STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235179	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Park Village	2525 7th Avenue South Escanaba, MI 49829

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety, resulting in the potential to spread food borne illness among all residents that consume food from the kitchen. Findings include:On 12/03/2025 at 3:20 PM, during a kitchen tour with the Dietary Manager (J), observed greyish white powdery mildew on the ceiling of the dish machine room around an electrical junction box, as well as some peeling paint in this same area. Powdery mildew was also noted in the upper corners of the room on either side of the dish machine ventilation hood system. According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. On 12/04/2025 at 8:30 AM, during a tour of the separate 'sister' facility that acts as the commissary for meal service and food preparation, observed that the vegetable prep sink drain line extends down below the lip of the floor bowl, with the drain line not having a proper air gap. On 12/04/2025 at 8:47 AM, during a tour of the separate 'sister' facility that acts as the commissary for meal service and food preparation, observed the drain line from the third compartment of the three-compartment sink extends down into the floor bowl drain. The lower part of the drain line and the bowl drain were also noted as being soiled with food debris. On 12/04/2025 at 10:45 AM, these observations were confirmed during interview with Maintenance Director (I) during a tour of the separate 'sister' facility kitchen. On 12/04/2025 at 10:50 AM, during a tour of the kitchen and dining room at the separate 'sister' facility that acts as the commissary for meal service and food preparation, observed the drain line coming from the dining room ice machine extended down into the floor bowl drain, not being properly air gapped. According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in ¶¶ (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. Findings include: Review of facility document titled Cooling Down Foods Temperature Log revealed that on 10/17/25, a start time and temperature of 118 degrees at 6:30 was recorded for lasagna. Two hours later the (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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature was recorded at 85 degrees. Further review of the document revealed that If food is more than 70 degrees at 2 hours, reheat to 165 degrees and start over (the cooling process) or discard. During an interview on 12/2/25 at 12:15 p.m., Dietary Manager J was queried regarding what the facility does with food that is above 70 degrees after two hours. Dietary Manager J reported the facility uses the food as a supplemental food item the next day. Review of policy titled Food Safety last revised 1/9/25, read in part .Foods will be rapidly cooled from 135 degrees F (Fahrenheit) to 70 degrees F in 2 hours. During an observation on 12/2/25 at approximately 12:25 p.m., the revealed green colored mildew on the ceiling at the entrance of the dishwashing area in the kitchen. Review of emergency food storage facility on 12/2/25 at approximately 12:35 p.m., revealed the following: - 1 large box of toasted oats cereal with a received day of 1/7/25 and a discard date of 11/19/25 - 2 cans of corned beef hash with a use by date of 11/25 - 4 large cans of three bean salad that were taken out of the original box with no received date, expiration date, or use by date on the cans During an interview on 12/2/25 at approximately 12:40 p.m., Dietary Manager J reported the staff sometimes forgets about rotating out the emergency food so that it is used before the expiration date. Review of policy titled Food Purchasing and Storage last revised 12/1024, read in part .It is the policy of this facility to receive, store, and efficiently issue foods.The stock date will be rotated when stored. All food items will be dated with the in date (or delivery date) .canned goods and other products will be stocked using the first in first out (FIFO) method.which ensures that older items are used first.

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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 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. Based on observation, interview, and record review, the facility failed to assess and document the wounds of one Resident (R53) of three residents reviewed for wounds. Findings include:On 12/2/25 at 2:22 PM, Resident #53 (R53) was observed lying in a medical reclining chair in his room with his eyes closed and his spouse at the bedside. R53's wife said, He's getting sores on his feet. I'm worried about it. He has such bad circulation - he's even had to have some toes amputated. According to the electronic medical record (EMR), R53 was admitted to the facility 3/4/25 with diagnoses including but not limited to Alzheimer's Disease and peripheral vascular disease (a progressive disorder of narrowed or blocked blood vessels that affects blood flow primarily to the legs and feet).A Minimum Data Set (MDS) assessment for significant change in status dated 11/20/25 documented R53 had a Brief Interview for Mental Status (BIMS) score of 00 indicating R53 had severe cognitive impairment. The MDS coded R53 as being dependent on staff for activities of daily living (ADL). The MDS documented R53 did not have pressure, venous, or arterial ulcerations.Past wound documentation in the EMR documented R53 had a facility-acquired venous ulcer on the dorsal portion (upper surface) of the right foot that developed 4/10/25. The ulcer was documented as healed on 10/21/25.The care plans for R53 did not contain a plan of care for actual skin breakdown or wounds on R53's feet.Further review of the EMR revealed a current physician's order dated 12/4/25 that read: Right foot, 4th digit, cleanse with normal saline, pat dry, cover with 2X2 border gauze every day shift. Physician's orders for R53 also included an