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	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Park Health Care Center	2415 5th 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2674136Based on interviews and record review the facility failed to implement, review and revise care plans and interventions for 1 of 3 residents (Residents #1) reviewed for quality of care resulting in delay in treatment for constipation, development of a small bowel obstruction, and hospitalization. Findings include:Resident #1 (R1)Review of the Face Sheet revealed R1 was originally admitted to the facility on [DATE] with a diagnosis of dementia. Review of the Minimum Data Set (MDS) dated [DATE] revealed R1 had a brief interview for mental status (BIMS) score of 8 out of 15 which indicated she was cognitively impaired. Section H Bowl and Bladder on the MDS assessment revealed: R1 was always continent of bowel movements.Review of a facility Communication Document from a facility nurse to a facility Physician dated 4/2/25 read in part: Concern: (R1) is constantly on the BM (Bowel Movement) list for not having a BM every 3 days .Review of R1's Care Plan read in part: FOCUS (R1) is at risk for constipation R/T (related to): decreased mobility, medications side effects, opioid use. Date Initiated: 1/13/2023. GOAL: Will have a normal bowel movement at least every 3 days through the review date. Date Initiated: 01/13/2023. INTERVENTIONS: Observe for s/sx (signs and symptoms) of constipation, consistency of bowel movements. distention/tenderness/guarding/rigidity, vomiting .Date Initiated:1/13/2023 .Administer medications as ordered and observe for ineffectiveness/side effects. Report abnormal findings to the physician. Date Initiated: 01/13/2023.Review of R1's Certified Nurse Aide (CNA) documentation for the month of October 2025 revealed. R1 had no bowel movements documented from 10/4/25 at 7:21 PM until 10/11/25 at 5:00 PM. (R1 went 6 days without a bowel movement).Review of R1's Certified Nurse Aide (CNA) documentation for the month of October 2025 revealed. R1 had 1 medium sized bowel movement documented from 10/14/25 at 6:40 PM until 10/25/25 at 7:30 AM. (R1 went 10 days with 1 medium bowel movement).Review of R1's Medication Administration Record (MAR) for the month of October 2025 revealed R1 had 3 alternative PRN (as needed medications) for constipation relief including stool softeners/laxatives, suppositories and enemas. None of which were documented as administered to R1 from 10/4/25 through 10/22/25.Review of R1's facility Progress Notes read in part: 10/29/2025 20:05 Nurses Notes Text: Resident had a large dark brown emesis (vomit) with food (content). No fecal smell or blood noted.Review of R1's facility Physicians Assistants (PA) Progress Notes read in part: Date of Service: 10/29/2025-Visit Type: Telehealth - Details: NOTES Received a call from facility regarding female resident: Resident had an episode of emesis which was dark brown with regurgitated meal fragments.Review of R1's facility Progress Notes read in part: 10/30/2025 19:01 Nurses Notes Position: Registered Nurse (RN) A Note Text: (R1) sent to (hospital emergency department-name omitted) for evaluation of Fever and hypotension.Review of R1's Hospital Discharge Paperwork dated 11/4/25 read in part: (R1) Patient presented to the emergency room due to fever of 101.3 along with lethargy. Interval History: Patient (R1) has had increasing pain and increasing nausea. Flat plate Abd (X-Ray) today shows evidence of higher-grade obstruction with transition point. (R1) Hospital Course: She (R1) was found to have a small bowel obstruction resulting in acute kidney injury and sepsis. Care plan discussed with daughter to describe her clinical findings and concern for possible death in days.In an interview on 12/16/25 at 5:06 PM., the DON reported R1's Care Plans should be person centered, and the interventions should be implemented to ensure R1, and all residents have the appropriate interventions to meet her/their goals. DON reported that R1's care plan was not followed to ensure accurate assessment and treatment for constipation was followed. Review of Fundamentals of Nursing ([NAME] and [NAME]) 8th edition revealed, If the patient's status has changed and the nursing diagnosis and related nursing interventions are no longer appropriate, modify the nursing care plan. An out-of-date or incorrect care plan compromises the quality of nursing care. Review and modification enable you to provide timely nursing interventions to best meet the patient's needs .It is necessary to revise related factors and the patient's goals, outcomes, and priories. Date any revisions. Revise specific interventions that correspond to the new nursing diagnoses and goals. Revisions need to reflect the patient's present status. [NAME], P. A., [NAME], A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 257-258 the requisite knowledge to complete an accurate assessment .Review of the MDS 3.0 RAI Manual v1.16, Chapter 3 Section N: Medications, revealed .The intent of the items in this section is to Revisions need to reflect the patient's present status. [NAME], P. A., [NAME], A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 257-258. Review of the Long-Term

