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	04/23/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to MI00152071. Based on interview and record review, the facility failed to maintain complete and accurate medical records for 1 of 11 residents reviewed (R7). Findings include: A review of R7's admission Record, dated 4/18/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included an infection of the left knee prosthesis. A review of R7's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 1/11/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R7 was cognitively intact. During an interview on 4/17/25 at 10:45 a.m., R7 stated they were sent to the hospital via ambulance the morning of 1/11/25 because the night nurse had left their PICC line (peripherally inserted central catheter- a line inserted into a peripheral site (usually the upper arm) and extends into a large vein that leads into the heart) uncapped (i.e., no cap on the end of the line to prevent bacteria and other contaminants from entering the line and contaminating it) all night long. R7 stated they had to have a new PICC line put in and they spent four days in the hospital receiving antibiotics. A review of R7's Nurse's Notes, a late entry dated 1/12/25 for 1/11/25, revealed, Patient (R7) transported to [name of hospital] at 12:00 pm via partner. Patient cleaned out room of patients belongings stating patient would never be returning to [initials of facility]. Patient not agreeable to filling out leaving AMA (against medical advice) paperwork. Patient not sent with medications due to being transferred out to hospital as status . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	04/23/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A further review of R7's medical record failed to reveal the reason for R7's transfer to the hospital. In addition, R7's medical record failed to reveal whether they were transported via private vehicle (which could be inferred from R7's Nurse's Note where it indicated R7 transported to hospital via partner and Patient not agreeable to filling out leaving AMA paperwork) or via ambulance (which could be inferred from R7's Nurse's Note where it indicated R7 not sent with medications due to being transferred out to hospital as status and would suggest a facility to hospital transfer via ambulance). R7's medical record also failed to reveal whether any transfer paperwork was filled out and/or sent with R7 to the hospital. During an interview with the Nursing Home Administrator (NHA) on 4/17/25 at 2:00 p.m., the NHA was informed that the surveyor could not locate any information on the reason why R7 had been transferred to the hospital on 1/11/25. The NHA stated they would see if they could locate any additional documentation that would explain the reason why R7 went to the hospital on 1/11/25. The NHA stated they would provide copies of any documentation that they could locate to the surveyor. During a second interview with R7 on 4/18/25, they confirmed that the facility called an ambulance for them to go to the hospital on 1/11/25 and their partner did not drive them. R7 stated the facility sent a large envelope with papers inside (transfer paperwork?) with them to the hospital. A review of the Emergency Department Report, dated 1/12/25, revealed R7 arrived in the emergency department (ED) on 1/11/25 for a vascular access problem (a problem with their PICC line). R7 had been administered an antibiotic (cefepime) during the night through a right upper arm PICC line and when staff went to administer another antibiotic (vancomycin) that morning they noticed that the cap was missing. During a second interview on 4/18/25 at 4:00 p.m., the NHA stated R7 did go by ambulance to the hospital. The NHA also verified that the Nurse's Note, dated 1/12/25 for 1/11/25, did not indicate why R7 went to the hospital and was it confusing as to how they went. The NHA stated that they would expect to see a reason for R7 leaving, even if it was AMA. They stated since R7 arrived by ambulance to the hospital, they would have expected the nurse to fill out paperwork for a transfer and indicate the reason for the transfer. The NHA also verified that there was not any transfer paperwork in R7's medical record. They stated even if R7 had personally called the ambulance to go to the hospital they would still have expected the nurse to have documented the reason why R7 was leaving, what they did to try and convince R7 to wait or stay until they could notify the physician/provider, and that they called the physician provider to let them know R7 wanted to leave the facility. The NHA stated from the facility's end, it looked like R7 went to the hospital without a documented reason. The NHA stated because all they had was the Emergency Department Report (which they confirmed had not been in R7's medical record), they could only conclude that R7 went to the hospital because the PICC line was not capped for an extended period of time. The NHA stated they cannot prove otherwise.