active order dated 11/14/25 that read: Left foot between great toe and 2nd digit place 2x2 border dressing over 2nd toe for protection every day shift every other day. A review of order history disclosed an order written 11/15/25 and discontinued 12/3/25 that read: Right foot, 2nd digit, cleanse with normal saline, pat dry, cover with 2x2 border gauze every day shift.The EMR of R53 contained a hospice document dated 11/20/25 that read, in part: .CLEANSE WOUND TO TOES, 2ND DIGIT OF LEFT FOOT, 4TH DIGIT OF RIGHT FOOT, THREE TIMES WEEKLY, IRRIGATE USING NORMAL SALINE. USING ASEPTIC TECHNIQUE, APPLY GAUZE BANDAGE. FACILITY STAFF WILL PERFORM WOUND CARE COORDINATED PLAN OF CARE [sic].A Hospice Certification and Plan of Care document signed by two RN's, dated as completed 11/14/25 and signed by the attending physician on 11/19/25 documented, in part: .CLEANSE WOUND TO BILATERAL FEET, THREE TIMES WEEKLY, IRRIGATE USING SALINE, ASEPTIC TECHNIQUE, APPLY GUAZE BANDAGE. FACILITY STAFF WILL PERFORM WOUND CARE ACCORDING TO COORDINATED PLAN OF CARE [sic]. There were no documented assessments of wounds to R53's feet found in the EMR. On 12/4/25 at approximately 9:45 AM, the Director of Nursing (DON) was asked to provide all wound documentation for R53 from 10/1/25 through 12/4/25. On 12/4/25 at 10:26 AM, four documents Skin & Wound Evaluation V7.0 were provided. All four documents contained weekly assessments of the previous venous ulcer of the right dorsal foot that healed on 10/21/25.On 12/4/25 at approximately 10:50 AM, the DON was asked for any additional wound documentation for R53. The DON confirmed the four documents for the healed venous wound on the right dorsal foot that had been provided were all the wound documents R53 had for the time frame 10/1/25 through 12/4/25. On 12/4/25 at 10:56 AM, Registered Nurse (RN) E confirmed she was the facility's wound and treatment nurse. RN E was queried regarding the wounds on R53's feet. RN E said, [R53] doesn't have any wounds on his feet - he only has a skin tear. RN E was asked to assess R53's bilateral feet in the presence of the surveyor.RN E, accompanied by the Assistant Director of Nursing (ADON), removed the sock on R53's right foot. The first, second, and third toes of the right foot were observed to be absent. A bandage covered the right fourth toe. When asked about the bandage on the fourth toe, RN E said, This is just preventative. After being asked to see the toe by the surveyor, RN E removed the bandage to reveal a circular, brownish-black wound on the dorsal fourth toe with a scant amount of clear drainage. RN E said, Oh! He does have a wound. When asked when the wound on the right fourth toe was initially identified, RN E said she did not know. RN E said she would review the orders, and she exited to the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room to obtain dressing supplies. The ADON was asked when the wound was initially identified. The ADON said, I'm not familiar with the wounds.RN E returned to the room and measured the wound on R53's right fourth toe as 0.3 cm (centimeters) x (by) 0.3 cm (length and width, respectively). RN E was asked by the surveyor to assess between the fourth and fifth toes of the right foot. RN E spread the right fourth and fifth toes and said, Oh, there is another one. A linear, brownish-black wound with a scant amount of drainage was evident on the inner proximal fifth toe. RN E was asked when the wound on the right fifth toe developed. She said, That must be a new one. I don't even think there's a treatment for it. The ADON shrugged her shoulder when asked when the right fifth toe wound developed. RN E measured the wound on the fifth toes at 0.6 cm X 0.2 cm.RN E removed the sock from R53's left foot. All five toes were noted to be present. A bandage was located between the first and second toes of the left foot. RN E removed the bandage to reveal a moderately-draining, brownish colored linear wound on the inner second toe. An unbandaged dark, crescent-shaped wound was also observed on the fifth toe near the base of the toenail. RN E was asked when the wounds on the left toes developed. RN E said, I'm not sure. There is an order for this one [indicated the left second toe wound]. These developed sometime within the last three months. RN E measured the wound on the second toe at 0.2 cm x 0.4 cm. The wound on the fifth toe was measured at 0.1 cm x 0.4 cm.RN E was interviewed on 12/4/25 at 12:04 PM. RN E said she had been off work on a scheduled leave and only recently returned to work. When asked if any of the current wounds on R53's bilateral feet had documented assessments, RN E said, I don't think so - not if they're [assessments] not in the chart [EMR]. RN E said wounds are expected to be assessed and documented upon identification, then every 7 days thereafter. RN E said photographs are usually included in the wound assessments and said she didn't think photographs were taken of wounds while she had been on scheduled leave.The policy Skin Management dated as last revised 8/14/2024 documented, in part: . Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes. Practice Guidelines: .5. The licensed nurse will initiate documentation in the electronic health record [EMR], which includes a description of skin impairment as follows: ˆ In Electronic Health record facilities, the licensed nurse will document on the skin and wound evaluation for pressure injury and vascular ulcers. ˆ Document weekly until the area is resolved. ˆ Photos may be taken of pressure injury and vascular ulcers. 9. The licensed nurse will monitor, evaluate and document changes regarding skin condition (to include: dressing, surrounding skin, possible complications and pain) in the medical record.13. Residents with pressure injury and lower extremity ulcers will be evaluated, measured and staged weekly (pressure injury and vascular ulcers only) in accordance with the practice guidelines until resolved. A photo may be initiated unless the resident refuses.