STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235244	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Park Health Care Center	2415 5th Ave 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981 This citation pertains to intake #MI00150692 Based on observation, interview, and record review, the facility failed to treat a resident with dignity and respect and failed to provide an environment that promoted and enhanced resident quality of life and individuality for 1 Resident (#1) of 4 residents reviewed for dignity and resident rights, resulting in R1 having increased anxiety, and feelings of frustration. Findings include: Resident #1 (R1) Review of an Admission Record for R1 revealed an original admission to the facility on [DATE] with diagnoses including paraplegia. Review of a Minimum Data Set (MDS) assessment for R1, with an assessment reference date (ARD) of 2/6/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15, indicating R1 was cognitively intact. Section D Mood of the assessment revealed R1 was Feeling down, depressed, or hopeless. for 2-6 days during the seven day look back period. Section E Behavior revealed no significant behaviors. Review of R1's Kardex (CNA care guide) revealed (R1) was unable to use his power wheelchair in the facility due to safety concerns and disregard for others as he will not listen to staff r/t (related to) w/c (wheelchair) speed. He (R1) transfers into the power wheelchair in the front lobby prior to leaving the facility. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 1:45 PM., an interview was conducted with Certified Nurse Aide (CNA) B who reported R1 has been upset lately, and has expressed his feelings about how certain management staff have treated him. R1 has been feeling disrespected because management has not honored his choices and rights. CNA B reported he recently had a care conference meeting where he told the former Nursing Home Administrator (NHA) he did not want the Director of Nursing (DON) present in the meeting. CNA B reported R1 told them, the DON was in the meeting and the former NHA said to him this is my building, my name is on the wall, I make the rules, and she (DON) will attend because I make the rules CNA B reported R1 has been very bothered by this, and feared anything he does will be considered grounds to have him discharged from the facility. CNA B reported R1 was a pleasant resident, who was younger than most residents, and had paraplegia (paralyzed from the waist down). CNA B indicated R1 was of sound mind. On 5/6/25 at 2:00 PM., an interview was conducted with R1 who reported he suffers from anxiety and indicated the way the former NHA and DON treated him, made it feel even worse. R1 reported he made a mistake and bumped into a resident in the past with his electric wheelchair over a year ago, and has since not been able to have it back. R1 reported other residents have theirs. R1 reported he feels targeted and bullied, the former NHA would not listen to him when he told her and the current DON he did not want the DON to attend his recent Care Conference meeting. R1 reported the DON did attend, and the former NHA said to him 'I run this building, I make the rules and you will follow them, and I said I want her (DON) there, so she will be at the meeting'. R1 reported he felt threatened, scared and targeted. R1 reported he is not perfect, but other residents hit one another, yell all the time, go into other resident rooms and other things and they are not treated the way he is treated. R1 reported he feels unworthy, and does want to move out of the facility because he has friends and family close that he can visit, and get to with his electric wheelchair. R1 reported he was sorry about the accident, but feels he shouldn't have pay for it forever, and have it held over his head as if he ran into the resident on purpose. R1 reported he fears speaking with this surveyor, but also has a sense of relief and has hope that the new NHA and DON can work towards a better relationship, and build trust up. R1 reported he doesn't feel like they (former NHA/DON) treated him fairly. R1 reported he has not spoken with the new NHA because he didn't want to have (former NHA/DON) speak about him. R1 reported, I just don't want her to be biased. R1 reported he has a great relationship with the staff in the facility and many try to advocate for him. Review of R1's Care Plans Revealed: Focus-(R1) is unable to use his power wheelchair in the facility due to safety concerns and disregard for others as he will not listen to staff r/t w/c speed. He transfers into the power wheelchair in the front lobby prior to leaving the facility. Date initiated 9/22/22 with a revision date of 8/28/23 . Interventions noted on the care plan revealed the most recent updated intervention: Remind resident (R1) of the facility's policy on leaving the property and risks of not following it. Date Initiated: 08/28/2023 . Review of R1's Care Plans Revealed: Focus-(R1) is at risk for safety concerns r/t he frequently leaves off site and smokes while he is off site. (R1) is non-compliant with the facility's policy on signing out when leaving the property. Per (R1) I will sign out in the a.m. and when I decide to go to bed. He will come and go throughout the day and not notify staff. Date Initiated: 09/22/2022 Created by: DON Revision on: 08/28/2023 . Interventions noted on the care plan revealed the most recent updated interventions: If the resident wishes to smoke the facility will assist them to find other placement to meet their needs. Date Initiated: 05/31/2024 . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Care Plans Revealed: Focus-(R1) has experienced trauma related to his disease process. Current diagnosis include Hereditary Spastic Paraplegia and Major Depressive Disorder. In the far past, resident had thoughts of harming himself and thinking he would be better off dead. He has not verbalized these thoughts since he has lived at (the facility). Trauma may be expressed by: -irritability, -fear, -anxiety, -loss of interest, -loneliness, -insomnia, Date Initiated: 04/20/2023 . Interventions noted on the care plan revealed the most recent updated interventions: Establish and maintain a trusting relationship date initiated 4/20/23, Maintain a calm non-threatening relationship by listening to (R1) .date initiated 4/20/23. On 5/6/25 at 3:10 PM., an interview was conducted with Registered Nurse (RN) F, who reported R1 has been through a lot. RN F reported currently R1 was unable to use his electric wheelchair in the facility because one time, well over a year ago he bumped another resident in the heel. RN F reported there was no injury to the resident, and R1 felt very bad about it. RN F reported, at the time the former NHA took his right to have his electric wheelchair near him, or in use throughout the facility. RN F reported no education to her knowledge was provided to him, or staff about it after the incident. RN F reported R1 has not receive a second chance and he has expressed that management keeps telling him No, he cannot be trusted with it. RN F reported R1 has expressed frustrations and feelings of being targeted because of that incident, his TV was recently off-line and he mentioned it to everyone, staff mentioned it to management and the Local Ombudsman was involved. RN F reported the former NHA did not do anything to remedy that situation, and it wasn't until R1 refused to pay money that the TV situation was fixed. RN F stated R1 really likes his certain TV programs, especially at night. RN F reported R1 goes out in the community on his own and visits family members he has in the community. RN F reported she thinks at certain times the previous NHA's approach towards R1 has been less than professional. RN F reported the former NHA and R1 did not get along at all, and R1 has had bad experiences with previous NHA's that the facility has had. RN F reported R1 has told her how he feels. When asked if RN F had documented this information, RN F reported she had not documented this in his progress notes, or filled out concern/grievance forms when R1 has expressed how he was feeling. RN F reported she also has not communicated this to the social worker or management. RN F reported she just thought it was common knowledge for everyone, because R1 speaks up and advocates for himself RN F reported R1 was a very sweet guy who doesn't really have any behaviors, and he has not been problematic. On 5/6/25 at 4:00 PM., an interview was conducted with CNA C who reported R1 often expresses his feelings about fear of being discharged and feels he is being targeted. CNA C reported R1 was upset that other residents can have their electric wheelchairs in the facility and because he had one accident his was taken away. CNA C reported R1 feels ignored, and it's painful for him to go back and forth from his regular wheelchair to the electric one when he goes outside to smoke. CNA C reported R1 was a paraplegic, but doesn't let that limit him. CNA C reported R1 goes out in the community almost daily, he goes shopping, uses the city bus, and visits friends and family. CNA C reported the former NHA made him put a huge orange flag on the back of his electric wheelchair for safety reasons, despite him not wanting it on there. CNA C reported R1 told her that he didn't want the flag but felt pressured into having it placed, because of the way the former NHA spoke to him, and how he felt if he said no, he would be in trouble. CNA C reported recently R1 had a care conference meeting and he expressed to the former NHA, the DON and staff numerous times, he did not want the DON present in the meeting. CNA C reported the DON attended the meeting regardless of his rights and choices. CNA C reported R1 has been extremely upset, and felt his rights were violated. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 4:30 PM., an interview was conducted with the facility Ombudsman (Omb) H who reported she has met with facility management including the former NHA and current DON. Omb H reported R1 often expresses frustration and feelings of fear/anxiety of being thrown out because one time he accidentally bumped into another resident with his electric wheelchair, and the fact the facility is a non-smoking campus but allow staff to smoke out front in their cars despite their own policy upsets him because he has to transfer in and out of his electric wheelchair just to go smoke and it can be painful. Omb H reported at R1's recent Care Conference meeting R1 requested to the NHA at the time the he did not want DON to attend the meeting. Omb H reported the former NHA did not care, nor did she follow the regulations on resident rights, dignity and/or their own policy. Omb H reported DON attended the meeting despite R1 expressing his feelings and his rights. Omb H reported there have been ongoing issues between management and R1, and it is unfortunate because R1 is always pleasant, does not exhibit behaviors that staff or management have expressed to her, besides at times he forgets to sign in and out when he leaves the facility. Omb H acknowledged there are safety concerns with R1's electric wheelchair and the fact that he did bump into another resident. Omb H reported that happened once, he has not been given another chance, and his rights have been violated. Omb H reported the former NHA bullied him into agreeing to have a large orange flag placed on his wheelchair for safety, despite the fact he said he didn't want it on there. Omb H reported the former NHA said she almost ran into him in the facility parking lot, Omb H responded to the former NHA with well how fast are you going in the parking lot, you know residents are outside in their wheelchairs, it is your facility . Omb H reported R1 is a younger resident, he has different needs than other residents. Omb