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	04/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to MI00152071. Based on interview and record review, the facility failed to maintain appropriate infection control practices for 1 of 11 residents reviewed (R7) and for 1 of 3 facility units (Blue Neighborhood), potentially affecting 18 of 70 residents. Findings include: R7 A review of R7's admission Record, dated 4/18/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included an infection of the left knee prosthesis. A review of R7's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 1/11/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R7 was cognitively intact. During an interview on 4/17/25 at 10:45 a.m., R7 stated they were sent to the hospital via ambulance the morning of 1/11/25 because the night nurse had left their PICC line uncapped (i.e., no cap on the end of the line to prevent bacteria and other contaminants from entering the line and contaminating it) all night long. R7 stated they had to have a new PICC line put in and they spent four days in the hospital receiving antibiotics. A review of R7's Nurse's Notes, a late entry dated 1/12/25 for 1/11/25, revealed, Patient (R7) transported to [name of hospital] at 12:00 pm via partner . [Name of hospital] called at 6:00 pm with update, patient is being admitted to hospital for new PICC line (peripherally inserted central catheter- a line inserted into a peripheral site (usually the upper arm) and extends into a large vein that leads into the heart), new antibiotics and new treatment for knee. Manager on call and DON (Director of Nursing) notified . During an interview with the Nursing Home Administrator (NHA) on 4/17/25 at 2:00 p.m., the NHA was informed that the surveyor could not locate any information on the reason why R7 had been transferred to the hospital on 1/11/25. The NHA stated they would see if they could locate any additional documentation that would explain the reason why R7 went to the hospital on 1/11/25. The NHA stated they would provide copies of any documentation that they could locate to the surveyor. A review of the Emergency Department Report, dated 1/12/25, revealed R7 arrived in the emergency department (ED) on 1/11/25 for a vascular access problem (a problem with their PICC line). R7 had been administered an antibiotic (cefepime) during the night through a right upper arm PICC line and when staff went to administer another antibiotic (vancomycin) that morning they noticed that the cap was missing. R7 was unable to tell the ED staff how long the cap had been off the PICC line, but estimated it was around 10 hours. R7 did not have any systemic symptoms (e.g., fever, chills, sweats) or local symptoms (e.g., erythema streaking (red streaks on the skin) or swelling). The PICC line was removed and replaced with a new one in the emergency department. (continued on next page)

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	04/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a second interview on 4/18/25 at 4:00 p.m., the NHA stated R7's Nurse's Note, dated 1/12/25 for 1/11/25, did not indicate why R7 went to the hospital. The NHA stated that they would expect that the nurse would have documented the reason why R7 was transferred to the hospital. The NHA stated because they did not have any documentation in R7's medical record as to the reason for their transfer to the hospital and all they had was the Emergency Department Report (which they confirmed had not been in R7's medical record), they could only conclude that R7 went to the hospital because the PICC line was not capped for an extended period of time. A review of the Mayo Clinic's Peripherally inserted central catheter (PICC) line article, dated 6/6/23, revealed, A PICC line requires careful care and monitoring for complications, including infection and blood clots . PICC line complications can include: bleeding . blood clots, infection . A cap is placed over the end of the catheter to keep it free of germs and prevent infection Blue Neighborhood A review of a sign on the double doors leading onto the Blue Neighborhood unit revealed, As of 4/10/2025 Blue surgical masks are REQUIRED for staff. N95 masks are recommended when visiting residents with COVID+ Please assist with protecting the residents! During an observation on 4/23/25 at 1:25 p.m., Certified Nursing Assistant (CNA) V was observed at the nurse's station (which was centrally located on the unit) wearing a blue surgical mask that was positioned below their nose. CNA V spoke with the surveyor for approximately five minutes and continued to wear their mask below their nose. During an observation on 4/23/25 at 1:50 p.m., CNA V was observed walking down the hall on the Blue Neighborhood unit with Housekeeper (HSK) W. CNA V was observed wearing a blue surgical mask that was positioned below their nose. HSK W was observed not wearing a surgical mask or an N95 respirator (mask). During an interview on 4/23/25 at 3:35 p.m., the Director of Nursing (DON) stated the facility had one resident left in the facility with COVID on the Blue Neighborhood unit. The DON stated all staff are required to wear surgical masks on the Blue Neighborhood unit. A review of the Centers for Disease Control and Prevention (CDC) Transmission-Based Precautions information page, dated 4/3/24, revealed, Use Droplets Precautions for patients (residents) known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking . Use personal protective equipment (PPE) appropriately. [NAME] mask upon entry into the patient room or patient space . (https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html) A review of the CDC's Use of Personal Protective Equipment (PPE) When Caring for Patients with Conformed or Suspected COVID-19 education poster, dated 6/3/20, revealed, Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients. (http://www.cdc.gov/coronavirus)