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	04/09/2026

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 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint # 2972928.Based on interview, and record review, the facility failed to timely readmit one Resident (#1) of three residents reviewed for admission, transfer, and discharge rights, resulting in Resident #1 feeling of unnecessary separation from family and friends and uncertainty related to continued medical care and financial stress, as well as psychological stress and anxiety.Findings include:Resident (R1)Review of an admission Record revealed R1 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: respiratory failure.Review of the Minimum Data Set (MDS) assessment for R1 dated 2/12/2026 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 indicating R1 was cognitively intact.Review of R1's EMR read in part: Date of Service 3/19/2026 14:16 Behavioral Health Visit Type Psychiatry Follow up - His Brief Interview for Mental Status (BIMS) score is 14.Review of a State Agency Complaint dated 4/2/2026 at 1:51 PM., read in part: Allegation Details-It was alleged that the facility failed to allow the resident (R1) to return to the facility after a discharge to a hospital .Please provide the location where the incident occurred. (out of state hospital name omitted). Hospital dumping refusal to re-admit resident . Resident Relation: Patient Advocate . Please provide the name or description of the witness/witnesses: Case Manager (CM) M at (out of state hospital name omitted) . Please describe the specific incident that is prompting this complaint including any injuries that resulted: Resident (R1) wishes to return to the nursing home. Resident has made a health decision not to be placed on a AVAPs (Average Volume-Assured Pressure-Oxygen (O2) Machine) but to return on the BiPAP (Bilevel Positive Airway Pressure-O2 Machine) as the nursing home does not manage AVAP. Resident was on BiPAP at this home; therefore, they are able to manage it. (Nursing Home Administrator-NHA) states that the resident is bipolar and making bad decisions and it is not a safe discharge back to the nursing home. The resident states he was bipolar, on BiPAP and made the same decisions before he left the nursing home. He knows the risks and wants to return on BiPAP. Resident states the hospital case manager has educated resident what this means. Hospital physician also has explained the risks to the resident, and he (R1) wishes to make this decision. Resident states he has a right to make his own decisions good or bad. Resident asks to be readmitted to this nursing home. This appears to be a case of hospital dumping.Review of R1's Electronic Medical Record (EMR) read in part: 3/26/2026 19:19 Alert Note Text: (R1) No BM (bowel movement) For 3 Days Sent to (Local emergency department (ED) name omitted) .In an interview/record review on 4/8/26 at 10:15 AM., R1's Assistant Director of Nursing (ADON) H. ADON H reported it appears R1 was discharged from the facility and admitted to the hospital on [DATE]. ADON H reported there should be more information in R1's EMR. ADON H and this surveyor reviewed R1's EMR which read in part: 3/26/2026 (R1) No BM For 3 Days sent to (ED). ADON H reported R1's EMR does not show R1's discharge was properly documented, and the information was not clear. ADON H stated I am honestly unsure exactly why R1 was sent out.ADON H reported there should be pertinent information in his EMR because the facility practice was not to send residents out because of not having a BM for 3 days, unless they are showing other signs/symptoms. ADON H reported R1 had alternative medications/measures that (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0627 Level of Harm - Actual harm Residents Affected - Few	should have been used to alleviate constipation. ADON H reported R1's discharge out of the facility was not properly documented, and it is unclear by review exactly why he would have been sent out that day. ADON H reported R1's baseline O2 sats are usually mid to upper 80% range. In an interview on 4/8/2026 at 1:29 PM., the NHA reported R1 initially transferred to the local ED because he had an hypoxic episode (a low oxygen level in the blood) R1 was then transferred out to a hospital (in another state-name omitted). NHA reported the local Ombudsman (OMB L) was recently in a to discuss R1 and his return to the facility. The NHA reported she received R1's discharge (return to this facility) referral last week from the Registered Nurse/Case Manager (RN/CM) M (from the out of state hospital). The NHA reported she did not think R1 was stable enough to come back to the facility. When the NHA was asked what stable meant, they stated I will not readmit R1 until he's stable, it's my understanding that he needs a AVAP machine, which we do not know how to use, and he also needs to have arterial blood gases (ABG's) drawn daily from the lab. The NHA reported R1 would like to come back to the facility, and she (NHA) has no problems re-admitting him when he was medically cleared. The NHA stated In my conversation with Omb L, I told her that I don't think that neither of us have the clinical knowledge to know for sure that R1 was clear to come back. She (Omb L) filed an appeal on behalf of R1 with the State Agency saying we are involuntary discharging him; the State Agency wanted me to forward the Involuntary Discharge form; I haven't gotten anything back on that. The NHA was asked to provide this surveyor with any and all information regarding R1's discharge from the facility to the emergency department (ED), then to the out of state hospital and all communications to and from the hospital. This surveyor informed the NHA that the last documented note in R1s EMR was that he had not had a bowel movement in 3 days. The NHA reported being unaware of the documentation in R1s EMR. The NHA reported that whatever was in R1's EMR was what the facility had for R1 and his discharge out on 3/26/26. The NHA stated R1 was sent out to the ED for a hypoxic episode, whenever a resident's O2 levels are blow 90% and in the 80% range they are sent out to the ED Review of R1's EMR oxygen saturations (O2's) from 1/23/26-3/25/36 revealed R1's O2 sats baseline results were documented in the mid 80's and lowest O2 sats documented were 69% and 71% .Review of R1's hospital (out of state) paperwork dated 1/5/26 read in part: nursing home resident. chronic hypoxic respiratory failure on 2 L of oxygen at baseline . Presented to the emergency room after long-term care facility noted his oxygen was 65% at baseline 2 L. He also had sepsis secondary to bilateral pneumonia-UTI-bacteremia- he also had respiratory coronavirus He also had an E. coli UTI, pneumonia.In an interview on 4/9/26 at 7:25 AM., Omb L reported R1's she has spoken with R1, CM M at the out of state hospital where R1 was currently, and with NHA. Omb L reported R1 wants to come back to the facility and has been educated for weeks on any risks if not on a AVAP machine when taking naps and going to bed. Omb L reported the NHA has been repeatedly delaying R1s readmission to the facility by telling R1 and CM M the facility cannot or does not have the ability to care for someone on an AVAP machine. Omb L stated that is just not true, I also advocate for residents in the sister facility, they have residents with AVAP machines, the staff there and the DON N are all one team (This information was corroborated by an interview on 4/9/26 aprx. 10:00 am with the Director of Nursing (DON) N from the sister facility, DON N reported she did have experience and a resident with an AVAP machine). Omb L reported after conversations with CM M and R1's status R1 has reported it was easier and smaller than the BiPAP machine he had previously been self-administering at the facility. Omb L reported the hospital respiratory department, CM M and doctors have been explaining to R1 all risks if he was unable to get a AVAP machine and only use the BiPAP. Omb L reported R1 has demonstrated to them that he indeed can use it properly. Omb L stated it is R1's right to leave the current hospital AMA (Against Medical Advice) and it is also his right to be able to go back to the facility. Omb L reported as for today, there are no concerns about his going back to the facility the hospital staff are confident he is capable to make his own medical decisions. Omb L reported R1 has had lengthy conversations with all medical personnel and knows that he could potentially die. Omb L reported the hospital sent him out a few weeks ago and the facility was ready (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	to re-admit him based on the same issues today, so the hospital discharged him. They put him in the ambulance style van, drove him to the facility which was a nearly 5-hour one way trip. Omb L stated NHA and the facility staff let R1 sit in that van for hours after a 5-hour drive, get to the facility door and lock it. The driver was trying to contact everyone and anyone but it was after hours, so the hospital staff (CM M) luckily receive one of the calls from the driver and she had him sent back another 5 hour drive to another state.that just breaks my heart to think of R1, or any resident being put under that much stress, and pain R1 called me the next day and said he felt like he was put in a meat wagon.Review of R1's EMR and hospital admission (out of state) dated 3/26/26 read in part: History obtained from: Chart review/Discussion with referring. chronic respiratory failure requiring nocturnal (night) BiPAP on 2L. presents from a nursing facility with acute worsening dyspnea and hypoxia.Oxygen saturation was 83% on 3 L nasal cannula and dropped to 55% while on BiPAP at the facility, prompting transfer to the emergency department Reviewed of R1's EMR progress notes, vital signs, documents scanned in and all pertinent records from 3/1/26-3/26/26 revealed no documentation of R1s O2 sats dropping to 55% as indicated in R1s hospital admission on [DATE] which read in part: History obtained discussion from referring.Review of R1s EMR progress notes read in part: Change In Condition (CIC) 3/26/202613:52 Summary for Providers Situation: The CIC reported are-evaluation are/were: Shortness of breath at the time of evaluation (R1's) vital signs, weight and blood sugar were: - Weight: W 548.8 lb. - 3/25/2026 08:00 Scale: Mechanical Lift- Pulse Oximetry: O2 84.0 % - 3/26/2026 12:38 Method: Oxygen via Nasal Cannula. Recommendations: Sent to ER for evaluation.In an interview on 4/9/26 at 9:54 AM., R1 reported he was sent out to the ED on 3/26/26 and did not know why. R1 reported he felt fine that day, he had not been experiencing any medical concerns that he was expressing to the staff. R1 reported one moment everything was fine the next thing I knew the nurse managers were worried about my oxygen status. R1 reported he initially went to the ED and then was sent to an out of state hospital. R1 reported he was obese and currently over 500 pounds, he has had respiratory problems for a long time and uses oxygen at 4 liters during the day, and a BiPAP machine for naps at night when he goes to bed. R1 reported he wants to go back to the facility to finish out his rehabilitation and hopefully return home. R1 reported he has a great family support system; his mother goes to the facility to see him daily and brings him lunch. R1 reported he was not always compliant with his diet and eating habits, but that is his right to eat what he wants and