H reported the facilities have Facility Reported Incidents (FRI's) for falls, accidents, allegations of abuse, as well as resident to resident abuse situations, and those residents are not treated any differently when these unsafe situations arise, why would it be any different for R1 who accidentally bumped into another resident, this does not mean his rights should be taken away, his electric wheelchair should be restricted, and flagged. On 5/6/25 at 5:30 PM., an interview was conducted with Director of Nursing (DON) who reported R1 was upset that his electric wheelchair had been taken away from him about a year ago. The DON reported he had run into another residents heel, no major injury was noted, but the resident had some pain following the incident. The DON reported at that time it was unwitnessed,and other residents reported it the following day or so, and when asked R1 openly admitted to bumping into the resident. The DON reported R1 did not deny the incident happened. The DON reported the electric wheelchair was taken away from him at that point. The DON reported he has not been given the chance to have it back, but he does get transferred into the electric wheelchair in the lobby when he wants to go outside to smoke or go out for the day. The DON reported recently he had a care conference and requested to the former NHA that he did not want me (The DON) present. The DON reported she did attend the care conference despite the fact R1 requested she not attend because the former NHA instructed her to attend the meeting. When asked if the DON advocated for R1's rights, The DON reported no, she did not, and attended the care conference regardless of R1 wishes, and rights. Review of a facility Policy with a revision date of 3/12/25 revealed: Resident Dignity & Personal Privacy Policy: The facility provides care for residents in a manner that respects and enhances each resident's dignity, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individuality, and right to personal privacy. Information Each resident's right to personal privacy includes the confidentiality of his or her personal and clinical affairs. Dignity means that when interacting with residents, staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth. Procedure 1. Care for residents in a manner that maintains dignity and individuality: a. Call individuals by their preferred name b. Use adult terms o Avoid terms commonly used with children - diaper rash, bibs, etc. c. Knock on doors before entering; ask for permission to enter and announce your presence d. Roll wheelchairs/geri-chairs in a forward direction e. Include the resident in conversation f. Dress in appropriate and desired clothing g. Groom appropriately and to resident's desire h. Maintain radio and television on desired setting. Do not change settings without resident's permission . Review of a facility Policy with a revision date of 5/14/24 revealed: Resident Rights Policy: The facility protects and promotes the rights of each resident. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outside the facility. The facility staff will safeguard the privacy of resident's protected health information from improper use and disclosure and will inform the resident both orally and in writing of his or her rights as a resident, as well as the rules and regulations governing the resident's conduct and responsibilities during his or her stay in the facility. Facility staff will assist residents in exercising their rights. Facility staff will not hamper, compel by force, treat differently, or retaliate against a resident for exercising his or her rights. Information: Residents have freedom of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules and regulations affecting resident conduct and those regulations governing the protection of resident health and safety All residents in long term care facilities have rights guaranteed to them under Federal and State law. Requirements concerning resident rights are specified in SS483.10, 483.12, and 483.15. Section 483.10 is intended to lay the foundation for the remaining residents' rights requirements which cover more specific areas. These rights include the resident's right to: o Exercise his or her rights; o Be informed about what rights and responsibilities he or she has); o If he or she wishes, have the facility manage his personal funds. o Choose a physician and treatment and participate in decisions and care planning; o Privacy and confidentiality; o Voice grievances and have the facility respond to those grievances; o Examine survey results; o Work or not work; o Privacy in sending and receiving mail; o Visit and be visited by others from outside the facility; o Use a telephone in privacy; o Retain and use personal possessions to the maximum extent that space and safety permit; o Share a room with a spouse, if that is mutually agreeable; o Self-administer medication, if the interdisciplinary care planning team determines it is safe; and o Refuse a transfer from a distinct part, within the institution. o Choose a physician and treatment and participate in decisions and care planning; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Privacy and confidentiality; o Voice grievances and have the facility respond to those grievances; o Examine survey results; o Work or not work; o Privacy in sending and receiving mail; o Visit and be visited by others from outside the facility; o Use a telephone in privacy; o Retain and use personal possessions to the maximum extent that space and safety permit; o Share a room with a spouse, if that is mutually agreeable. o Self-administer medication, if the interdisciplinary care planning team determines it is safe; and o Refuse a transfer from a distinct part, within the institution. A facility must promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability. 5. Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction .