

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2025
NAME OF PROVIDER OR SUPPLIER Heartwood Lodge Trinity Health		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat one of three residents (Resident #8) with dignity. Findings: Resident #8 (R8) Review of an admission Record revealed R8 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses of dementia. During an observation on 8/22/25 at 8:57 AM, R8 sat at the dining table in the common area of the yellow unit eating breakfast. R8 asked Certified Nurse Aide (CNA) G to warm up his eggs, they are ice cold. CNA G responded to him and told R8 that the microwave was broken. CNA G then turned and left the area. R8 did not finish his breakfast. During an interview on 8/22/25 at 9:15 AM, Dietary Manager (DM) O stated that there was a working microwave in the kitchen. During an interview on 8/26/25 at 9:10 AM, R8 recalled the incident on 8/22/25 (when his eggs were cold and he asked the aide to warm them up) and stated that CNA G sometimes did not help him. During an interview on 8/26/25 at 10:00 AM, the Administrator indicated that CNA G 's interaction with R8 on 8-22-25 was not acceptable and not how staff were expected to treat residents.</p>		

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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