

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Christian Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to complaint #3053535Based on interview and record review, the facility failed to ensure the safe wheelchair transportation of one resident (R4) of three residents reviewed for accidents and environmental hazards. This deficient practice resulted in actual harm when the resident's leg slipped from the wheelchair footrest during transport, causing hyperextension of the knee, an inoperable femur fracture due weight and respiratory status, chronic pain, and confinement to bed.Findings include:Resident #4 (R4)Review of R4's Minimum Data Set (MDS) assessment dated [DATE], revealed R4 was admitted to the facility on [DATE]. R4 scored 15 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of intact cognition.An interview was conducted with R4 on 7/14/26 at 3:00 p.m. R4 stated a Certified Nurse Aide (CNA) was propelling his wheelchair down the hall to take him to therapy. Resident #4 reported, I told the nurse's aide to slow down because I could feel my foot slipping off the footrest. She did not slow down, and my foot came off the footrest and went underneath the wheelchair. I heard a loud snap - it just popped. R4 further stated that the incident caused immediate and severe pain, adding, I knew my leg was broken.R4 reported being transported to the hospital, where diagnostic imaging confirmed a fracture (femur-leg bone above the knee) of the lower extremity. R4 explained surgical intervention was not an option and stated, Now all I do is lie in this bed. I was working with therapy to get stronger so I could go home, but now all I can do is lie here. This injury has really set me back.Regarding the ongoing effects of the injury, R4 reported persistent, severe pain despite prescribed analgesic medication, stating, My leg constantly throbs, and the pain medication doesn't touch it. At the time of the interview, the resident rated the pain as 9.4 on a 10-point scale and expressed significant emotional distress, stating, I am so sad and depressed.An observation of R4's leg was conducted on 7/14/26 at 3:12 p.m. R4's leg was externally rotated as he lay in bed with an ace wrap dressing below his knee to his ankle.Review of the discharge paperwork from the emergency department (ED) dated 6/8/26 read in part Primary diagnosis: Closed fracture of distal end of right femur .Review of progress notes revealed the following:6/9/26 Nurse reported pt (patient) returned yesterday from ER (emergency room) with report of fracture to distal end of right femur. It (sic) now c/o (complained of) pain, had a norco (pain medication) while in ER but was not continued on pain medication from ER discharge.6/11/26 Notified [physician's name] office and spoke with LPN (Licensed Practical Nurse) about [R4} is stating that he was in a lot of pain after this nurse had administered his oxycodone.6/16/26 Xray transport scheduled for 6/17.R4 refused to go last week due to the amount of pain in the recent fracture.orthopedics to see him and decide what comes next.Review of physician documentation dated 6/17/26 read in part x-rays of the knee.There does appear to be some slight shift of the fracture compared to prior films.Review of progress notes revealed the following:6/22/26 .PCP (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 0689 Level of Harm - Actual harm Residents Affected - Few	(primary care physician) in for acute visit [physician ordered] .6/30/26 for x-ray of recent RLE (right lower extremity) fracture.6/29/26 .new order from [orthopedic physicians name] .for x-ray of the Rt (right) knee.6/30/26 .Resident will be transferred to [hospital name].for evaluation of right leg fracture and possible surgical intervention.7/1/26 .resident returned from hospital per ambulance; No hospital will to accept him at this time.he is not a candidate for surgery at this time.Review of orthopedic consult dated 7/1/26 read in part, Noted this type of fracture is very difficult to fix and especially at 3 weeks out would likely need a total knee replacement.Review of a physician progress note dated 7/3/26, read in part .Closed minimally displaced fracture of distal end of right femur without routine healing worsening displacement.fracture is worsening, now displaced from initial x-ray. Today [R4's] leg appears to be slightly inward rotated.patients' leg has not been splinted since date of injury, likely causing displaced fracture.pain is not well controlled due to very poor respiratory status.Review of physician documentation dated 7/8/26 read in part, .Will continue with ace wrap.at facility and recommended bedrest x12 weeks.During an interview on 7/14/26 at 3:17 p.m., the Director of Nursing (DON) reported, The wheelchair pedal malfunctioned and went off to the side of the chair. [R4's] leg hyperextended and the resident was sent to the hospital. As a result of the incident the x-ray revealed a fracture. It is now too painful for him to get out of bed, so he has been in bed since the return from the hospital. He was attending therapy to regain strength to his legs and feet. Therapy is no longer working with him since the incident. He was sent out to the orthopedic surgeon, and the surgeon has elected not to perform surgery. The Certified Nurse Aides (CNA's) that were working with him that morning were [CNA C and CNA F]A phone interview was conducted on 7/14/26 at 3:25 p.m., and CNA C reported, He wanted to get up that day.[CNA F and Registered Nurse (RN) H] were assisting him to get out of bed with the lift.The wheelchair leg rest moved away from the wheelchair when CNA F and I were in the room. I thought I put it back in place and thought the latch was hooked, though it still moved a little.I pushed him down the hallway. Then suddenly he yelled and asked me to stop. He said his leg went back under the wheelchair and I pulled the wheelchair back. He complained of pain and I went to get the nurse. He went to the hospital. He has not been out of bed since and has been in pain. His leg is rotated outwards ever since that happened.During an interview on 7/14/26 at 3:38 p.m., Licensed Practical Nurse (LPN) D reported, I was charting at the nurse station by the 500 hall and saw the wheelchair leg rest swung out to the side and his leg twisted under his chair.He hollered out in pain.A follow up interview with the DON was conducted on 7/14/26 at 3:46 p.m., and the DON reported, The ace wrap is used to try to keep his leg straight.The ace wrap is supposed to be placed from his mid-thigh to just above his ankle.it will take time to heal this break.this injury really has set him back.An interview was conducted on 7/14/26 at 4:00 p.m., with Rehab Director E. Rehab Director E reported I was working with him prior to the incident on transfers, wheelchair mobility, repositioning, and strengthening.his strength and repositioning was improving.An interview was conducted on 7/15/26 at 7:55 a.m., and CNA F reported, [R4] has two chairs in his room. One is for appointments and the other is for use in the nursing home. He had an appointment that day, so we put him in his appointment chair.CNA C was still in training and I worked with her that day.His feet do not fit right on the foot rests.but we were in a hurry that day to get him up for his appointment.His foot came off the pedal and the foot rest had swung out to the side.His leg was twisted under the chair and CNA C backed the chair up and the RN came.he went to the hospital and now has a broken leg.I had heard after the incident that the pedal was broken but Central Supply Director A would know.I don't know if it has ever gotten fixed.the communication around here isn't the greatest.An interview was conducted on 7/15/26 at 8:24 a.m., with Central Supply Director A who reported, The wheelchair pedal was broken on his wheelchair that (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	he uses in the facility, and a new one was ordered and came in prior to the incident with [R4]. The pedals are used interchangeably with his appointment chair.During an interview on 7/15/26 at 8:58 a.m., with Rehab Director E. Rehab Director E reported, the wheelchair pedals that I had Central Supply Director A' order could not be used with his appointment chair.I have not heard if the wheelchair pedals for his appointment chair are broken.I am not sure where that chair is currently. During a follow-up interview at 9:36 a.m., Rehab Director E reported, I don't know what happened the day of the incident.all I can think of it was operator error and the CNAs did not latch the pedal into place.During a follow up interview on 7/15/26 at 11:17 a.m., CNA F reported We used the appointment chair that day.it's the chair with smaller wheels. I was told he had an appointment.I heard later that there was an issue with the chair pedals latching.we don't hear when equipment is broke or when it gets fixed.During an interview on 7/15/26 approximately 12:00 p.m., nursing Home Administrator (NHA) and the Director of Nursing (DON) acknowledged that R4 sustained a fracture during transportation in the facility.		