likes. R1 reported that the hospital wants him to have an AVAP machine at night and for naps, but the facility is refusing to accept him back, stating reasons that make no sense to him. R1 reported he knows he can leave the hospital AMA and does not want to do that. R1 reported he now knows how to use the AVAP machine, which is better for him, and easier to use than the BiPAP which is at the facility. R1 stated I told them I don't care about the AVAP machine I can use my regular BiPAP, I understand the risks, and that I could die. I would much rather die near my hometown, my mother and family than being stuck in another state. R1 reported he was in the hospital at the beginning of the year because he had the flu, pneumonia and covid-19. R1 stated [NAME] me this, how can I get that sick when I stay in my room, that's the staffs fault for bringing those infections to me, not the other way around which is why I stay in my room, there is always something going on with infections that staff and other residents being sick or a bug going around. When I was sick, the facility took me back then, this time I am not even sick. That's because the (NHA) does not like me and doesn't want to have a 500-pound man to take care of because it takes 2 staff and a long time to do my cares so they have to staff more on my unit. R1 reported the first time I went to the hospital (January) I felt like I was going to die. R1 reported they had a meeting and I was supposed to go back to the facility; everything was set up. R1 reported he was fully aware of his weight and how facility staff and other people treat him, which makes it worse for him to want to leave his room, R1 reported he hears what they say. When asked who they were, R1 stated I don't want to get into it, it's not worth it R1 reported he wants to return to the facility, his home for now and hopes to continue rehab, lose weight and properly discharged to the community so he can spend time with his family. R1 stated I was driven (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	from the hospital I am in now, in another state about 5 hours or more. When we go to the facility the doors were locked and the facility staff was told by NHA not to open the doors, answer the calls from the driver or me and not to let me in.the driver had to turn around and take me back to the hospital out of state.the ride made me feel like I was a piece of garbage to be thrown out of a meat wagon.In an interview on 4/9/26 at 11:01 AM., CM M (RN-Case Manager- out of state hospital) reported R1 has been repeatedly denied re-admission back to the facility. CM M reported R1 has been medically stable since on 3/31/26. CM M reported initially the physician wanted R1 to have daily labs and be on a AVAP machine. CM M reported by the end of March it was evident that R1 understood the risk of leaving the hospital without those in place. R1 was educated over. CM M reported ultimately it is R1's choice to make his own medical choices. CM M reported the driver was told by staff when he was at the facility door he had to leave with R1, they would not open the door. CM M reported after that incident we decided as a team it was time to get the State Agency involved for R1. CM M reported R1 had to suffer over a 10 hour round trip car ride, which had to be painful, embarrassing and stressful for R1. CM M stated I have been sending the progress notes to NHA only to have her say she wasn't getting them. CM M reported I called again I spoke with the receptionist to ask to speak with the admissions coordinator, or NHA. CM M reported the receptionist said it has been really busy here, I will let them know. state is here CM M stated I said well if state I there, they may want to speak with me . CM M reported it wasn't until early this morning that I had a request from the NHA that she wanted R1s discharge paperwork, and a good contact number because a state surveyor would like to speak to me. CM M reported he does not need the ABG's (daily labs). CM M reported she was hoping for a resolve with this situation for R1 and what he has gone through the last few months. CM M reported all R1s medical records, discharge summary and referral have now been sent to the facility and NHA confirmed that she had received them at 8:20 AM today (4/9/26).Interview/Record review on 4/9/26 at 8:30 AM., this surveyor made requests to NHA for R1's hospital records, pertinent documents not noted in R1s EMR. On 4/9/26 at 9:02 AM., this surveyor received 9 pages of a 54 pages (R1's discharge summary) NHA reported at first the medical records from CM M were sent on 4/8/26 and faxed to the sister facility on 4/8/26, when this surveyor asked why there were only 9 pages, NHA stated our admissions coordinators printer ran out of paper This surveyor had requested documents throughout the survey 4/6/26-4/9/26 from NHA with multiple delays. (speaking with CM M, she reported none of R1's medical records were faxed to the sister facility, she has/had only been faxing to R1's current facility on both of his hospital stays)Review of a facility Transfer and Discharge policy dated 4/22/25 read in part: Purpose The transfer and discharge process must provide sufficient preparation and orientation of residents to ensure a safe and orderly transfer or discharge from the facility.Definitions Transfer and discharge: Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.Criteria for Transfer/Discharge1. The facility will transfer or discharge a resident under the following documented conditions in the medical record:A. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;B. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;C. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;D. The health of individuals in the facility would otherwise be endangered;The facility may not transfer or discharge the resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility, unless the failure to discharge or transfer would endanger the health or safety of the resident (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.Criteria for Transfer/Discharge DocumentationFor circumstances under the criteria for transfer/discharge (1) A and B above the resident's physician or a non-physician practitioner (in accordance with State law) must document information on the basis of the transfer or discharge: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. For (A) above, the inability to meet the resident's needs, the documentation made by the resident's physician must include: The specific resident needs the facility could not meet. The facility efforts to meet those needs; and The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the facility.If a resident's clinical or behavioral status (or condition) endangers the health or safety of individuals in the facility, documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician.Timing of notice1. The notice of transfer or discharge required under this section must be made by the facility in writing at least 30 days before the resident is transferred or discharged and in a manner they understand.Contents of the notice1. The reason for transfer or discharge;2. The effective date of transfer or discharge;3. The specific location to which the resident is transferred or discharged (if a change in destination indicates that the original basis for discharge has changed, a new notice is required);4. A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;5. The name, address (mailing and email) and telephone number of the Office of the State Long- Term Care Ombudsman;6. For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000; and7. For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally III Individuals Act; or8. Per State law.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Complaint # 2972928.Based on interview and record review, the facility failed to fully implement their policy and procedure and provide applicable bed hold policy information, written transfer notifications, and required hospital documents for 1 (Resident #1) of four residents reviewed for hospitalizations resulting in worry, fear and frustration for R1 and the delay in his re-admission from a lengthy out of state hospitalization.Findings include:Resident (R1)Review of an admission Record revealed R1 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: respiratory failure.Review of a Minimum Data Set (MDS) assessment for R1 with a reference date of 2/12/2026 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated R1 was cognitively intact.Review of R1's Electronic Medical Record (EMR) read in part: 3/26/2026 19:19 . (R1) No BM (bowel movement) For 3 Days Sent to (Local emergency department-name omitted) .During an interview/record review on 4/7/26 at 9:51 a.m., ADONH reviewed the EMR and reported there was no written notification of transfer from the facility to the hospital and indicated it should have been in the EMR.Review of R1's EMR Hospital Discharge Summary dated 1/23/26 read in part: 1/5/26-Presentation and hospital course R1 is [AGE] year-old year old male with a history of diabetes, class III obesity, chronic hypoxic respiratory failure on 2 L oxygen at baseline, hypothyroid,-hypertension (high blood pressure) was transferred to our (out of state hospital) from outside emergency room. (R1) Presented to the emergency room after long-term care facility noted his oxygen saturation was 65% at baseline 2 L. Patient was admitted for acute on chronic hypoxic respiratory failure and acute hypercapnic respiratory failure. He also had sepsis secondary to bilateral pneumonia-UTI-bacteremia-cellulitis that was present on admission.In an interview/record review on 4/8/26 at 10:15 AM., R1's EMR progress notes, under the miscellaneous tab (contains original paper copies/documents scanned into the facilities EMR belonging to individual residents) were reviewed with Assistant Director of Nursing (ADON) H. ADON H reported it appears R1 was discharged from the facility and admitted to the hospital on both 1/5/26 and 3/26/26. Further review with ADON H revealed R1's EMR had no evidence of a written notification of transfer and no bed hold policy being provided to R1.At the time of exit on 4/9/26 at approximately 3:30 PM., there was no required documentation in R1's EMR requested during this investigation. Including bed hold, transfer notice, and hospital transfer paperwork. Review of a facility policy and procedure with a revision dated 4/22/25 read in part: Transfer and Discharge Purpose.The transfer and discharge process must provide sufficient preparation and orientation of residents to ensure a safe and orderly transfer or discharge from the facility. Definitions Transfer and discharge: Includes movement of a resident to a bed outside of the certified facility. Procedure: Emergency Transfer to Acute Care1. When a resident is transferred on an emergency basis to an acute care facility, notice of the transfer is provided to the resident and the resident representative as soon as practicable.2. A physician's order is obtained including the date of the transfer and the reason for the transfer.3. A facility designee will provide notice, in writing, of the facility's bed-hold and readmission policies to the resident.at the time of transfer, or in the case of emergency transfer within 24-hours and documented in the medical record.4. A transfer form is completed; a list of medications and a copy of the care plan goals is sent to the receiving hospital 5. Nursing documents the hospital transfer in the medical record.