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	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dimondale Nursing Care Center	4000 N Michigan Road Dimondale, MI 48821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure grievances were promptly documented, investigated, tracked and resolved for one resident of one resident reviewed for grievances (Resident #8). Findings include:Review of the clinical record reflected R8 was admitted to the facility for long term care with diagnoses that included diabetes and hemiplegia. Review of the Minimum Data Set (MDS) dated [DATE], R8 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). On 07/01/25 11:25 AM, during an interview with R8, he reported multiple missing clothing items that have not been replaced despite multiple complaints. R8 reported this had been an ongoing issue and since his most recent hospitalization from 5/03/25 to 5/08/25 additional items were missing. R8 reported due history of former facility administration rummaging through his personal property and discarding items at will, R8 did not trust facility staff and reached out to the local Ombudsman to get involved in effort to assist in recovering the missing items. Review of the facility grievance log from January 2025 to June 2025, revealed there were no grievance/concern forms from R8. On 07/03/25 at 10:43 AM, during a phone interview with Ombudsman HH it was reported that R8 reported that in April of 2024 while hospitalized the multiple items were missing. An interim Nursing Home Administrator (NHA) was aware and attempting to work with R8 on recovering the items, then the Interim NHA left and current NHA A took over. Ombudsman HH stated she had met with NHA A and R8 and NHA A was agreeable to replacing some items but not all since the list provided by R8 went back to April of 2024. R8 went to the hospital (May 2025) reported additional missing items and no resolutions have occurred. On 07/03/25 12:06 PM, during an interview with NHAA he reported he started at the facility in January of 2025 and was aware of R8 concerns regarding missing items and reported he had multiple conversations and a meeting with R8 and Ombudsman HH in March or April. NHA A during the meeting R8 did not want staff to look for the missing items and did not want to be reimbursed. When asked if perhaps R8's history and lack of trust may have been a reason for declining housekeeping to search his room, NHA A stated he didn't know. When queried why R8 would pursue the issue of missing items, get the Ombudsman involved then decline wanting items found or items to reimbursed, NHA A stated he could not respond to the question. Documentation related the meeting held with R8 and Ombudsman HH was requested. When queried why the missing items were not tracked in the grievance log and missing item/concern form filled out, NHA A stated because R8 didn't want to file a complaint. When queried why NHA A wouldn't want to track, monitor and resolve issue to identify patterns for the facility, NHA A did not respond. On 07/03/25 12:11 PM during a follow up interview with Ombudsman HH she reported at no time did R8 say that he didn't want to be reimbursed for the lost items, R8 did say he did not want staff to search his room and go through belongings but had no objections for staff to search laundry. By the close of the survey on 7/08/2025 there was no documentation provided by the facility that R 8 did not want resolution, that laundry had been searched, there was no documentation of the meeting that was held with NHA A, R8 and Ombudsman HH.

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure for two out of two residents (Resident #11 and #242) the right to be free from abuse, and involuntary seclusion. Findings Include: Resident #11 (R11) Per the facility face sheet R11 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS) dated [DATE], revealed R11 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R11 was cognitively intact.Record review of a concern form dated 5/17/2025, revealed R11 had documented on the concern form that she had run out of oxygen, and Certified Nurse Aid (CNA) JJ told her that she had to wait, and proceeded the leave to attend to another resident leaving R11 with no oxygen. R11 documented on the concern form that CNA JJ made her sit in urine soak brief for over six hours, until a nurse made CNA JJ change her. R11 documented that CNA JJ was being rude, R11 told CNA JJ she needed her labia washed due to the soap had not been washed out of that area yet, and it was burning. The concern form further revealed that R11 stated CNA JJ started to scream at her, and was then asked to leave her room, but CNA JJ stated that she did not have to leave and then slammed R11's room door. The concern form revealed that R11 did not want CNA JJ in her room, and this was the third time that this type of incident had happened, and she was not going to be an abused patient.In an interview on 7/07/2025 at 12:22 PM, CNA EE stated he went into R11's room to assist CNA JJ with R11's care when CNA JJ started to yell at R11, and then they both yelled back and forth. CNA EE stated that she told CNA JJ to leave R11's room, and at first CNA JJ would not want to leave, but when she finally did she slammed the room door. CNA EE said CNA JJ told R11 that she could not be this rude to be people who took care of her. CNA EE said he reported the incident to Administrator A immediately, along with R11. CNA EE said Administrator A asked him if there was any abuse involved, and then said he told Administrator A the same thing he just stated in this interview. CNA EE also said CNA JJ told R11 that she did not have to do a damn thing, and it was an argument that got out of control. CNA EE did state that CNA JJ did tell R11 that she did not have to leave the room and R11 said yes you do. CNA EE said he told CNA JJ that she did have to leave the room. In an interview on 7/07/2025 at 12:38 PM, R11 stated that CNA JJ had come into her room to help with care and just started yelling and getting angry. R11 said she asked CNA JJ to leave the room, and CNA JJ said she did not have to, then slammed her room door. In interview with R11 on 7/08/2025 at 10:45 AM, R11 stated that she did ask to be cleaned in her peri area because it burned, but the CNA JJ just began to verbalize how she can find another job, and went on and on, and then she asked her to leave, but CNA JJ she said she did not have to, and then slammed her room door. In an interview on 7/07/2025 at 1:00 PM, CNA JJ stated that she went in to provide care for R11, when R11 started to talk badly to her, and yelled at me and told me to get. CNA JJ said she the door just closes as if it slams. The concern form revealed that the facility's response was that R11 and CNA JJ were spoken to, and CNA JJ was provided with education. However, R11's right to be free from abuse was not maintained due to the fact that CNA JJ was not removed from providing care to R11 and other residents, because the facility did not perform an abuse investigation.Resident #242 (R242):Per the facility face sheet R242 was admitted to the facility on [DATE].Review of an MDS dated [DATE], revealed R242 had a BIMS score of 12 out of 15. Review of a concern form dated 1/30/2025, revealed CNA KK had an attitude every time R242 opened her mouth CNA KK would respond rudely, and when she asked a question CNA KK would come back with a sarcastic attitude/response. The concern form revealed that on 1/30/2025 CNA KK got pissed, and upon leaving R242's room, hide R242's remote (call light) turned off all lights, and shut the door on R242. The concern form further revealed that when R242 would call for CNA KK, CNA KK would get mad at her and she was tired of it.The concern form revealed that the facility's response was to provide education to CNA KK in regards to satisfactory customer service practices. CNA KK signed the concern form on 2/12/2025 that she received the education to ensure resident care spoken to with respect and professionalism, and residents will be treated with professionalism. In an interview on 07/08/2025 at 8:09 AM, via the phone R242's daughter (Dtr) RR stated that R242 was not available for interview, however stated she was very familiar with the incident. Dtr RR stated that the situation with CNA KK went on for several days, then she requested a concern form. Dtr RR said CNA KK was sarcastic, had an attitude when R242 asked for anything, would shut R242's door and hide her call light. Dtr RR said R242 would have to yell out for help because she did not have her call light. Dtr RR stated that this had happened twice, and said she was on the phone with R242 one of the times that it happened, she

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 9 out of 10 resident's (Residents #'s 11, 37, 42, 65, 94, 108, 124, 134, & 242) allegations of abuse were reported to the state agency.Findings Included:Per the facility face sheet R11 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS) dated [DATE], revealed R11 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R11 was cognitively intact. Record review of a concern form dated 5/17/2025, revealed R11 had documented on the concern form that she had run out of oxygen, and Certified Nurse Aid (CNA) JJ told her that she had to wait, and proceeded the leave to attend to another resident leaving R11 with no oxygen. R11 documented on the concern form that CNA JJ made her sit in urine soak brief for over six hours, until a nurse made CNA JJ change her. R11 documented that CNA JJ was being rude, R11 told CNA JJ she needed her labia washed due to the soap had not been washed out of that area yet, and it was burning. The concern form further revealed that R11 stated CNA JJ started to scream at her, and was then asked to leave her room, but CNA JJ stated that she did not have to leave and then slammed R11's room door. The concern form revealed that R11 did not want CNA JJ in her room, and this was the third time that this type of incident had happened, and she was not going to be an abused patient. The concern form revealed that the facility's response was that R11 and CNA JJ were spoken to, and CNA JJ was provided with education. The allegations of abuse were not identified as allegations of abuse, nor reported to the state agency upon checking the state agency reporting system. In an interview on 7/08/2025 at 1:35 PM, Administrator A stated that he went and talked to R11 to see what happened. Administrator A said R11 leaves her window open the wind pushes the door shut, CNA JJ is new, and stated that he asked CNA EE if the incident that had taken place was abuse or customer service, in which Administrator A stated that the decision was made by CNA JJ, CNA EE, and R11 that is was not abuse; just a customer service concern, despite the fact that R11 specifically stated on the concern form that she was not going to be an abused patient. Therefore, Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R11 had to be costumer service concerns and not abuse allegations. Resident #37 (R37): Per the facility face sheet R37 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R37 had a BIMS score of 15 out of 15 which indicated R37 was cognitively intact. Review of a documented concern on a concern form dated 6/1/2025, revealed that R37 did not get her meds on time, and when she asked the nurse (did not state name) when she could get her meds the nurse said to R37 I'll get to you when I get to you with an attitude. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The concern form documentation revealed that the facility’s response to R37's concern was that Administrator A spoke with both R37 and the nurse, and it was determined that R37 would go outside to smoke during medication administration times. Education was provided to nurse regarding customer service, spoke with residents about letting staff/nurse know when she is going outside so staff know where she is. The facility did not identify, nor address R37's statement that the nurse had an attitude, and told her, I'll get to you when I get to you In an interview on 7/08/2025 at 1:21 PM, Administrator A was asked about the allegation of abuse R37 documented on the concern form regarding the nurse. Administrator A stated that she spoke with R37 who said the nurse was close to her room and she asked if it was time for her medications, and the nurse said I will get to you when I get to you. Administrator A said he asked R37 how she felt about it, whether she felt it was abuse or customer service concern. Administrator A said R37 stated she felt the nurse could have said it in a different way. Administrator A also said he asked R37 to let staff know when she was leaving and coming, because she was frequently outside, and he would talk to the nurse about customer service. Administrator A stated R37 had no abuse concerns, however nowhere on Administrator A's follow-up documentation was that documented. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R11 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, not reported to the state agency upon checking the state agency reporting system. Resident #42 (R42): Per the facility face sheet R42 was admitted on [DATE]. Review of the clinical record, including the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/17/25 revealed R 42 was [AGE] years old, admitted to the facility with diagnosis that included cerebral vascular accident (stroke). R42 scored 12 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Section B of the MDS reflected R42 had clear speech and adequate hearing, was usually understood and usually understood others Review of a concern form that R42 filled out revealed Licensed Practical Nurse (LPN) E spoke to R42 in a mean way on 1/21/2025, and that R42 had to wait for her morning meds, in a very mean way, when R42 asked for her meds. The concern form revealed that R42 stated this type of behavior from LPN E happened often. R42 wrote on the concern form that she had asked for her medications before breakfast, but as of 9:45 AM, R42 still had not received her medications. R42 also documented on the concern form that LPN E treats other residents the same way. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The concern form revealed that the facility's response was that R42 was frustrated that she had to wait for her blood pressure to be taken before receiving her meds, and it was documented that R42 now changed her mind and made a statement that LPN E was not mean to her. The documented action to be taken was that the CNAs will attempt to get R42's vital signs at the start of the day shift. However, R42 requested on the concern form that LPN E be spoken to about the way she talks to residents, and needs to talk kindly, as LPN E does this often to many patients. The concern form did not document any education or speaking to LPN E about how she spoke to R42 in a very mean way. In an interview on 7/08/2025 at 1:15 PM, Administrator A stated that R42 had to be interviewed by the Speech Therapist (ST) because R42 had expressive dysphasia (cannot speak whole sentences), so someone had to assist R42 with getting her words out. Administrator A said the only thing R42 could do was nod yes and no so the ST had to guess what R42's frustration was telling her. So, ST felt R42 was trying to say LPN E was rude. Review of another concern form dated 6/18/2025, revealed R42 made a complaint that a CNA (did not name the CNA) was very rude while serving her breakfast, and CNA ignored her and had a rude tone. The facility's response was that a nurse spoke with R42 and the CNA an both stated it must have been a misunderstanding. In an interview on 7/08/2025 at 1:05 PM, Administrator A said, regarding the 6/18/2025 concern, R42 felt the CNA was ignoring her. Administrator A said he spoke with the CNA who did not understand where the resident’s frustration was coming from so it must of been a misunderstanding, Review of another concern dated 1/7/2025 revealed when R42 would lay down after lunch and then wanted to get back up at 2:00 PM for group, staff would not get her up, but would tell her to go to sleep I can't get you up and down. None of these allegations of abuse were identified as allegations of abuse, nor were they reported to the state agency. Resident #65 (R65): Per the facility face sheet R65 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R65 had a BIMS score of 10 which indicated R65 had only a moderate cognitive impairment. Review of a concern form dated 6/17/2025, revealed LPN MM got upset with R65, and refused to give R65 her pain medication, and it was not until the night shift arrived that R65 then received morphine because her pain was so bad. The concern form further stated that LPN MM was very rude. Facility resolution was educating the resident on the process of obtaining a narcotic to administer. The concern did not identify the allegation of abuse regarding LPN MM being very rude. Under FACILITY RESPONSE and ACTION TO BE TAKEN revealed no documentation of LPN MM receiving any education, or anything else regarding the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In 7/08/2025 at 12:54 PM, Administrator A said he went and talked with R65, and the process was explained to R65 for obtaining a controlled substance. Administrator A said he told R65 the definition of abuse, then asked R65 if he believed LPN MM was abusive versus a customer service concern. Administrator A said he did ask R65 what he meant by LPN MM being rude, and R65 said he meant he felt misunderstood. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R11 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, not reported to the state agency upon checking the state agency reporting system. Resident #94 (R94): Per the facility face sheet R94 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R94 had a BIMS score of 12 out of 15 which indicated a moderate cognitive impairment. Review of a concern form, date unknown, revealed an allegation that R94 was being sex trafficked. In an interview on 7/08/2025 at 1:00 PM, Administrator A stated that the police received an anonymous call that R94 was being sex trafficked. So, Administrator A said he spoke to R94 who denied it, so that was why he did not report the allegation to the state agency. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R11 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, not reported to the state agency upon checking the state agency reporting system. Resident #108 (R108): Per the facility face sheet R108 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R108 had a BIMS score of 12 out of 15. Review of a concern form dated 6/30/2025, revealed CNA OO had an unfriendly and gruff personality. The form revealed CNA OO could be rough when providing care, and the problem was ongoing. The action to be taken was to talk to CNA OO In an interview on 7/08/2025 at 12:41 PM, Administrator A stated he did not consider abuse with R108's concern. Administrator A said R108 told him that CNA OO was unfriendly and gruff. Administrator A said he asked R108 if CNA OO was acting intentionally and/or willfully, if he should provide coaching, and if it was customer service concern. Administrator A stated that he defined abuse to R108 and told him to let him talk to CNA OO, and then he would come back and ask R108 what his recommendations would be for what he should do with CNA OO. Administrator A said after he defined abuse to R108, R108 said it was a customer service concern. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R108 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, not reported to the state agency upon checking the state agency reporting system. Resident #124 (R124): Per the facility face sheet revealed R124 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R124's BIMS score was 14 out of 15. R124 was the roommate of R108. Both residents filled out a concern form on 6/30/2025 which were identical concerns. Review of a concern form dated 6/30/2025, revealed CNA OO had an unfriendly and gruff personality. The form revealed CNA OO could be rough when providing care, and the problem was ongoing. The action to be taken was to talk to CNA OO In an interview on 7/08/2025 at 12:41 PM, Administrator A stated he did not consider abuse with R124's concern. Administrator A said R124 told him that CNA OO was unfriendly and gruff. Administrator A said he asked R124 if CNA OO was acting intentionally and/or willfully, if he should provide coaching, and if it was customer service concern. Administrator A stated that he defined abuse to R124 and told him to let him talk to CNA OO, and then he would come back and ask R124 what his recommendations would be for what he should do with CNA OO. Administrator A said after he defined abuse to R124, R124 said it was a customer service concern. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R124 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, not reported to the state agency upon checking the state agency reporting system. Resident #134 (R134): Per the facility face sheet R134 was admitted the facility on 5/23/2025. Review of an MDS dated [DATE], revealed R124 had a BIMS score of 15 out of 15. Review of a concern form dated 5/30/2025, revealed Physical Therapy Assistant (PTA) QQ spoke to R134 in a way that left her feeling upset. The facility's action was that R134's physical therapy would be provided by another PTA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/08/2025 at 12:50 PM, Administrator A stated that he had no concerns with R134's concern being an allegation of abuse, because R134 said PTA QQ went into her room while she had an IV antibiotic running, and because of that R134 did not want to start therapy until the antibiotic was completed. PTA QQ stated R134 that she was not going to get any better if she did participate in therapy. Administrator A said R134 did not want PTA QQ to treat her anymore because his comments made her feel bad. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R124 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, not reported to the state agency upon checking the state agency reporting system. Resident #242 (R242): Per the facility face sheet R242 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R242 had a BIMS score of 12 out of 15. Review of a concern form dated 1/30/2025, revealed CNA KK had an attitude every time R242 opened her mouth CNA KK would respond rudely, and when she asked a question CNA KK would come back with a sarcastic attitude/response. The concern form revealed that on 1/30/2025 CNA KK got pissed, and upon leaving R242's room, hid R242's remote (call light) turned off all lights, and shut the door on R242. The concern form further revealed that when R242 would call for CNA KK, CNA KK would get mad at her and she was tired of it. The concern form revealed that the facility's response was to provide education to CNA KK in regard to satisfactory customer service practices. CNA KK signed the concern form on 2/12/2025 that she received the education to ensure resident care spoken to with respect and professionalism, and residents will be treated with professionalism. In an interview on 07/08/2025 at 8:09 AM, via phone R242's daughter (Dtr) RR stated that R242 was not available for interview, however stated she was very familiar with the incident. Dtr RR stated that the situation with CNA KK went on for several days, then she requested a concern form. Dtr RR said CNA KK was sarcastic, had an attitude when R242 asked for anything, would shut R242's door and hide her call light. Dtr RR said R242 would have to yell out for help because she did not have her call light. Dtr RR stated that this had happened twice, and said she was on the phone with R242 one of the times that it happened. She told me the CNA KK hid her remote (call light) and shut her door. Dtr RR said R242 had started screaming out, help me help me, and said they (staff) were not coming. Dtr RR said she then called the nursing desk over and over until someone answered. Dtr RR said she wrote the incident on a concern form, and gave the form to LPN SS, but did not know where the form went from there. On 7/08/2025 at 8:43 AM, an attempt was made to contact LPN SS” but was unsuccessfully. In an interview on 7/08/2025 at 8:55 AM, CNA KK stated that she did not recall R242, did not recall the incident, and did not recall receiving a one-to-one Inservice that she signed on 2/12/2025, asked if she wanted to change anything about her statement in which CNA KK stated No (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dimondale Nursing Care Center	4000 N Michigan Road Dimondale, MI 48821

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/08/2025 at 1:25 PM, Administrator A stated that he would say the allegations could be abuse, and that he would have spoken to R242 and got her statement, talked to staff, and done a thorough investigation. Administrator A said based on what is written on the concern form, those are allegations of abuse, and said yes he would do an investigation and report it to the state agency. However. Administrator A was not able to explain why the allegations were not reported to the state agency. In an interview on 7/08/2025 at 2:01 PM, LPN U, who was the Unit Manager for the one south unit, stated that the concern form was given to her by Administrator A. LPN U said she spoke with R242, and CNA KK about the incident, but stated she had no documentation of those interviews. Upon asking LPN U stated that she had no concerns with allegations of abuse, and no concerns with allegations of involuntary seclusion in R242's concern that was written on the concern form. In an interview on 7/08/2025 at 238 PM, Director of Nursing (DON) B, after reading R242's concern form, stated yes and also stated that she had a concern with CNA KK shutting the door on R242, and allegations of abuse. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R124 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, not reported to the state agency upon checking the state agency reporting system.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure 9 out of 10 residents (Residents #'s 11, 37, 42, 65, 94, 108, 124, 134, & 242) allegations of abuse were thoroughly investigated, assure prevention of further potential abuse, and report the finding within five working days to the state agency. Findings Included:Per the facility face sheet R11 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS) dated [DATE], revealed R11 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R11 was cognitively intact. Record review of a concern form dated 5/17/2025, revealed R11 had documented on the concern form that she had run out of oxygen, and Certified Nurse Aid (CNA) JJ told her that she had to wait, and proceeded the leave to attend to another resident leaving R11 with no oxygen. R11 documented on the concern form that CNA JJ made her sit in urine soak brief for over six hours, until a nurse made CNA JJ change her. R11 documented that CNA JJ was being rude, R11 told CNA JJ she needed her labia washed due to the soap had not been washed out of that area yet, and it was burning. The concern form further revealed that R11 stated CNA JJ started to scream at her, and was then asked to leave her room, but CNA JJ stated that she did not have to leave and then slammed R11's room door. The concern form revealed that R11 did not want CNA JJ in her room, and this was the third time that this type of incident had happened, and she was not going to be an abused patient. The concern form revealed that the facility's response was that R11 and CNA JJ were spoken to, and CNA JJ was provided with education. The allegations of abuse were not identified as allegations of abuse, no investigation was done, CNA JJ was not removed from continuing to provide resident care, and the allegations were not reported to the state agency, nor was a 5-day investigation upon checking the state agency reporting system. In an interview on 7/08/2025 at 1:35 PM, Administrator A stated that he went and talked to R11 to see what happened. Administrator A said R11 leaves her window open the wind pushes the door shut, CNA JJ is new, and stated that he asked CNA EE if the incident that had taken place was abuse or customer service, in which Administrator A stated that the decision was made by CNA JJ, CNA EE, and R11 that is was not abuse; just a customer service concern, despite the fact that R11 specifically stated on the concern form that she was not going to be an abused patient. Therefore, Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R11 had to be costumer service concerns and not abuse allegations. Resident #37 (R37): Per the facility face sheet R37 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R37 had a BIMS score of 15 out of 15 which indicated R37 was cognitively intact. Review of a documented concern on a concern form dated 6/1/2025, revealed that R37 did not get her meds on time, and when she asked the nurse (did not state name) when she could get her meds the nurse said to R37 I'll get to you when I get to you with an attitude. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The concern form documentation revealed that the facility’s response to R37's concern was that Administrator A spoke with both R37 and the nurse, and it was determined that R37 would go outside to smoke during medication administration times. Education was provided to nurse regarding customer service, spoke with the resident (R37) about letting staff/nurse know when she is going outside so staff know where she is. The facility did not identify, nor address R37's statement that the nurse had an attitude, and told her, I'll get to you when I get to you In an interview on 7/08/2025 at 1:21 PM, Administrator A was asked about the allegation of abuse R37 documented on the concern form regarding the nurse. Administrator A stated she spoke with R37 who said the nurse was close to her room and she asked if it was time for her meds, and the nurse said I will get to you when I get to you. Administrator A said he asked R37 how she felt about it, whether she felt it was abuse or customer service concern. Administrator A said R37 stated she felt the nurse could have said it in a different way. Administrator A also said he asked R37 to let staff know when she was leaving and coming, because she was frequently outside, and he would talk to the nurse about customer service. Administrator A stated R37 had no abuse concerns, however nowhere on Administrator A's follow-up documentation was that documented. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R11 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, no investigation was done, no identified staff member (nurse) was not removed from continuing to provide resident care, and the allegations were not reported to the state agency, nor was a 5-day investigation upon checking the state agency reporting system. Resident #65 (R65): Per the facility face sheet R65 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R65 had a BIMS score of 10 which indicated R65 had only a moderate cognitive impairment. Review of a concern form dated 6/17/2025, revealed LPN MM got upset with R65, and refused to give R65 her pain medication, and it was not until the night shift arrived that R65 then received morphine because her pain was so bad. The concern form further stated that LPN MM was very rude. Facility resolution was educating the resident on the process of obtaining a narcotic to administer. The concern did not identify the allegation of abuse regarding LPN MM being very rude. Under FACILITY RESPONSE and ACTION TO BE TAKEN revealed no documentation of LPN MM receiving any education, or anything else regarding the allegation. In 7/08/2025 at 12:54 PM, Administrator A said he went and talked with R65, and the process was explained to R65 for obtaining a controlled substance. Administrator A said he told R65 the definition of abuse, then asked R65 if he believed LPN MM was abusive versus a customer service concern. Administrator A said he did ask R65 what he meant by LPN MM being rude, and R65 said he meant he felt misunderstood. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R11 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, no investigation was done, LPN MM was not removed from continuing to provide resident care, and the allegations were not reported to the state agency, nor was a 5-day investigation upon checking the state agency reporting system. Resident #94 (R94): Per the facility face sheet R94 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R94 had a BIMS score of 12 out of 15 which indicated a moderate cognitive impairment. Review of a concern form, date unknown, revealed an allegation that R94 was being sex trafficked. In an interview on 7/08/2025 at 1:00 PM, Administrator A stated that the police received an anonymous call that R94 was being sex trafficked. So Administrator A said he spoke to R94 who denied it, so that was why he did not report the allegation to the state agency. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R11 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, no investigation was done, and the allegations were not reported to the state agency, and no 5-day investigation results were reported upon checking the state agency reporting system. Resident #108 (R108): Per the facility face sheet R108 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R108 had a BIMS score of 12 out of 15. Review of a concern form dated 6/30/2025, revealed CNA OO had an unfriendly and gruff personality. The form revealed CNA OO could be rough when providing care, and the problem was ongoing. The action to be taken was to talk to CNA OO In an interview on 7/08/2025 at 12:41 PM, Administrator A stated he did not consider abuse with R108's concern. Administrator A said R108 told him that CNA OO was unfriendly and gruff. Administrator A said he asked R108 if CNA OO was acting intentionally and/or willfully, if he should provide coaching, and if it was customer service concern. Administrator A stated that he defined abuse to R108 and told him to let him talk to CNA OO, and then he would come back and ask R108 what his recommendations would be for what he should do with CNA OO. Administrator A said after he defined abuse to R108, R108 said it was a customer service concern. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R108 had to be costumer service concerns and not abuse allegations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The allegations of abuse were not identified as allegations of abuse, no investigation was done, CNA OO was not removed from continuing to provide resident care, and the allegations were not reported to the state agency, nor was a 5-day investigation upon checking the state agency reporting system. Resident #124 (R124): Per the facility face sheet revealed R124 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R124's BIMS score was 14 out of 15. R124 was the roommate of R108. Both residents filled out a concern form on 6/30/2025 which were identical concerns. Review of a concern form dated 6/30/2025, revealed CNA OO had an unfriendly and gruff personality. The form revealed CNA OO could be rough when providing care, and the problem was ongoing. The action to be taken was to talk to CNA OO In an interview on 7/08/2025 at 12:41 PM, Administrator A stated he did not consider abuse with R124's concern. Administrator A said R124 told him that CNA OO was unfriendly and gruff. Administrator A said he asked R124 if CNA OO was acting intentionally and/or willfully, if he should provide coaching, and if it was customer service concern. Administrator A stated that he defined abuse to R124 and told him to let him talk to CNA OO, and then he would come back and ask R124 what his recommendations would be for what he should do with CNA OO. Administrator A said after he defined abuse to R124, R124 said it was a customer service concern. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R124 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, no investigation was done, CNA OO was not removed from continuing to provide resident care, and the allegations were not reported to the state agency, nor was a 5-day investigation upon checking the state agency reporting system. Resident #134 (R134): Per the facility face sheet R134 was admitted the facility on 5/23/2025. Review of an MDS dated [DATE], revealed R124 had a BIMS score of 15 out of 15. Review of a concern form dated 5/30/2025, revealed Physical Therapy Assistant (PTA) QQ spoke to R134 in a way that left her feeling upset. The facility's action was that R134's physical therapy would be provided by another PTA. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/08/2025 at 12:50 PM, Administrator A stated that he had no concerns with R134's concern being an allegation of abuse, because R134 said PTA QQ went into her room while she had an IV antibiotic running, and because of that R134 did not want to start therapy until the antibiotic was completed. PTA QQ stated R134 that she was not going to get any better if she did participate in therapy. Administrator A said R134 did not want PTA QQ to treat her anymore because his comments made her feel bad. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R124 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, no investigation was done, and the allegations were not reported to the state agency, nor was a 5-day investigation upon checking the state agency reporting system. Resident #242 (R242): Per the facility face sheet R242 was admitted to the facility on [DATE]. Review of an MDS dated [DATE], revealed R242 had a BIMS score of 12 out of 15. Review of a concern form dated 1/30/2025, revealed CNA KK had an attitude every time R242 opened her mouth CNA KK would respond rudely, and when she asked a question CNA KK would come back with a sarcastic attitude/response. The concern form revealed that on 1/30/2025 CNA KK got pissed, and upon leaving R242's room, hide R242's remote (call light) turned off all lights, and shut the door on R242. The concern form further revealed that when R242 would call for CNA KK, CNA KK would get mad at her and she was tired of it. The concern form revealed that the facility's response was to provide education to CNA KK in regard to satisfactory customer service practices. CNA KK signed the concern form on 2/12/2025 that she received the education to ensure resident care spoken to with respect and professionalism, and residents will be treated with professionalism. In an interview on 07/08/2025 at 8:09 AM, via phone R242's daughter (Dtr) RR stated that R242 was not available for interview, however stated she was very familiar with the incident. Dtr RR stated that the situation with CNA KK went on for several days, then she requested a concern form. Dtr RR said CNA KK was sarcastic, had an attitude when R242 asked for anything, would shut R242's door and hide her call light. Dtr RR said R242 would have to yell out for help because she did not have her call light. Dtr RR stated that this had happened twice, and said she was on the phone with R242 one of the times that it happened. she told me the CNA KK hid her remote (call light) and shut her door. Dtr RR said R242 had started screaming out, help me help me, and said they (staff) were not coming. Dtr RR said she then called the nursing desk over and over until someone answered. Dtr RR said she wrote the incident on a concern form, and gave the form to LPN SS, but did not know where the form went from there. On 7/08/2025 at 8:43 AM, an attempt was made to contact LPN SS” but was unsuccessfully. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/08/2025 at 8:55 AM, CNA KK stated that she did not recall R242, did not recall the incident, and did not recall receiving a one-to-one Inservice that she signed on 2/12/2025, asked if she wanted to change anything about her statement in which CNA KK stated No In an interview on 7/08/2025 at 1:25 PM, Administrator A stated that he would say the allegations could be abuse, and that he would have spoken to R242 and got her statement, talked to staff, and done a thorough investigation. Administrator A said based on what is written on the concern form, those are allegations of abuse, and said yes he would do an investigation and report it to the state agency. However. Administrator A was not able to explain why the allegations were not reported to the state agency. In an interview on 7/08/2025 at 2:01 PM, LPN U, who was the Unit Manager for the one south unit, stated that the concern form was given to her by Administrator A. LPN U said she spoke with R242, and CNA KK about the incident, but stated she had no documentation of those interviews. Upon asking LPN U stated that she had no concerns with allegations of abuse, and no concerns with allegations of involuntary seclusion in R242's concern that was written on the concern form. In an interview on 7/08/2025 at 238 PM, Director of Nursing (DON) B, after reading R242's concern form, stated yes and also stated that she had a concern with CNA KK shutting the door on R242, and allegations of abuse. Administrator A did not report the allegations of abuse to the state agency, because he considered the concerns R124 had to be costumer service concerns and not abuse allegations. The allegations of abuse were not identified as allegations of abuse, no investigation was done, CNA KK was not removed from continuing to provide resident care, and the allegations were not reported to the state agency, nor was a 5-day investigation upon checking the state agency reporting system. Resident #42 (R42) R42 review of the clinical record, including the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/17/25 revealed R 42 was [AGE] years old, admitted to the facility with diagnosis that included cerebral vascular accident (stroke). R42 scored 12 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Section B of the MDS reflected R42 had clear speech and adequate hearing, was usually understood and usually understood others. Review of a facility concern form dated 1/21/25 revealed R42 went to the nurse's station requesting her morning medications and License Practical Nurse (LPN) E responded to her in a very mean way and told her she had to wait. The form went on to say LPN E often responds like this. The section of the same form asks how the concern can be resolved in which R42's response was Talk to her about talking to residents kindly, she does this often and to many patients. The facility response to R42's allegation of abuse was that R42 was frustrated and inpatient from having to wait for her medication and LPN E was not mean. There was no investigation done by the facility, no statements, no interviews with other residents, no interviews with other staff, no protection placed to ensure R42 was safe, so suspension for LPN E pending an investigation. On 07/08/25 10:39 AM, during an interview with R42, it was queried if she recalled talking to the form Director of Nursing and recanting on the statements about LPN E talking mean to her and other residents. R42 stated she did not recant her statement and LPN E still was mean and had a nasty attitude. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/08/2025 at 1:15 PM, Administrator A stated that R42 had to be interviewed by the Speech Therapist (ST) because R42 had expressive dysphasia (cannot speak whole sentences), so someone had to assist R42 with getting her words out. Administrator A said the only thing R42 could do was nod yes and no so the ST had to guess what R42's frustration was telling her. So, ST felt R42 was trying to say LPN E was rude. Review of another concern form dated 6/18/2025, revealed R42 made a complaint that a CNA (did not name the CNA) was very rude while serving her breakfast, and CNA ignored her and had a rude tone. The facility's response was that a nurse spoke with R42 and the CNA and both stated it must have been a misunderstanding. In an interview on 7/08/2025 at 1:05 PM, Administrator A said, regarding the 6/18/2025 concern, R42 felt the CNA was ignoring her. Administrator A said he spoke with the CNA who did not understand where the resident’s frustration was coming from so it must of been a misunderstanding, Review of another concern dated 1/7/2025 revealed when R42 would lay down after lunch and then wanted to get back up at 2:00 PM for group, staff would not get her up but would tell her to go to sleep I can't get you up and down. The allegations of abuse were not identified as allegations of abuse, no investigation was done, LPN E nor a CNA was removed from continuing to provide resident care, and the allegations were not reported to the state agency, nor was a 5-day investigation upon checking the state agency reporting system.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Deficiency Text Not Available

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to correctly identify, treat, resulting in worsening and non-healing of pressure ulcers for three residents (R29, R32, R81) out of five residents reviewed for pressure ulcers. Findings Include: Resident #29 (R29) Wounds were reviewed for R29. Review of the medical record reflected R29 was admitted to the facility on [DATE], with diagnoses that included chronic pain, delirium, and reduced mobility. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], reflected R29 scored 9 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Terminal Kennedy ulcers (KTU) and pressure ulcers are both types of skin breakdown, but they are different in their cause, appearance, and meaning. A pressure ulcer happens when there is prolonged pressure on one area of the skin, usually over bony parts of the body. This pressure reduces blood flow to the tissue, eventually leading to skin and tissue damage. Pressure ulcers develop gradually and are usually preventable with frequent repositioning, good nutrition, skin care, and pressure-relieving devices. The Centers for Medicare & Medicaid Services (CMS) and the National Pressure Injury Advisory Panel (NPIAP) classify pressure ulcers into stages based on how deep the damage goes, from Stage 1 (reddened, unbroken skin) to Stage 4 (deep tissue loss exposing muscle or bone) (NPIAP, 2016). KTU's, on the other hand, are a specific type of skin breakdown often seen at the end of life. They usually develop very quickly, sometimes in just a matter of hours, and are commonly found on the sacrum or coccyx area. These ulcers tend to have a distinct appearance. They can be shaped like a pear, butterfly, or horseshoe and may have a sudden dark purple or black color. Unlike pressure ulcers, Kennedy ulcers are not caused by pressure alone. Instead, they are believed to result from skin failure during the dying process, when the body is shutting down and blood is being directed away from the skin to protect vital organs (Langemo & Brown, 2006). The rapid onset and worsening of a Kennedy ulcer is often a signal that death is near, sometimes within hours to weeks. On [DATE] at 10:53 AM, R29 was observed in bed. R29's left hand was wrapped in gauze. A Nurse's Note dated [DATE] at 7:07 AM revealed On am (morning) assessment some drainage was noted coming from her (R29's) palm, staff saw that her finger nails were all inside her palm and it was cleaned and finger nails trimmed and the palm was covered with wrapped up. Wound was draining with a very foul smell. wound was cleaned and wrapped up. Review of a Hospice Note dated [DATE] stated new wound to palm of L (left) hand noted d/t (due to) hand contractures and finger nails causing skin break . Review of the Physician Orders revealed an order initiated on [DATE] and revised on [DATE] for Hand Carrot to right and left hands as tolerated. This was initiated after the development of the left palm skin wound. Further review of the Physician order's revealed an order initiated on [DATE] which stated left palm skin concern, cleanse with wound cleanser, pat dry, place AquaCell AG patch (AquaCell Ag is an antimicrobial wound dressing designed to manage wounds at risk of infection or showing signs of infection) over and cover with AquaCell foam. Wrap with Kerlix. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dimondale Nursing Care Center	4000 N Michigan Road Dimondale, MI 48821

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Skin and wound tab revealed no documentation or assessment for the wound on the left palm despite the skin concern clearly being described and treated as an open wound. In an interview on [DATE] at 1:20 PM, Clinical Care Coordinator (CCC) S confirmed that R29's hands were contracted, however, had no information about the left palm wound, such as when and how it occurred, or knew any information about when the hand carrot order was implemented, despite having access to R29's medical record. CCC S stated there should have been photos and assessments for the left hand wound but had no information as to why those were not obtained. Review of the Medical Record showed no evidence of R29's Physician being notified of the left palm wound. Review of the Medical Record showed no evidence of a Change in Condition form being completed for the left palm wound. Review of the Incident report dated [DATE] revealed nursing discovered R29's fingernails inside her palm. Under the section of the Incident Report stated, people notified, only a family member for R29 was listed. No Physician was listed. Record Review revealed on [DATE], it was discovered that R29 developed a sacral wound (just above the tailbone) which was initially identified as a Stage 3 Kennedy ulcer. The wound was noted as in-house acquired. At the time, it measured 6.62 cm², with a length of 4.37 cm and a width of 1.96 cm. The wound bed was 80% epithelial and 20% slough (soft, yellow, white, or greenish dead tissue), showing no signs of granulation (new healthy tissue). Review of the sacral wound photograph in the electronic medical record can be described as an open wound with red, moist tissue. The wound bed contains yellowish slough. The wound borders appear to be irregular and macerated (skin has become soft, wet, and broken down from being in contact with too much moisture for too long), suggestive of prolonged moisture exposure. KTU's are not staged, like pressure ulcers. KTU's are identified through their characteristics rather than through a staging system. No scholarly or regulatory source supports staging KTUS. Record review revealed that on [DATE], R29's sacrum wound area had minimally decreased to 6.56 cm², with a length reduction to 4.05 cm but a slight width increase to 2.34 cm. The wound depth was recorded at 0.1 cm. PUSH (PUSH Tool, Pressure Ulcer Scale for Healing, is a standardized instrument developed by the National Pressure Injury Advisory Panel (NPIAP) to monitor the healing progression of pressure injuries over time. It assigns numerical values to three key wound characteristics: surface area (length × width), exudate amount, and tissue type present in the wound bed. The cumulative score ranges from 0 (completely healed) to 17 (severe), with higher scores indicating more severe wounds) score was 11, with 20% epithelial tissue and 80% granulation. Review of R29's sacral wound photograph on the electronic medical record revealed an open area with bright, red moist tissue, rolled wound edges, and widespread redness surrounding the wound. The wound was described as a Stage 3 [NAME] Ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE], R29's sacral wound area increased to 11.11 cm² with significant length growth to 7.12 cm. Eschar (necrotic tissue) was first documented at 30%, and slough increased to 50%, suggesting tissue deterioration. PUSH score rose to 14. The wound was classified as an Unstageable (full depth of the wound bed can ' t be seen yet. This is usually because the wound is covered with dead tissue such as slough or eschar) [NAME] Ulcer. Record Review revealed on [DATE], the wound area grew slightly to 11.28 cm², though length decreased to 5.62 cm. The wound now contained 60% eschar and 40% slough. The PUSH score remained at 14. The wound was classified as an Unstageable [NAME] Ulcer. On [DATE], the area expanded to 13.63 cm². While the length further decreased to 4.14 cm, the width had grown to 4.85 cm. Slough and eschar remained stable at 40% and 60%. The wound was classified as an Unstageable [NAME] Ulcer. Review of the photograph of the wound in the electronic medical record revealed R29's wound contained eschar and areas of bright red bleeding tissue. On [DATE], the wound continued to expand, reaching 19.75 cm² with eschar increasing to 80%, signaling significant necrosis. The wound continued to be classified as an Unstageable pressure ulcer. The PUSH score was 16. The photograph depicted a bright, red wound bed and surrounding tissue area, which was a continuation of previous photographs reviewed and indicated profusion to the area, which is uncharacteristic of a KTU. On [DATE], R29's wound measured with an area of 33.87 cm², with a length of 5.59 cm and width of 8. 77 cm. Granulation was first noted again at 10%, while slough and eschar accounted for 40% and 50% of the wound bed. The PUSH score maintained at 16. On [DATE], the wound assessment showed a decrease in wound area to 28.09 cm² and eschar reduced to 30%, slough remained at 40% with 30% granulation. The PUSH score maintained at 16. Per the wound assessment, the surrounding tissue was red and blanchable. On [DATE], the area increased again to 33.25 cm². Redness, inflammation, and gangrene were noted, indicating localized infection. Granulation remained at 30%, slough at 30%, and eschar increased to 40%. The wound was being described as Unstageable, however, after review of the photograph, the wound bed was visible, suggesting a depth and stage could have been documented. The wound presented as beefy red. On [DATE], R29's sacral wound area had decreased slightly to 30.09 cm². Granulation improved to 50% and eschar dropped to 20%. The wound was being described as Unstageable, however, after review of the photograph, the wound bed was visible, suggesting a depth and stage could have been documented. The wound presented as beefy red. On [DATE], the sacral wound reached its largest size at 49.28 cm², measuring 6.68 cm in length and 10.23 cm in width. Granulation increased to 70%, while slough and eschar were down to 20% and 10%. On [DATE], the wound slightly decreased to 47.94 cm², with depth reaching 3.0 cm. Epithelial tissue was documented at 30%, granulation at 50%, and slough at 20%. The PUSH score was 15. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE], per the measurements documented in the medical record, R29's wound measurements implied wound improvement, with the wound area reducing to 32.86 cm², though the length increased to 7.15 cm. Depth reduced to 1.0 cm, granulation rose to 70%, and slough remained stable at 20%. The wound bed was beefy read and the wound was being classified as a Stage Four [NAME] Ulcer. On [DATE], the wound area was consistent at 32.89 cm². Granulation increased to 90%, and slough remained at 20%, indicating positive healing progress. The wound was described as stable. The PUSH score remained at 15. On [DATE], the area had decreased to 29.79 cm². Granulation was 60%, slough increased to 30%, and eschar reappeared at 10%. Undermining was documented at 3.0 cm from 7 to 3 o'clock. The PUSH score was 16. Review of the photograph in the medical record depicted a Stage 4 pressure ulcer on the sacral region with a beefy, moist wound bed. On [DATE], the area increased to 34.52 cm², and undermining extended to 3.5 cm from 8 to 4 o'clock. Granulation improved to 80% and slough decreased to 20%. On [DATE], the wound area decreased again to 28.53 cm², with a length of 4.05 cm and a width of 8. 76 cm. Depth measured at 2.0 cm. Granulation tissue was at 90%, and slough had decreased to 10%. On [DATE] at 4:35 PM, a request was made to observe wound care the following day. On [DATE], Director of Nursing (DON) B reported that R29's wound care was completed overnight and that R29's wound care was scheduled during night shift. Over the 16-week period, the wound showed consistent progression and regression, a pattern uncharacteristic of a Kennedy terminal ulcer. According to the National Pressure Injury Advisory Panel (NPIAP, 2019) and [NAME] et al. (2019), Kennedy terminal ulcers are rapidly progressing wounds that develop within hours to a few weeks before death, exhibit irregular shapes (such as pear, butterfly, or horseshoe-shaped), and typically do not exhibit healing. This resident's wound demonstrates a gradual and prolonged evolution, improvement in tissue composition, and absence of significant end-of-life status, key factors that clearly align with a diagnosis of a pressure injury. Review of the Physician Order's revealed a treatment order for R29's sacral wound active since [DATE] which stated sacral wound: cleanse with wound cleaner, pat dry, crush Flagyl 500 milligram tab then apply to wound bed, moisten gauze with NS (normal saline), squeeze out excess, lightly pack wound to depth, cover with border foam dressing. Despite the non healing status of the wound, the treatment order remained the same since [DATE]. R29's sacral wound persisted for approximately 16 weeks, which is inconsistent with the expected clinical trajectory of a KTU. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Separately, on [DATE], second wound developed on R29's right trochanter (right hip) with an initial area of 4. 13 cm² (3.77 cm in length and 1.56 cm in width). Review of the photograph in the electronic medical record revealed a dark colored closed area that presented as a suspected deep tissue injury (dark purple or deep red area, or a blood-filled blister, on skin that may feel firm, mushy, or warmer/cooler than the surrounding skin. Even though the top layer of skin may not be open, the tissue underneath is already damaged from pressure). The assessment noted a PUSH score of 11. Review of the Wound assessment dated [DATE] revealed R29's right trochanter wound area expanded dramatically to 14.02 cm², with full epithelial coverage noted and a PUSH score of 10. Clinical records indicate that a circular implanted pain pump was located under the skin in that area. The wound started to notably mirror the round shape of the underlying medical device. On [DATE], the area decreased to 10.61 cm², showing 80% epithelialization, 10% granulation, and 10% eschar. The wound continued to present in a circular shape mirroring the underlying pain pump. On [DATE], the wound expanded again to 18.7 cm², characterized by 90% slough and only 10% granulation. Review of the photograph located in the medical record revealed that the wound had opened, revealing a wound bed of eschar. The skin surrounding the wound appeared red, and the wound edges were well-demarcated (round and easy to see). Review of the wound assessment dated [DATE] revealed that R29's right trochanter wound nearly doubled in size to 35.9 cm², with tissue breakdown now consisting of 80% slough and 20% eschar. The wound had a PUSH score of 15. On [DATE], the wound had regressed to 19.17 cm², but was now 100% slough, suggesting continued necrotic progression. Review of the photograph revealed that the pain pump was now exposed. On [DATE], the wound size increased to 25.81 cm² with 40% slough. Review of the wound photograph revealed the exposed hardware, specifically a intrathecal pump (a pump that is surgically placed under the skin). A pressure ulcer developed over the surface of the implanted intrathecal pump. The wound edges were rolled and undermined, with black eschar along the margin. On [DATE], R29's wound had an area of 47.87 cm². At that time, the wound presented with 40% granulation and 60% slough. Clinical notes confirmed that the intrathecal pain pump eventually became exposed through the wound bed and ultimately dislodged and fell out of the resident's body, indicating advanced soft tissue destruction due to persistent pressure and device-related trauma. R29's right trochanter wound persisted for about 8 weeks, which is inconsistent with the expected clinical trajectory of a KTU. In an interview on [DATE] at 1:51 PM, Registered Nurse (RN) D stated that she was familiar with R29's care, including her pressure ulcers. RN D reported that she cares for R29 about two times a week under R29's hospice care. RN D reported that KTU'S typically present as a dark discoloration and deteriate rapidly. RN D reported that initially, R29's sacral and right trochanter pressure ulcers were classified as KTU's however, in retrospect, using her professional knowledge she would classify them as pressure injuries due to the long-standing nature of the wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on [DATE] at 11:06 AM, Physician H stated that KTU's come on very quickly and indicate that the patient is terminal with the potential to pass within days or weeks. Physician H stated that KTU's are thought to occur due to perfusion issues, skin failure, or the body shutting down. In an interview on [DATE] at 2:13 PM, Physician LL stated that KTU's were classified as [NAME] Ulcers due to the patients decline and weight loss. Physician LL also reported that [NAME] Ulcers are not stageable. Regarding treatment, Physician LL added if the ulcer is not infected we don't treat them. A review of R29's total body skin assessments revealed that every weekly assessment conducted throughout the duration of her admission consistently documented normal findings. Specifically, R29 was noted to have good skin turgor, skin color appropriate for her ethnic background, warm (normal) skin temperature, normal moisture levels, and overall skin condition described as normal. If R29 had experienced hypoperfusion and/or organ failure to a degree that impacted her skin integrity, such changes would have been reflected in the weekly skin assessments. Review of R29's Blood Pressures revealed the following: [DATE] 12:16 PM 114 / 71 mmHg [DATE] 1:19 PM 121 / 75 mmHg [DATE] 7:17 AM 110 / 78 mmHg [DATE] 2:30 PM 100 / 55 mmHg [DATE] 2:27 PM 100 / 55 mmHg Review of these blood pressure readings show evidence that R29's Mean Arterial Pressure (MAP- the average pressure in a person's arteries during one cardiac cycle. It represents the perfusion pressure delivered to the organs and tissues of the body. Unlike simple systolic or diastolic pressure readings, MAP provides a more accurate reflection of the blood flow and pressure that organs actually experience) was above the normal range of 70-100 mmHg which indicated adequate perfusion. In an interview conducted on [DATE] at 12:37 PM, Licensed Practical Nurse (LPN) D stated that physicians are primarily responsible for reviewing, staging, and initiating wound care orders. When asked whether wounds are assessed in person, LPN D explained that this is not always the case. She noted that if she encounters an issue, she may request the physician to assess the wound in person, otherwise, they typically rely on photographs and documentation in the electronic medical record. They do not round every week, she added. When asked about the process for changing wound treatments, LPN D stated that if a wound is not healing, the physician will usually consider modifying the treatment plan after approximately two weeks. Regarding R29's left palm, LPN D stated the skin was never visibly open, therefore, she did not believe it was necessary to monitor or assess the area further. Per the medical record, there was clear indication that the left palm had in fact, opened. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Physician Order's revealed an order for R29's sacral wound active from [DATE] and discontinued on [DATE]. The order stated to cleanse the sacral wound with normal saline, pat dry, place AquaCell AG over the wound and cover with AquaCell dressing. As mentioned, AquaCell AG is a antimicrobial wound dressing designed to manage wounds at risk of infection or showing signs of infection. AquaCell is utilized for the management of both chronic and acute wounds, such as leg ulcers, pressure injuries (stages 2-4) and diabetic ulcers; surgical wounds (post-operative, donor sites, dermatological); partial-thickness (second-degree) burns . wounds that are prone to bleeding, such as wounds that have been mechanically or surgically debrided and donor sites . (https://www.woundsource.com/product/aquacel-foam-dressing). Per the manufacturer's website, AquaCell is a ConvaTec brand and stands out for its unique gelling action based on Hydrofiber technology. This property allows the dressing to absorb and lock in exudate and bacteria. It is a versatile primary wound dressing indicated for use on moderate to highly exuding chronic and acute wounds. AquaCell supports wound healing by providing a moist wound healing environment. Further review of the wound care orders for R29's sacral and right trochanter wound revealed AquaCell and AquaCell AG were utilized for R29's wound care treatments. Review of the literature provided by the facility states Setting realistic wound management goals that are situated around comfort and odor control rather than healing ([NAME] et al., 2019). Labeling these wounds as Kennedy terminal ulcers misrepresented the clinical scenario and may falsely imply unavoidability. The wound's trajectory, characteristics, and treatments support the conclusion that R29 experienced chronic, in-house acquired pressure injuries. Additionally, Kennedy terminal ulcers (KTUs) are not staged using the standard pressure injury staging system because they are considered a distinct type of skin failure related to the dying process. Unlike traditional pressure injuries, KTUs appear suddenly, often within hours to a few weeks before death, and they progress rapidly. Their unique presentation and association with end-of-life changes make them inappropriate for classification under the National Pressure Injury Advisory Panel's staging guidelines. Instead, KTUs should be described in narrative form, noting their appearance, location, size, and progression, rather than assigning a numerical stage. Applying a pressure injury stage to a Kennedy ulcer can lead to misclassification and clinical confusion (NPIAP, 2016). (https://pubmed.ncbi.nlm.nih.gov/30801349). Additionally, Accurate assessment is vital to distinguish Kennedy terminal ulcers from pressure injuries to ensure appropriate care planning and to avoid misinterpretation of unavoidable skin changes. ([NAME], S., [NAME], J., Hunt, T., [NAME], K., & [NAME], B. M. (2019). Kennedy terminal ulcers: A Scoping Review. Journal of Hospice and Palliative Nursing, 21(3), 202-208). R29 expired in the facility on [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to correctly identify, treat, resulting in worsening and non-healing of pressure ulcers for three residents (R29, R32, R81) out of five residents reviewed for pressure ulcers Findings Include:Resident #81 (R81)Review of the medical record reflected that R81 was admitted to the facility on [DATE], hospitalized on [DATE] and was readmitted to the facility on [DATE]. Diagnoses of Dementia, Pressure-induced Deep Tissue Damage, Pressure Ulcer of Sacral region, unstageable.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] revealed R81 had a Brief Interview of Mental Status (BIMS) of 00 (unable to answer any questions) out of 15.Under section G0100, Activities of Daily Living (ADL) Assistance reveals R81 is dependent for all care. During an interview on [DATE] at 12:29 PM, R81's family member II stated that R81 developed a pressure ulcer after admission to this facility.Physician Order: Clean pressure ulcer on the coccyx with wound cleanser, pat dry apply Aquacel AG (used for managing moderate to heavily exuding wounds, including pressure ulcers, to be changed every 3-5 days for proper usage,), cover with Aquacel foam (AQUACEL® Ag Foam may be used for the management of both chronic and acute wounds, such as leg ulcers, pressure injuries (stages 2-4) to be changed every 3-5 days for proper usage,) and cover with bordered form every shift for Skin integrity, ordered on [DATE], discontinued on [DATE]. Record review revealed a nursing progress note dated [DATE] 1:43 PM, Nurse's Progress Note, Note Text: During routine care resident was noted to have a Pressure Ulcer on the coccyx. The nurse cleaned the area with a wound cleaner, patted dry covered with Aquacel form. Family, on call and provider were notified. A change in condition was initiated.Record review revealed a document labeled Wound Evaluation on [DATE] labeling #2 Pressure-Kennedy terminal ulcer-Deep Tissue Injury- Unstageable- Sacrum. The wound evaluation has a picture of the sacrum showing measurements of area 9.11 cm x 3.24 cm x 5.57 cm with a push score of 14 and 0% change.Record review of an Skin and Wound Evaluation dated [DATE] revealed R81's type of wound was Pressure-Kennedy terminal ulcer, unstageable due to slough and eschar, in house acquired on [DATE]. Wound measurements were 3.2cm x 5.6cm depth unknown with area 9.1cm. Granulation of 50% of wound bed filled and eschar of 50% of wound bed.Record review revealed a document labeled Wound Evaluation on [DATE] labeling #2 Pressure-Kennedy terminal ulcer-Deep Tissue Injury- Unstageable- Sacrum. The wound evaluation has a picture of the sacrum showing measurements of area 9.44 cm (+4%) x 5.94 cm (+83%) x 2.38 cm (-57%) with a push score of 14, with a push score of 14 and -4% change. Physician Order: Clean Pressure Ulcer on the coccyx with wound cleanser, pat dry apply aquacel AG (used for managing moderate to heavily exuding wounds, including pressure ulcers, to be changed every 3-5 days for proper usage, cover with Aquacel foam (AQUACEL® Ag Foam may be used for the management of both chronic and acute wounds, such as leg ulcers, pressure injuries (stages 2-4)and cover with bordered foam every evening shift every 3 day(s) for Skin integrity, ordered on [DATE] and discontinued on [DATE]. Record review revealed a nursing progress note dated [DATE] 12:45 PM, Nurse's Progress Note, Note Text: Family requesting resident be sent to emergency department for ulcer to sacrum. Education given to family regarding Pressure Ulcer being a [NAME] Ulcer which is terminal and not curable. Resident sent for further evaluation on the ulcer per family request; physician notified. Transfer packet sent with bed hold policy and ombudsman information.Physician Order: Clean Pressure Ulcer on the coccyx with wound cleanser, pat dry apply aquacel AG (used for managing moderate to heavily exuding wounds, including pressure ulcers, to be changed every 3-5 days for proper usage, cover with Aquacel foam (AQUACEL® Ag Foam may be used for the management of both chronic and acute wounds, such as leg ulcers, pressure injuries (stages 2-4)and cover with bordered foam every evening shift every 3 day(s) for Skin integrity, ordered on [DATE] and discontinued on [DATE].Physician Order Clean Pressure Ulcer on the coccyx with wound cleanser, pat dry apply Aquacel AG (used for managing moderate to heavily exuding wounds, including pressure ulcers to be changed every 3-5 days for proper usage,), cover with Aquacel foam (AQUACEL® Ag Foam may be used for the management of both chronic and acute wounds, such as leg ulcers, pressure injuries (stages 2-4), and cover with bordered form every evening shift every 3 day(s) for Skin integrity AND every 24 hours as needed. Ordered on [DATE] and discontinued on [DATE].Physician Order Clean pressure ulcer on the coccyx with wound cleanser, pat dry apply Medi honey (Medi honey is used for wound care and has several benefits: Pulls moisture from wounds and reduces bacterial growth. Has an anti-inflammatory effect that speeds up healing time and reduces pain. Stimulates blood flow and oxygen release, aiding wound healing

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to label and store medication in accordance with accepted professional principles, for one resident (#111) of seven residents during observation of medication administration, one of eight medication carts (to include medication for resident #342), and one medication refrigerator (one east refrigerator) of six refrigerators reviewed. Findings Included:Resident #111 (R111)Review of the medical record revealed R111 was admitted to the facility 02/16/2024 with diagnoses that included type 2 diabetes, congestive heart failure (CHF), atherosclerotic heart disease (build up of substances in artery walls), hypertension, sleep apnea, insomnia, bilateral cataracts, depression, and gastro-esophageal reflux. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/09/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 15 (intact cognition) out of 15. During observation of medication administration on 7/03/2025 at 08:24 a.m. Licensed Practical Nurse (LPN) Q was observed entering R111's room to provide prepared medication. R111 was observed sitting up in bed eating her breakfast. LPN Q was observed providing an insulin injection to R111. LPN Q asked R111 if she would like to take her medication (9 different medications in a medication cup) at this time. R111 responded that she would like to take her medication once she had completed her breakfast. LPN Q was observed leaving the medication cup (with 9 different medications) on R111's overbed table and then leaving R111's room. During observation and interview on 07/02/2025 at 08:27 a.m. R111 was observed lying down in bed. The medication cup (with medication) was observed sitting on the over bed table. When inquired if nursing staff left medication with her to take without their supervision, R111 explained that usually staff do leave the medication with her to take later because she does not like to consume her mediation until after she has eaten.Review of R111's medical record did not demonstrate a physician order that she as able to take her medication independently. R111's medical record did not demonstrate that and assessment for self-administration of medication had been conducted. R111's medication record did not have a plan of care specifying that she could self-administer medication. During an interview on 07/03/2025 at 09:17 a.m. Director of Nursing (DON) B explained that the process of self-administering of medication required an assessment by the interdisciplinary team, a physician order, and the residents plan of care would include self-administering of medication. DON B confirmed that R111's medical record did not include the required assessment, physician order, or plan of care for self-administration of medication. Resident #342 (R342) Review of the medical record revealed R342 was admitted to the facility 06/13/2025 with stroke, cognitive communication deficit, left sided hemiplegia (weakness or paralysis), type 2 diabetes, dysphagia (difficulty swallowing), malnutrition, hyperlipidemia (high fat content in blood), history of seizures, and hypertension. The most recent Minimum Data Set (MDS), with an Assessment Reference [NAME] (ARD) of 06/19/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 03 (severe cognitive impairment) out of 15.On 07/03/2025 at 10:56 a.m. during inspection of 1 [NAME] back medication cart, it was observed that the second drawer contained a medication cup with medication present. The unlabeled medication cup contained three white pills, one light orange pill, one yellow pill, and one dark orange pill. Licensed Practical Nurse (LPN) E explained that the cup contained R342's morning medication. LPN E explained that she was unable to provide R342 with his morning medication because care was being provided. LPN E explained that she had placed the medication cup, with the medication, in the medication cart at an earlier time. LPN E could not list the names of the medication and could not explain why the medication cup was not labeled with R342's name or the names of the medications.During an interview on 07/08/2025 at 10:59 a.m. Director of Nursing (DON) B explained that it was not acceptable to leave mediation in a medication cup without the cup being labeled with the resident name and the names of the medication. DON B' explained that medication should only be stored in packaging from the pharmacy or medication company. During review of one east medication refrigerator June temperature log it was observed to not have temperatures recorded for 06/25/2025, 6/26/2025, 06/28/2025, and 06/30/2025. During an interview on 07/03/2025 at 09:57 a.m. with Infection Preventionist (IP) R explained that it is the responsibility of the midnight nurses to record the temperature of the medication refrigerator on the log. IP R also explained that it was her responsibility to review the logs daily. IP R could not explain why the dates, list above, did not have recorded temperatures.

