

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 6/10/2025
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NAME OF PROVIDER OR SUPPLIER HEARTWOOD LODGE TRINITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 18525 WOODLAND RIDGE DRIVE SPRING LAKE, MI 49456
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E0000 SS=	Initial Comments On June 10, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Heartwood Lodge, Trinity Health was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0006 SS= F	Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events	E0006	Element 1- Upon identification of the finding, the Nursing Home Administrator reached out to its corporate organization to verify support in the event of a catastrophic event. This support was confirmed by the Vice President of Operations. Concurrently, the assistance of our Regional Environmental Services Coordinator was provided to assist Heartwood Lodge- Trinity Health in the construction of a comprehensive and compliant Hazard Vulnerability Assessment (HVA). Element 2- The Emergency Preparedness Plan including the HVA will be constructed to include a scoring methodology based on the percentage and probability of each identified emergency event occurring within the facility's specific context on or before July 10th, 2025 Element 3- The HVA will be revised to be entirely site-specific, incorporating unique aspects of the facility's layout, patient population, services provided, and surrounding environment. The Nursing Home Administrator, Environmental Services Director, and Director of Nursing will be reviewing and updating the Emergency Preparedness Plan and Hazard Vulnerability Assessment as required to maintain compliance on or before July 10th, 2025. Any identified issues will trigger retraining and/or	7/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/06/2025

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.

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	<p>identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to maintain an Emergency Preparedness plan that must be reviewed and updated annually and be based on and include a documented, facility-based and community based risk assessment, utilizing an all-hazards approach, including missing residents, and include strategies for addressing emergency events identified by the risk assessment. This deficient practice could potentially affect all occupants and staff in the event of an area disaster.</p>		<p>corrective action.</p> <p>Element 4- The QAPI Committee will be reviewing and updating Emergency preparedness plan and hazard vulnerability assessment annually with a reminder recurrence online work order that occurs the first Monday of January.</p> <p>Element 5- The Nursing Home Administrator is responsible for maintaining compliance.</p>	

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E0025 SS= F	<p>Findings Include:</p> <p>On June 10, 2025 between 12:30 PM and 2:30 PM, review of the facility emergency preparedness plan hazard vulnerability assessment revealed the assessment was not scored based on percentage and probability of the facility listed emergency events occurring. The plan was not updated and overall was not site specific to the facility. This finding was confirmed by interview with the facility Maintenance Director and Administrator at the time of observation.</p> <p>Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184.(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at</p>	E0025	<p>Element 1- A comprehensive review of the current emergency preparedness plan was initiated to identify all missing or incomplete documentation related to agreements with other facilities for patient transfer, shelter-in-place, or other mutual aid scenarios. Upon identification of the finding, the Nursing Home Administrator reached out to its corporate organization to verify support. This support was confirmed by the Vice President of Operations and a list of all skilled nursing facilities, EMS providers and transportation resources owned and operated by Trinity Health was provided.</p> <p>Element 2- Heartwood Lodge entered into an agreement "Multi Organization Agreement" with Region 6 Healthcare Coalition on June 30th, 2025. Heartwood Lodge procured an additional agreement with a local skilled nursing facility, Christian Care Nursing Center on June 30th, 2025. Emergency transportation for Heartwood Lodge was confirmed through Region 6 MOU, multiple company owned buses, and additionally our Trinity Health (ProMed) ambulance service. The Emergency Preparedness Plan will be updated to reflect these implementations on</p>	7/10/2025

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	<p>§483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHC patients. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to develop arrangements with other Long Term Care (LTC) facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. This deficient practice could potentially affect all occupants and staff in the event of a facility wide emergency requiring evacuation of residents to other facilities.</p> <p>Findings Include:</p> <p>On June 10, 2025 between 12:30 PM and 2:30 PM, review of the facility emergency preparedness plan revealed the facility failed to provide documentation of arrangement with other facilities. This finding was confirmed by interview with the facility Maintenance Director and Administrator at the time of observation.</p>		<p>or before July 10th, 2025. Element 3- The Environmental Services Director and the Nursing Home Administrator will be educated on the requirement to develop arrangements with other Long Term Care (LTC) facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients on or before June 10th, 2025 Element 4- The QAPI Committee will be tasked with reviewing the updated risk assessments and emergency preparedness plan quarterly x3 to ensure ongoing relevance and effectiveness until substantial compliance has been determined by the QAPI Committee. Any identified issues will trigger retraining and/or corrective action. Element 5- The Nursing Home Administrator is responsible for maintaining compliance.</p>	

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K0000 SS=	<p>INITIAL COMMENTS</p> <p>On June 10, 2025, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Heartwood Lodge Trinity Health was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 482.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code.</p> <p>The facility is a single story building of type V (111) construction, built in 2006. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors.</p> <p>The facility has 84 certified beds. At the time of the survey the census was 74.</p>	K0000			

