STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235373	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Lodge Trinity Health	18525 Woodland Ridge Drive Spring Lake, MI 49456

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observations, interviews, and record review, the facility failed to accurately assess, monitor and treat wounds for 3 Residents (R1, R2 and R3) of 3 residents reviewed for wound care. Findings included: Review of R1's face sheet dated 2/12/25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: encounter for other orthopedic aftercare, infection of amputation stump, osteomyelitis, muscle weakness, need of assistance with personal care and obesity. R1 was his own responsible party. Review of R1's Skin assessment dated [DATE] revealed that he and a left knee surgical incision. (no description). Review of R1's orders revealed, 1/4/25, reinforce dressing if staining, if saturation noted please contact ortho (orthopedic) PA (physician assistant). Do not remove dress for any reason unless discussed with ortho PA. Review of R1's surgical note dated 1/8/25 Revealed, He states that he is doing okay, patient says they are using a sit to stand at his nursing home, patient says the sit to stand pinched his amputation twice now and he says it causes a lot of pain. Impression infected left lower extremity BKA (below the knee amputation). I have recommended return to the hospital operative debridement and VAC placement probably doing that serially for some time until we get his joint stable wound stabilized again. Review of R1's orders revealed no wound care orders in place when he returned from the hospital on 1/22/25. Review of R1's orders revealed, 1/30/25 Wound Vac (vacuum) to be changed 3 times a week every Tuesday, Thursday and Saturday. Cleanse area with saline and change wound vac dressing. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R1's Treatment Administration Recorded (TAR) for January 2025 revealed. LBKA (left below the knee amputation) - wet to dry dressing, saline soaked gauze, covered with ABD (type of dressing) pad and secured with ACE wrap, xeroform to open areas on anterior shine, changed daily (D/C when wound vac applied). Every day shift for wound. Start date 1/23/25 at 7:15 D/C date 1/25/2025 at 10:31. The box for 1/23/25 was completed as done, the box for 1/26/25 was marked (6) for hospitalized and the box for 1/26/25 was blank indicating the treatment was not done. Review of R1's TAR for January 2025 revealed LBKA (left below the knee amputation) wet to dry dressing, saline soaked gauze, covered with ABD pad and secured with ACE wrap, xeroform to open areas on anterior shin, change daily (D/C (discontinued) when wound vac applied). At bedtime for Wound. Start date 1/25/25 at 19:00 and D/C (discontinued) on 1/31/2025 at 00:18. Treatments were documented as completed 1/25 to 1/29/25. 1/30/25 was marked as 5 for see nurses notes. Review of R1's medical record from 1/22/25 to 1/30/25 revealed no facility assessments of R1's surgical wound on his left below the knee amputation. Review of R1's nursing progress notes for 1/30/25 revealed no indication of any treatment of R1's wound (as indicated documented in notes on MAR for this date) on his left below the knee surgical incision. Review of R1's electronic medical record revealed no description of R1's surgical wounds were completed when dressing was changed. Review of a Report of consultation for R1 dated 1/29/25 revealed, Large wound hematoma that was closed over top with an ABD and 2-inch ACE wrap. Hematoma debridement and wound packed. Patient has not had ordered vac dressing for a week with no communication indicating such. Please investigate and apply ordered vac dressing. At least pack wound with wet to dry (unreadable word) 2 weeks. Review of R1's surgical services note dated 2/13/25 revealed, Significant improvement in wound over the last couple of weeks. Continue with his wound VAC. Recheck with him in about 4 weeks. R1 was observed in bed on 2/12/25 at 9:16 AM. R1 was not clear on the timeline of events since his admission to the facility on [DATE] but did recall getting his leg stump pinched in a stand-up lift prior to 1/8/25. R1 was readmitted to the hospital on 1/8/25 because the surgical wound on his left leg opened and was infected. R1 had a wound vacuum and dressing over the end of his stump (below the knee amputation) on his left leg. During an interview with the Director of Nursing (DON) on 2/12/25 at 9:27 AM the DON confirmed she was aware of problems with R1's wound care and the facility had started an investigation. A request for the full investigation and all documents relating to R1's wound care was requested. On 2/12/25 at 3:45 PM another request for all R1's wound care and investigation into wound care issues was requested. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 2/13/25 at 3:15 PM. They reported they were ready to review wound documentation for R1. They did not have a timeline or all documentation of wound care available. They did not have an investigation into his wound care issues. They denied any knowledge or documentation of R1 having an injury involving his stump when standing in a stand-up lift. They did not have any description of the initial wound or assessments completed by facility staff. They did have documentation from the surgeon that documented the wound was open an infected on 1/8/25 (4 days after his admission to the facility) and suffering injury in a stand-up lift 2 times prior to that appointment, he was in the hospital from 1/8/25 to 1/22/25. No description of the surgical wound on 1/22/25 when R1 returned to the facility. R1 returned to the surgeon on 1/29/25 and the facility received documentation that they were not following wound care orders, and the physician wanted the lack of wound care investigated. The facility did not provide any documentation of any investigation. The facility received orders to start a wound vacuum on 1/30/25 and it was to be changed on the day shift on Tuesday, Thursday and Saturday. R1's Treatment Administration Record Revealed that the wound vacuum was not placed until 2/4/25 and was not changed as ordered on 2/8/25. The DON and NHA said they were in the process of investigating R1's lack of wound documentation and working on why orders were not sent from the hospital for wound care on 1/4/25 or on 1/22/25, treatment and addressing the wound care issues were still in the process of investigation. R1 did go to the surgeon's office on 2/13/25 and the facility provided documentation that the wound was healing, and they were to continue with the wound vacuum and changing the wound vacuum 3 x a week. Upon exit, the facility did not provide any investigation into R1's wound care not being treated as ordered by the surgeon or any wound measurements or assessments completed by facility staff. During an interview with the Director of Nursing DON, Nursing Home Administrator (NHA) and Corporate Nurse (CN) J on 2/13/ 24 at 3:45 PM, they said they did not have any policy or set expectations for nurses to document and assess wounds or surgical wounds. CN J said when they do not have a policy, they use [NAME] (name of nursing procedure book). CN J. Printed the Surgical wound dressing application of [NAME] and gave it to this Surveyor stating that it did not cover any assessment requirements or details on assessment of surgical wounds. Review of that document on, page 10 revealed: Documentation associated with surgical wound dressing applications includes: date and time of the procedure, type of wound dressing procedure, amount of soiled dressing, any packing removed, wound appearance (size, condition of margins, presence of necrotic tissue, wound odor, type color consistency and amount of drainage (for each wound) include drainage on intake and output record, presence and location of drains, additional procedures performed irrigation, packing application of topical medication, type and amount of new dressing or pouch applied, any allergic reactions, date and time of practitioner notification, name of practitioner notification, name of practitioner notified, prescribed interventions. Response to those interventions, tolerance to procedure, detailed wound care instructions, detailed pain management steps, teaching provided to the patient and family. R2 Review of R2's face sheet dated, 2/12/25 revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: Multiple Sclerosis, osteomyelitis of vertebra, sacral and sacrococcygeal region, muscle weakness, and muscle spasm. R2 was her own responsible party. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2 was observed to have a dressing change on her coccyx on 2/12/25 at 10:30 AM by Registered Nurse (RN) F. R2's dressing did not have a date or any information on it that indicated when it was last changed. RN F did not measure the wound. RN F reported that she had changed R2's dressing multiple times and it was healing. RN F did not know where to locate wound measurements or documentation that would indicate the wound was healing or declining. During an interview with R2 on 2/13/25 at 11:15 AM, R2 was asked if the facility always the dressings and medication had needed to treat her coccyx wound and she said she did. When questioned why the facility was documenting they were not always doing the treatments R2 said she wants the treatments done between 10:00 and 11:00 AM and 10:00 PM and midnight so that her muscle spasm medication would be working. R2 said because of staffing the facility