if sleeping or lethargic. During a interview and record review on 5/7/25 at 12:26 p.m., Unit Manager (UM) N reported would expect nurse staff to check blood pressure prior to administration of beta blocker because if too low can bottom out resident and they will end up in ICU on ventilator. UM N reported facility staff not required to document monitoring for narcotic use side effects and reported was nursing judgement. UM N reported would not expect nursing staff to administer beta blocker and/or narcotic with low blood pressure or sleep/lethargic. During second interview on 5/7/25 at 1:35 p.m., DON B verified Plan of Correction was 4/26/25 and focused on staff failed to monitor blood pressure prior to administration of blood pressure medication and verified no education was provided for monitoring of side effects of narcotics. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included interventions and actions to correct monitoring of blood pressure parameters the past noncompliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.