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2674136Based on interview and record review, the facility failed to implement preventative measures, promptly assess and treat constipation for 1 resident (Resident #1) of 3 residents reviewed for quality of care and prevent further medical complications from constipation. This failure resulted in actual harm when R1was hospitalized for a small bowel obstruction, leading to acute kidney injury and sepsis. Findings include:According to Legal and Ethical Issues in Nursing, 4th Edition, ([NAME], G, 2006), a major responsibility of all health care providers is that they keep accurate and complete medical records. From a nursing perspective, the most important purpose of documentation is communication. The standards for record keeping attempt to ensure patient identification, medical support for the selected diagnoses, justification of the medical therapies used, accurate documentation of that which has transpired, and preservation of the record for a reasonable time-period. Documentation must show continuity of care, interventions used, and patient responses. Nurses' notes are to be concise, clear, timely, and complete. Resident #1Review of the Face Sheet revealed R1 was originally admitted to the facility on [DATE] with a diagnosis of dementia. Review of the Minimum Data Set (MDS) dated [DATE] revealed R1 had a brief interview for mental status (BIMS) score of 8 out of 15 which indicated she was cognitively impaired. Section H Bowl and Bladder on the MDS assessment revealed: R1 was always continent of bowel movements. Review of R1's facility Progress Notes read in part: 10/24/2025 10:52 Nurses Notes Text: No BM (Bowel Movement) x 3 days. Senna 8.6-50 mg) given.Review of a facility Communication Document from a facility nurse to a facility Physician dated 4/2/25 read in part: Concern: R1 is constantly on the BM (Bowel Movement) list for not having a BM every 3 days, she (R1) is currently getting Senna (stool softener/laxative medication) 1 time daily . can we increase to 2 tabs . Review of R1's current Medication Administration Record (MAR) read in part: Senna Plus Oral Tablet 8.6-50 MG [Sennosides-Docusate Sodium) Give 2 tablet by mouth one time a day for Constipation Start Date-4/05/2025 .Review of R1's current (October 2025) MAR for PRN (As needed medications) had the following orders for relief of constipation: Senna Oral Tablet 8.6 MG (Sennosides) Give 8.6 mg by mouth every 72 hours as needed for Constipation-Start Date-09/16/2024 Bisacodyl Rectal Suppository (Bisacodyl) Insert 1 unit rectally every 72 hours as needed for Constipation-Start Date- 09/16/2024 Fleet Saline Enema Rectal Enema 7-1 9GM/197ML (Sodium Phosphates) Insert 1 unit rectally every 72 hours as needed for Constipation-Start Date-09/16/2024Review of R1's Certified Nurse Aide (CNA) toilet continence documentation for the month of October 2025 revealed. R1 had no bowel movements documented from 10/4/25 at 7:21 PM until 10/11/25 at 5:00 PM. (R1 went 6 days without a bowel movement). Review of R1's current MAR revealed R1 had 3 alternative PRN (as needed medications) Fleet Saline Enema Rectal Enema, Senna Oral Tablet 8.6 MG and Bisacodyl Rectal Suppository for relief of constipation, none of which were documented as administered to R1 from 10/4/25 through 10/22/25.Review of R1's CNA toilet continence documentation for the month of October 2025 revealed. R1 had 1 medium sized bowel movement (10/18/25) documented from 10/14/25 at 6:40 PM until 10/25/25 at 7:30 AM. (R1 went 10 days with 1 medium bowel movement).Review of R1's facility Progress Notes read in part: R1-10/29/2025 16:12 Nurses Notes Text: Resident had complaints of abdominal pain. Abdominal assessment: Bowels sounds active in all four quadrants, rectal suppository given. Resident had medium bowel movement but says she still has some abdominal pain .Review of R1's facility Progress Notes read in part: 10/29/2025 18:55 Nurses Notes Text: Resident still having abdominal pain. Resident put to bed shortly after dinner arrived and she did not eat much. Residents still have active bowel sounds and abdomen is soft and tender to touch.Review of R1's facility Progress Notes read in part: 10/29/2025 20:05 Nurses Notes Text: Resident had a large dark brown emesis (vomit) with food (content). No fecal smell or blood noted. Writer assessed resident abdomen, bowel sound present in all quadrants. Vital signs: BP (blood pressure) 171/98, T- 99.0 (Temperature) .Writer called PA (Physician's Assistant) . Order an abdominal Xray, a one-time Zofran 4mg (antinausea medication) .Liquid diet until we have abdomen Xray result. (PA) said to continue monitoring and call if anything changes. Review of R1's facility Physicians Assistants (PA) Progress Notes read in part: Date of Service: 10/29/2025-09:00 Visit Type: Telehealth - Details: NOTES Resident had an episode of emesis which was dark brown with regurgitated meal fragments. No evidence of hematemesis, fecal residue or blood. complain of slight discomfort to the lower (abdominal) fields. Medical course of action/plan: I have placed her on liquid diet until abdominal X-ray is done tomorrow (10/30/25). Concerns for