can not always keep these times and she does refuse when they can not stay on the schedule. Review of R2's Treatment Administration Record (TAR) for February 2025 revealed, coccyx wound care: Pack wound with Dakins 1/4 strength solution soaked kerlix, cove with ABD pad and tape. Every shift for wound care. Start date 12/6/24 and D/C (discontinue) 2/9/25. The number 2 was marked in the following boxes 2/1/25 day shift, 2/3/25 night shift, 2/4/25 night shift, 2/5/25 day shift, 2/7/25 night shift. Number 2 in a box indicated drug refused. Review of R2's medical record revealed no wound measurements being performed. During an interview with the DON and NHA on 2/13/25 at 3:15 PM the DON provided a timeline of R2's coccyx wound. The only wound measurement on the timeline was completed on 11/20/24 when the wound was noted to be a pressure ulcer it was 2 x 2 x 0.2. The timeline revealed R2 had surgery and returned from the hospital on 12/5/24 and the coccyx wound was now considered a surgical wound. The DON said pressure ulcers are followed weekly by a wound service, but they did not have any system in place to measure and monitor surgical wounds. The DON was not able to locate any facility assessments of R2's surgical wound since she returned from the hospital on 12/5/24. The timeline revealed that R2 returned to the wound clinic on 2/3/25 and shows we are doing a great job of keeping the wound clean and dry. The timeline indicated the resident was refusing care. The DON said the #2 on the TAR's were due to the resident refusing care. The DON said she was not aware of R2's requested times for care and did not have any documentation to show why R2 had been refusing care. The DON said she would follow up with R2 for preferred treatment times. The DON said they are working on a process to document and assess wounds. R3 Review of R3's face sheet dated, 2/13/25 revealed she was an [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: Alzheimer's disease and urinary infection. She was not her own responsible party. R3 was observed to have a dressing on her right elbow on 2/12/25 at 8:55 AM. No date on the dressing. R3 was not aware of what happened to her elbow or when the dressing was placed. Review of R3's admission skin assessment dated [DATE] at 9:36 AM revealed, Abrasion to right elbow knees. Bruise to left hand. No size or description of any of these abnormal findings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R3's comprehensive skin assessment dated [DATE] at 9:28 AM revealed, scattered bruising on RUE (right upper extremity), bilateral knees have open areas, open area on left elbow and bilateral heels soft. No description of size, color or drainage. On 2/13/25 at 2:36 PM, R3 was observed to have a dressing on her right elbow with no date and a dime size scab on her right knee and a quarter size scab on her left knee. Both scabbed areas were red on the boarder around the scabs. Certified Nurse Aide (CNA) K said she knew R3 was new to the facility. CNA K did not report the scabbed area's being red around the boarder and was not aware of when R3 would get the dressing changed on her right elbow. During an interview with Licensed Practical Nurse (LPN) L on 2/13/25 at 2:45 PM, LPN L did not know anything about R3's dressing on her right elbow or wounds on her knees. LPN L reviewed R3 orders and did not find any wound dressing orders. During an interview with Unit Manager (UM) M on 2/13/25 at 2:50 PM, UM M said R3 was admitted with the wound on her right elbow and both knees. UM M said the dressing was placed on R3's elbow after her shower yesterday and they have standing orders to do wound care. UM M said yesterday the scabbed areas on R3's knees were not red around the boarders, and she would need to review the standing orders to determine what treatment to use. UM M confirmed that the wound on the right elbow was open yesterday and removed the dressing on R3's right elbow at this time and the dressing was soiled showing it remained open it was approximately 1.5 inches long and 1/2 inch wide. UM M confirmed she did not implement any standing orders or treatment for R3's wound after she saw them on 2/12/25. UM M was not aware of any assessment process or record for recording the size or description of resident wounds. During an interview with the DON and NHA on 2/13/25 at 3:45 PM, they reviewed R3's medical record and confirmed that there was no description of R3's wounds on her right elbow or knees. They were able to locate an order that was placed on 2/13/25 at 15:03 (3:03 PM) for R3, Wound to right elbow: Cleanse with normal saline, pat dry. Apply xeroform gauze and bordered gauze. No wound measurements or description was located. No orders or description of the wounds on R3's knees were located.