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K0211 SS= E	<p>Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure aisles, passageways, corridors, exit discharges, exit locations and accesses are in accordance with Chapter 7. This deficient practice could potentially affect 18 occupants within the smoke compartment in the event of a fire emergency and evacuation.</p> <p>Findings Include:</p> <p>1. On June 10, 2025 at approximately 9:35 AM, observation revealed isolation carts stored in the corridor outside residents rooms 121 and 122 located at 100 hall without wheels attached. This finding was confirmed by interview with facility Maintenance #1 and #2 at the time of observation. As required by 7.1.10.1</p> <p>2. On June 10, 2025 at approximately 10:10 AM, observation revealed isolation carts without wheels attached stored in the corridor outside of residents room 213 located at 200 hall.</p>	K0211	<p>Element 1- Environmental service staff removed all isolation carts without wheels stored in the corridor outside resident rooms 121 and 122 located at 100 hall and isolation carts without wheels stored in the corridor outside resident room 213 located at 200 hall with isolation carts with wheels to meet Means of Egress compliance.</p> <p>Element 2- The Environmental Services Director or designee inspected all remaining isolation carts to ensure compliance with Means of Egress</p> <p>Element 3- Environmental Services Director or designee will complete monthly inspections on aisles, passageways, corridors, and exit locations for isolation carts being stored without wheels for 3 months to ensure compliance with NFPA 101 Chapter 7.</p> <p>Element 4- The Environmental Services Director or designee will report audit findings to the Quality Assurance / Performance Improvement (QAPI) Committee quarterly x 3 with further monitoring per QAPI recommendations. Any identified issues will trigger retraining and/or corrective action.</p> <p>Element 5- The Nursing Home Administrator is responsible for maintaining compliance.</p>	7/10/2025

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K0223 SS= E	<p>Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area are self-closing and kept in the closed position unless held open in accordance with 7.2.1.8.2. This deficient practice could potentially affect 16 occupants within the smoke compartment in the event the doors fail to close and latch to prevent the passage of smoke into the resident corridor at the time of a fire.</p> <p>Findings Include:</p> <p>On June 10, 2025 at approximately 10:06 AM, observation revealed the doors on the clean linen closet located at 200 hall near room 216 were observed to be open and failed to close to a positive latch upon testing. This finding was confirmed by interview with the facility Maintenance #1 and #2 at the time of observation. As required by 7.2.1.8.2</p>	K0223	<p>Element 1- Upon identification environmental services staff repaired latch to the clean linen closet located at the 200 hall near room 216. This latch now closes "per positive latch" as required.</p> <p>Element 2- Environmental Services Director Designee inspected all other clean linen closet doors to assure compliance.</p> <p>Element 3- The Environmental Services Director /designee will complete monthly audits for 3 months of auto latching doors to ensure compliance in accordance with NFPA 101 7.2.1.8.2.</p> <p>Element 4- The Environmental Services Director /designee will report audit findings to the Quality Assurance / Performance Improvement (QAPI) Committee quarterly x 3 with further monitoring per QAPI recommendations. Any identified issues will trigger retraining and/or corrective action.</p> <p>Element 5- The Nursing Home Administrator is responsible for maintaining compliance.</p>	7/10/2025

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K0324 SS= E	<p>Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure cooking facilities are protected in accordance with NFPA 96 and 17A. This deficient practice could potentially affect kitchen staff and occupants in the nearest smoke compartment event of a fire emergency within the kitchen hood as a result of delayed or missed service checks on the kitchen hood suppression systems.</p> <p>Findings Include:</p> <p>On June 10, 2025 between 12:30 PM and 2:30 PM, record review revealed there was a 11 month time period between service inspections on the kitchen hood fire suppression system. The reports</p>	K0324	<p>Element 1- Environmental Services Director was able to locate the inspection report from Summit Fire Protection conducted on 6/28/24 to comply with semi-annual kitchen hood fire suppression inspections with the reviewed indicated dates of 1/2/24 and 12/2/24.</p> <p>Element 2- Environmental Services Director placed inspection report for the semi-annual kitchen hood suppression system with other inspection reports to verify compliance.</p> <p>Element 3- - Environmental Services Director or designee will audit report documentation annually and follow up on inspection reports from outside vendors with a recurring work order to ensure compliance with NFPA 96.</p> <p>Element 4- The Environmental Services Director or designee will report audit findings to the Quality Assurance Performance Improvement (QAPI) Committee annually with further monitoring per QAPI recommendations. Any identified issues will trigger retraining and/or corrective action.</p> <p>Element 5- The Nursing Home Administrator is responsible for maintaining compliance.</p>	7/10/2025	

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K0920 SS= E	<p>reviewed indicated dates of 1/2/24 and 12/2/24 by two different vendors. Hood fire suppression services inspections are required semi-annually. This finding was confirmed by interview with the facility Maintenance #1 and #2 at the time of observation. As required by NFPA 17 A 7.3.3</p> <p>Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure power strips are in compliance with NFPA 99 and NFPA 70. This deficient practice could potentially affect 16 occupants within the smoke compartment in the event of an</p>	K0920	<p>Element 1- Upon identification environmental services removed the extension cords that were in use in resident room 218 located at 200 hall the time of observation. The residents were educated on the safety risk and acknowledged compliance.</p> <p>Element 2- The Environmental Services Director inspected all resident rooms to ensure no other deficiencies concerning extension cords existed.</p> <p>Element 3- The Maintenance Director/designee will complete monthly audits for 2 months for extension cords to ensure compliance with NFPA 70 400.8.1.</p> <p>Element 4- Any trends will be reported to the Administrator monthly by the Environmental Services Director /designee. The Environmental Services Director or designee will report audit findings to the Quality Assurance Performance Improvement (QAPI) Committee quarterly for monitoring per QAPI recommendations.</p> <p>Element 5- The Nursing Home Administrator is responsible for maintaining compliance.</p>	7/10/2025

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	<p>electrical fire as a result of the use of unauthorized electrical cords.</p> <p>Findings Include:</p> <p>On June 10, 2025 at approximately 10:08 AM, observation revealed an extension cord in use in residents room 218 located at 200 hall. This finding was confirmed by interview with facility Maintenance #1 and #2 at the time of observation. As required by NFPA 70 400.8.1</p>			