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	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dimondale Nursing Care Center	4000 N Michigan Road Dimondale, MI 48821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to effectively create and maintain the Water Management Plan effecting 144 residents, resulting in the increased likelihood for development of Legionellosis and other opportunistic waterborne pathogens.Findings include:On 07/01/25 at 09:30 A.M., Record review of the facility Water Management Plan was reviewed with Director of Maintenance (DM) K. The following items were noted:The facility Water Management Plan was observed missing the following content:1. A clear definition of the current Water Management Team Members.2. A written narrative of the potable water supply system from headwork's to sanitary discharge.3. A clear identification of increased and/or high-risk areas within the potable water supply for legionella bacterium development.4. Failure to utilize and follow an accepted industry standard reference resource (American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) 188, Centers for Disease Control and Prevention (CDC), etc.).On 07/01/25 at 10:55 A.M., An interview was conducted with Infection Preventionist (IP) L regarding any cases of Legionellosis since the last annual survey. (IP) L stated: No.On 07/02/25 at 10:06 A. M., An environmental tour of the second-floor unoccupied area was conducted with (DM) K. The following item was noted:The hand sink potable water supply was observed discolored (amber colored) for at least 5-10 seconds upon actuation flushing.On 07/02/25 at 10:25 A.M., An interview was conducted with (DM) K regarding the last time the second-floor unoccupied area was occupied. (DM) K stated: The area has not been occupied for at least 12 years.On 07/02/25 at 11:20 A.M., Record review of the Legionella Prevention potable water supply flushing logs for the last three months revealed a statement notated on the form that read: All areas above need to run for 1 minute each to properly flush stagnant standing water from pipes in low use areas.On 07/02/25 at 11:33 A.M., An interview was conducted with Senior Maintenance Technician (SMT) M regarding how long ago the second-floor unoccupied area was occupied. (SMT) M stated: Since the early 90's. (SMT) M also stated: The unoccupied space is considered 2-East and 2-South.On 07/02/25 at 02:30 P.M., An interview was conducted with [NAME] President of Clinical Services (VPCS) I regarding the second-floor unoccupied area potable water supply. (VPCS) I stated: We have plumbers on-site to disconnect and drain the water pipes.On 07/02/25 at 02:42 P.M., An interview was conducted with (Company Name) Plumbing Vendor Technician (PVT) N regarding the potable water separation plan between the facility unoccupied areas and occupied areas. (PVT) N stated: We plan to cut and cap 48 water supply risers on Monday (7-7-25).On 07/03/25 at 09:00 A.M., Record review of the Centers for Disease Control and Prevention (CDC) publication entitled: Controling Legionella in Potable Water Systems dated 1-3-2025 revealed under Flushing: Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) for at least 5-minutes regularly as needed to maintain water quality parameters within control limits.

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	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dimondale Nursing Care Center	4000 N Michigan Road Dimondale, MI 48821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 144 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased air quality.Findings include:On 07/01/25 at 11:47 A.M., A common area environmental tour was conducted with Director of Housekeeping and Laundry Services (DHLS) J. The following items were noted:1 East (149-170)Soiled Utility Room: The room was observed heavily malodorous from limited return-air exhaust ventilation. (DHLS) J indicated he would contact maintenance for necessary repairs.Shower Room: The return-air-ventilation grill was observed heavily soiled with accumulated and encrusted dust/dirt deposits. (DHLS) J indicated he would have staff thoroughly clean and sanitize the return-air ventilation grill as soon as possible.1 South (300-324)Nursing Station: 1 of 5 chairs were observed (etched, scored, particulate). The damaged area measured approximately 3-inches-long by 1-inch-wide twice. Pantry/Clean Utility Room: The plaster surface was observed (etched, scored, particulate), adjacent to the entrance door. The damaged area measured approximately 2-inches-wide by 18-inches-long. (DHLS) J indicated he would contact maintenance for necessary repairs as soon as possible.1 North (122-147)Nursing Station: 1 of 4 chairs were observed (etched, scored, particulate). The damaged area measured approximately 2-inches-wide by 4-inches-long. (DHLS) J indicated he would contact maintenance for necessary repairs as soon as possible.Oxygen Room: The utility sink atmospheric vacuum breaker was observed leaking water during faucet actuation. (DHLS) J indicated he would contact maintenance for necessary repairs as soon as possible. 1 [NAME] (100-121)Nursing Station: The oscillating wall fan was observed soiled with accumulated and encrusted dust/dirt deposits.Shower Room: 2 of 2 privacy curtains were observed soiled with bodily fluids and human waste. The commode base perimeter rim was also observed severely (etched, scored, worn). The commode base caulking was additionally observed (etched, scored, stained, particulate). (DHLS) J indicated he would contact maintenance for necessary repairs as soon as possible.Beauty Shop: The desk fan was observed soiled with accumulated and encrusted dust/dirt deposits.Staff Breakroom: The utility sink atmospheric vacuum breaker was observed leaking water upon faucet actuation. (DHLS) J indicated he would contact maintenance for necessary repairs as soon as possible.2 [NAME] (200-225)Soiled Utility Room: The hand sink faucet handles were observed loose-to-mount. The hot and cold handles were also observed to separate completely from the valve stem assembly upon upward force. (DHLS) J indicated he would contact maintenance for necessary repairs as soon as possible.2 North (Memory Care Unit) (226-251)Shower Room: The return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust/dirt deposits. (DHLS) J indicated he would have staff thoroughly clean and sanitize the return-air ventilation grill as soon as possible.Soiled Utility Room: The (PTAC) Unit filters were observed soiled with accumulated and encrusted dust/dirt deposits. The hand sink faucet cold water handle was also observed loose-to-mount. (DHLS) J indicated he would contact maintenance for necessary repairs as soon as possible.Oxygen Room: The utility sink faucet atmospheric vacuum breaker was observed leaking water upon actuation. (DHLS) J indicated he would contact maintenance for necessary repairs as soon as possible.On 07/02/25 at 10:15 A.M., An interview was conducted with Director of Maintenance (DM) K regarding the facility work order system. (DM) K stated: We have the TELS system.On 07/03/25 at 10:00 A.M., Record review of the Policy/Procedure entitled: Housekeeping Policies & Procedures Check List dated (no date) revealed under (12) Discharge Room Clean: (p) Check privacy curtains & replace if needed. (q) Wall vents & heat/AC unit vent cleaned.On 07/03/25 at 10:30 A.M., Record review of the Direct Supply TELS Work Orders for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns.