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

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F 0880 Level of Harm - Actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement a complete infection control program as evidenced by failure to:Effectively mitigate outbreaks of COVID-19 and Influenza A resulting in widespread dissemination of infection disease throughout the facility.Properly disinfect and store multiple-resident use glucometers and individual insulin pens following use.Maintain clean and sanitary medication carts, andProperly clean and sanitize resident bed pans for 5 of the 5 residents in the facility that use bed pans.This deficient practice resulted in the harm when COVID-19 and Influenza A outbreaks in January and February 2026, respectively, spread throughout all Halls of the facility, infecting 25 Residents with one death for COVID-19, infecting 10 Residents with one death for Influenza A, and a decreased quality of life. Findings include: 1. Outbreak Mitigation Failure/Infection Control Surveillance and Tracking/Timely Implementation of Contact Precautions. During an interview on 4/8/2026 at 11:00 a.m., Licensed Practical Nurse (LPN) U, was observed donning Personal Protective Equipment (PPE) prior to entering R69's room which was posted for Contact Precautions. When asked why R69 was under contact precautions, when the Resident (R69) the transmission-based precautions (TBP) had not been posted the previous day when this Surveyor entered R69's room, LPN U was unsure of the answer. During an interview on 4/8/26 at approximately 11:02 a.m., when asked why R69's room was not posted for Contact Precautions Infection Preventionist (IP) H stated, [R69] is on (contact precautions) because she has a MDRO (multi-drug-resistant organism) in her urine. When asked why contact precaution signage was not posted outside of R69's room the previous day, IP H stated, That is because I didn't see it (MDRO) documentation (from the hospital) and didn't put the signage up. IP H said the Contact Precaution signage had been put up that morning (4/8/26) but should have been posted the previous day (4/7/26). During an interview on 4/8/26 at 11:31 a.m., the Director of Nursing (DON) was asked when the results from R69's urine culture results were noted by the facility. The DON said R69 went out to the hospital on 4/1/26, the urine culture was done in the hospital on 4/1/26 and she (R69) came back the same day (4/1/26) with the culture results. The DON stated, I would think someone would have checked the culture when she came back. When asked who she would have expected to check those culture results, the DON said [IP H]. The DON confirmed IP H was not out of the building (on 4/1/26)and acknowledged that no contact precaution signage was posted outside R69's room until 4/8/26. Review of the Infection Control Binder on 4/9/2026 at 7:58 a.m., revealed the following, in part: The April 2026 section of the binder contained no documentation, including no line listing of infections (including documentation for R69 who was currently in contact precautions), and no infection mapping (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 0880 Level of Harm - Actual harm Residents Affected - Some	within the facility. During an interview on 4/9/26 at 8:42 a.m., the Director of Nursing (DON) reviewed the Infection Control binder, and confirmed no documentation was present for April 2026 section of the binder. The line listing for April was empty. The March 2026 section had a line listing with infection mapping that appeared to have been completed at the end of the month. The February 2026 section included a line listing detailing a facility Influenza A outbreak beginning including 10 facility residents with onset dates beginning 2/16/26 through 2/20/26. Resident #93 (R93) acquired Influenza A on 2/18/26 and died in the facility on 2/22/26. The February 2026 line listing revealed the Influenza A outbreak began on the 200 Hall within the facility and spread to both the 400 and 500 Halls on 2/20/26 and 2/18/26 respectively. No Outbreak Summary was present for review. The January 2026 section included a COVID-19 outbreak line listing detailing the spread of COVID-19 within the facility to 25 facility residents with onset dates of 1/7/26 through 1/27/26. The COVID-19 outbreak began on the 500 Hall and spread to the 200 Hall on 1/10, the 400 Hall on 1/19, the 300 Hall on 1/23/26. Resident #93 (R93) contracted COVID-19 on 1/16/26 and died in the facility on 1/19/26. No COVID-19 Outbreak Summary was present for review. During an infection control interview on 4/9/26 at 8:45 a.m., the DON, DON N (from a corporate sister facility) and Infection Preventionist (IP) H were asked about the lack of April 2026 infection control documentation. IP H acknowledged the infection control mapping was not completed for April 2026, and said the mapping gets done at the end of the month, not in real time. When asked about the absence of [R69] on the April 2026 line listing, the DON and IP H acknowledge R69 should have been placed on the line listing on 4/1/26, based on urine culture results received that day (4/1/26). IP H acknowledged all the residents on the infection control line listings received antibiotics. IP H confirmed tracking of issues such as nausea and vomiting were not routinely documented on the line listing. During an interview on 4/9/2026 at 9:13 a.m., IP H confirmed they had not prepared or completed an Influenza A outbreak summary for February 2026. When asked about the outbreak of Influenza A, IP H said the outbreak began on 2/17/26 when two or more residents within the facility contracted Influenza A. During an interview on 4/9/2026 at 9:16 a.m., IP H confirmed 25 residents within the facility contacted COVID-19 during the January 2026 outbreak for COVID-19. IP H said the hallway double doors were not closed during the COVID-19 outbreak in an attempt to contain the outbreak from spreading from the 500 Hall (first COVID-19 positive resident) to all of the other halls. DON N, present during the interview, when asked why the Hall doors would have been closed, stated, You can close the (Hallway) doors to decrease the spread (mitigate spread of infectious disease). IP H reported the following COVID-19 details: No outbreak investigation summary was completed for the January 2026 COVID-19 outbreak, infection mapping was completed at the end of the outbreak, communal dining and activities continued throughout the outbreak and staff positive for COVID-19 were not tracked as they worked within the facility for source tracking of the virus. IP H and DON H said they had received a CDC recommendation from the local public health department to leave communal dining open. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	During an interview on 4/9/2026 at 9:46 a.m., when asked why the hallway double doors were not closed to mitigate the spread of both COVID-19 and Influenza A outbreaks in January and February 2026, respectively, IP H stated, I did not consider closing the doors, even though someone said, ' . you know [previous IP T] always closed the doors (with an outbreak) . During an interview on 4/9/26 at 12:15 p.m., a repeat interview was conducted with IP H, the DON, and DON N. When asked about the hallway doors remaining open during infectious disease outbreaks in January 2026 and February 2026, IP H stated, .(we) used to close the doors. I didn't even think about it. IP H acknowledged the hallways doors were wide open between all the hallways, and the facility did not restrict communal dining. We did not restrict communal dining. When asked if IP H, DON N, or the DON had read the local public health departments article provided via email that recommended leaving communal dining in place, all three said they had not read the article. IP H said she was told not to close the doors because it was considered a restraint by administrative staff. Review of the Center for Disease Control (CDC) Viral Respiratory Pathogens Toolkit for Nursing Homes, received by the facility via email on 1/16/26 at 4:37 p.m. from their local public health department, revealed the following, in part: .When an infection due to a respiratory virus is suspected in a resident or HCP, it is important to take rapid action to prevent the spread to others in the facility . Residents placed in Transmission-Based Precautions for acute respiratory infection should primarily remain in their rooms except for medically necessary purposes. If they must leave their room, they should practice physical distancing and wear a facemask for source control. The resident should be removed from Transmission-Based Precautions as soon as they are deemed no longer infectious to others . Investigate potential spread . Perform active surveillance to identify any additional ill residents or HCP using symptom screening and evaluating potential exposures. If transmission is limited to specific units, consider limited quarantine of those units (e.g., restricting those units from group activities or communal dining with residents from other units). Take additionalˆmeasures if initial interventions fail Consult with the local or state public health department about additional interventions. Consider establishing cohort units for residents with confirmed infections. Dedicate HCP to care for residents in cohort units and Minimize HCP movement from areas of the facility where residents are having illness to areas not affected by the outbreak. Limit group activities and communal dining. Consider limiting the use of communal areas where residents or HCP might congregate over multiple units or facility wide . Review of the email from the local public health department to the IP H, dated 1/16/26 at 4:37 p.m., revealed the following, in part: .If you feel you have executed all the initial steps to control spread and are still seeing cases, then you are supposed to move on to the additional measures. Under the (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	additional measures, it suggests considering limiting the use of communal areas. Because only you know the extent you have taken to control spread and whether you feel they are working, Public Health would never tell you that you have to suspend communal dining. However, if you feel it would be helpful, we will support your decision. From our conversation, I did think that you felt suspending communal dining would make a difference at this time . During an interview on 4/9/26 at 12:30 p.m., the Nursing Home Administrator (NHA) said the double doors on all Halls were not closed during the January 2026 COVID-19 and February 2026 Influenza A outbreaks. Review of the facility Outbreak Investigation policy, last revised 10/17/23, revealed the following, in part: . An outbreak is typically one or more of the following: A single case of an infection that is highly communicable (such as COVID-19). Trends that are ten percent (10%) higher than the historical rate of infection for the facility that may reflect an outbreak or seasonal variation and therefore warrant further investigation. Occurrence of three (3) or more cases of the same infection over a specified length of time in the same unit as defined by the local/state health department . PREPARE: 1. Part of routine education of staff should include description of what an outbreak is, their roll in an outbreak and methods of prevention such as: a. Hand hygiene. B. Following appropriate precautions as directed during an event . F. Control measures that may be implemented during an outbreak such as isolation or quarantine . h. The need for nursing staff to monitor for clusters of infection and to report suspected cluster of infection to the Infection Control or their manager . IDENTIFY .f. Develop a line listing .Develop a map to identify clusters or trends of signs and symptoms of potential infection and confirmed cases of infection in residents or staff .CONTAIN, CONTROL AND PREVENT MORE CASES . 4. Other measures may include isolating individuals who are ill from those who are not, discontinuing group activities, discontinuing main dining room services . ADJUST: 1. If control measures are followed but remain ineffective, er-evaluate and modify as needed including possible closure of a unit or the facility to new admissions or transfers out (except in medical emergency), restrict movement of staff between units, restrict visitors, vendors and non-essential staff. RESOLVE:1. When there have been no new cases for at least 72 hours, you may consider the outbreak resolved. 2. Strict quarantine and control measures may be lifted .ANALYZE DATA .1. Compile data gathered during the outbreak and analyze for possible improvement opportunities in identification and management of disease. 2. Determine actions that were effective and actions that were ineffective and possible reasons for the disease. 3. Develop a written report of the outbreak details including an epidemiologic curve, attack rates, risk factors identified, actions that were taken, and control measures that were effective or ineffective. 4. Identify possible strategies that could be implemented to prevent future outbreaks or improve the process. 2. Disinfection of Multiple Use Resident Equipment and Insulin Pens During an observation and interview on 4/8/26 at approximately 11:00 a.m., LPN U prepared a glucometer (used for multiple residents' blood glucose assessments) and an insulin pen for insulin administration to R69. LPN U placed the insulin supplies on a small rectangular tray. The foam tray was placed on R69's overbed table while the glucometer was used to verify the Resident's blood glucose level, and the insulin pen was used to administer 18 units of Glargine insulin to R69. Upon exit from R69's contact precaution room on 4/8/2026 at 11:23 a.m., LPN U was observed as they removed the small white tray from R69's room and placed the tray directly on top of the 400 Hall medication cart, with no barrier present. A new, clean tray was used to place the used (considered dirty) glucometer on, and a bleach disinfectant wipe was folded around the glucometer. LPN U did not (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	wipe (clean) the exterior surfaces of the glucometer, which was then placed on the white, foam tray. LPN U asked this Surveyor if the insulin pen needed to be disinfected (after being in R69's contact precaution room) and stated, We usually don't clean them (insulin pens) before we put them back in the medication cart. Review of the [Name Brand] Blood Glucose Monitoring System User's Guide, copyright 2024, revealed the following disinfection instructions: Cleaning and disinfecting your meter and lancing device is very important in the prevention of infectious disease. Cleaning is the removal of dust and dirt from the meter .so no dust or dirt gets inside. Cleaning also allows for subsequent disinfection to ensure germs and disease-causing agents are destroyed on the meter . surface . 1. Wash hands with soap and water and dry thoroughly. 2. Inspect for blood, debris, dust or lint anywhere on the meter . 4. To disinfect your meter, clean the meter with one of the validated disinfecting wipes listed below .(included [Name Brand Healthcare Bleach Germicidal and Disinfectant Wipes) .Wipe all external areas of the meter .including both front and back surfaces until visibly clean .Allow the surface of the meter . to remain wet at room temperature for the contact time listed on the wipe's directions for use. 5. Wipe meter dry or allow to air dry . During an interview on 4/8/2026 at 12:31 p.m., when asked about disinfection of multiple resident use glucometers (measures blood glucose levels) and resident-specific insulin pens IP H said glucometers were disinfected with a [Name Brand] disinfectant wipe that has a three (3) minute kill time (required for effectiveness of disinfectant), and glucometers and the insulin pens should have been wiped (wet all surfaces) prior to wrapping the wipe around the items for the required kill time. IP H confirmed any disposable items (such as a small foam tray for medical supplies) taken into a contact precaution room should be discarded prior to exit from the room and agreed that all insulin pens taken into a resident's room should be disinfected prior to being placed back into a medication cart. IP H acknowledged failure to implement the above procedures would reflect a control of infection control principles. During an interview on 4/9/2026 at 9:41 a.m., IP H agreed with the infection control concerns related to disinfection of glucometers and insulin pens. 3. Clean, Sanitary Medication Cart During a medication pass observation on 4/8/2026 8:41 a.m., a [Name Brand] concentrated, liquid protein medical food designed to manage wounds, pressure injuries, and protein-energy malnutrition bottle was covered with multiple spills from the top of the bottle when removed from the 300 Hall medication cart for administration to Resident #70 (R70). The dosage was poured into a 30 ml (milliliter), plastic medication cup; the cover replaced on the [Name Brand] liquid protein medical food liquid; and the bottle was placed back into the 300 Hall medication cart with all of the sticky, yellowish liquid dripping down the sides. During an observation on 4/9/26 at 7:30 a.m., RN S retrieved the [Name Brand] concentrated liquid protein medical food designed to manage wounds, pressure injuries, and protein-energy malnutrition from the 300 Hall medication cart. The bottle was inside a black, plastic holder with the sticky, yellowish liquid observed dripping from multiple sides of the bottle top. When the DON and IP H were asked to observe the bottle and comment on whether the condition of the [Name Brand] concentrated liquid protein container was acceptable storage within the medication cart. The DON stated, No, is it not acceptable. I will take it and clean it up. IP H stated Oh God. when she saw the condition of the bottle. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	4. Properly clean and sanitize bedpans On 4/7/2026 at 1:45 PM in interview with Certified Nursing Assistant (CNA) B stated that bed pans were taken to the soiled linen room and rinsed out with the water nozzle at the hopper and then placed in a clean garbage bag and taken back to the resident's room and placed in the closet. On 4/7/2026 at 1:50 PM the Director of Nursing (DON) was asked to provide in writing and upload the number of residents that are on bed pans, along with the facility policy for cleaning and sanitizing reusable medical equipment. On 4/7/2026 at 2:08 PM in an interview with CNA C she stated that clean bedpans are put into a clean garbage bag in the room. When she goes to work with a resident that needs a bed pan, she puts down a clean garbage bag on the floor of the room, removes the bedpan from under the resident and places it on the garbage bag. She then takes the bed pan with the garbage bag underneath it and dumps it in the resident toilet in that room. She uses water from the sink in the resident restroom to rinse out the bed pan and said there is no soap or sanitizer in the restroom to clean the bed pan. On 4/7/2026 at 2:20 PM in an interview with the Social Services Director (SSD) D stated they used to be a CNA here for 11 years up until five weeks ago. They stated that bed pans are kept in the rooms in garbage bags. The bed pan would be removed from the garbage bag and placed under the resident. After the resident was finished using the bed pan, the bed pan was rinsed out into the sink in the resident bathroom using a cup and if available some foam soap. The pan was rinsed with water and placed in a garbage bag and stored again for the next use. On 4/7/2026 at 2:34 in an interview with CNA's F and G, CNA F stated bedpans are stored in the closets in the room of the resident and after use by the resident, the bed pans are emptied in that resident's toilet. CNA G stated that some CNA's dry the bed pan after rinsing and place baby powder in the bedpan, before placing the pan in a garbage bag for storage. On 4/7/2026 at 3:00 PM the DON provided the policy/procedure for bedpan and urinal use and stated the facility currently had 5 residents that required bed pan usage. The Bedpan and urinal use policy Revised: December 15, 2025 states that after the contents of the bedpan or urinal are emptied into a toilet or designated waste area, the bedpan or urinal is to be rinsed with water and cleaned thoroughly using a facility-approved disinfectant solution to prevent the spread of infection.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to protect the residents' right to be free from willful neglect in answering a call light for one Resident (8) of 4 residents reviewed, resulting in Resident #8 waiting for over 20 minutes to be addressed while moaning, crying out and thrashing. Based on the reasonable person concept Resident #8 exhibited signs and symptoms of extreme pain and overwhelming anxiety caused by this extended time of unmet needs.Findings include: Review of a facility Abuse Prohibition Policy dated 10/14/2022 read in part: Policy-Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the guests/residents. Allegations of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator and reported to the appropriate state agencies.The subject of abuse should be routinely and openly discussed.Staff members, volunteers, family members, and others shall immediately report incidents of abuse and suspected abuse, and should be assured that they will be protected against repercussions. Abuse can be guest/resident-to-guest/resident, staff-to-guest/resident, family-to-guest/resident, visitor-to-guest/resident etc.Neglect is the failure of the facility, its employees or service providers to provide goods and services to a guest/resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware, or should have been aware of, goods or services that a guest/ resident(s) requires but the facility fails to provide them to the guest(s)/resident(s), resulting in physical harm, pain, mental anguish or emotional distress. Alleged violations of neglect include cases where the facility demonstrates indifference or disregard for guest/resident care, comfort or safety, resulting in physical harm, pain, mental anguish or emotional distress.Resident #8 (R8)Review of an admission Record revealed R8 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral palsy, anxiety and difficulty swallowing.Review of a Minimum Data Set (MDS) assessment for R8, with a reference date of 1/14/2026 revealed a Brief Interview for Mental Status (BIMS) score of 99/15 which indicated R8 was severely impaired.Review of R8's Care Plan read in part: FOCUS: R8 was at risk for pain r/t Chronic Physical Disability = cerebral palsy, scoliosis and contractures Date Initiated: 01/28/2025.INTERVENTIONS: Observe and report any (signs/symptoms) of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Report abnormal findings to the physician. Date Initiated: 01/28/2025.Review of R8's Kardex (CNA care guide) read in part: MONITORS: Observe and report any s/sx (signs/symptoms) of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Report abnormal findings to the physician.During initial pool observations on 4/6/2026 at 2:42 PM., a crying/moaning sound was coming from a resident's room and could be heard from the middle of the unit, from approximately 25 feet or more away. This surveyor proceeded down the unit to find the resident who could be heard crying. This surveyor reached the end of the unit to the last room on the right-hand side and the resident in the first bed was noted to be R8. This surveyor knocked but there was no answer and crying was still heard. This surveyor announced self and entered the room. In the first (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	bed, R8 was observed lying on her right side with a pillow underneath her left side. R8 was hooked up to a feeding tube which was running. R8 continued crying, moaning and thrashing her head back and forth. This surveyor approached the right side of the bed and observed R8's hair matted to the back of her head and it appeared greasy and unkempt. R8 was noted to have tears coming from her eyes. There were dried crusted tears in which the white substance (aqueous layer-watery part from lacrimal glands, containing salts, proteins, and enzymes) from the tears was noticed to be dry on her right temple and upper cheek, there was also a collection of wet tears on her left inner eye canthus (the corner of the eye nearest the nose where the upper and lower eyelids meet, playing a key role in tear drainage). R8 appeared sweaty and her bed linens were strewn about the bed. R8 appeared to be restless, tense and it seemed as though she was trying to swallow. R8 had a copious (abundant) amount of secretions in her mouth, her tongue was moving back and forth and sticking in and out. R8 was still crying and there was a noticeable rattle-gurgling sound from her throat. This surveyor made their presence known, although R8 was unable to answer questions, or make any verbal contact she appeared to be calming down, she began pushing her head back into her pillow with less thrashing. R8's front upper and bottom teeth had a thick dry, stuck on plaque, tarter and sputum in layers approximately three quarters of an inch thick. R8's teeth could not be seen. R8's mouth, lips and chin also had areas of wet and dry crusted sputum-secretions. R8's call light was noted to be clipped to the pillow behind her out of reach. R8 was noted to have limited range of motion with her upper extremities, and her arms were contracted inward up near her chest. R8 continued to cry and moan, as well as continued distress and thrashing of her head. At approximately 2:47 PM, this surveyor pressed R8's call light to note call light wait times. This surveyor noted R8's roommate was in her bed asleep, her call light was a round pad type, R8s call light was a button press style. This surveyor noted approximately 2-3 Certified Nurse Aides (CNA) staff members enter the room directly across from R8. The sign on the door read Employee Breakroom This surveyor looked outside R8's bedroom doorway above the door to ensure the call light had triggered properly for staff to respond timely. The call light was on and was lit up. At this time, which was 3:04 PM., no staff were noted on the unit. R8 appeared to have noticed this surveyor when reapproaching the right side of her bed, taking note of the bedside table which held a basin full of mouth swabs, suction pieces individually wrapped and various other oral-mouth care items. This surveyor took note of R8's garbage next to her bed, noted it was a clear garbage bag with nothing in it and the bathroom garbage was also empty.On 4/6/2026 at 3:10 PM., CNA J was observed entering R8's room and walked in front of this surveyor (standing 1-foot away from the foot of R8's bed). CNA J walked around R8's bed on the right side, and shut the call light off. CNA J did not make eye contact, look at or say anything to R8. CNA J then walked over to R8's roommate who was asleep. CNA J asked the roommate if she needed anything, no answer or sound was made by R8's roommate and her eyes remained closed. CNA J walked past this surveyor, not looking at R8 and exited the room.This surveyor then approached CNA J, and in an interview/observation on 4/6/26 at 3:12 PM., was asked what he completed in R8's room. CNA J stated I saw the call light on and know that R8 cannot use her call light, so I went over to bed 2 and asked her what she needed. She (R8's roommate) said she hit the call light by accident. when further prompted, CNA J responded by stating I am assigned to both residents in R8's room, I did not look closely at R8, and I have not done cares on her since this morning CNA J was asked what R8's baseline for breathing, oral-mouth appearance, hair, toileting and her typical behaviors were. CNA J stated R8 cries out when something was wrong or she is uncomfortable and/or in pain. CNA J stated I didn't look at her or check on her when I turned the call light off, I did not notice the 2 call lights were not the call lights for the residents. CNA J stated I lied, R8's roommate did not say anything to me when I asked her if she needed anything, she was asleep. I did not do anything to assist R8 when it was clear she was uncomfortable, and I lied to you when you (this surveyor) asked me, because I don't know the answers to the questions you were asking about R8. CNA J reported he should have looked at R8's Kardex, and/or gotten assistance from the nurse on duty to ensure R8 was okay. CNA (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	J reported he has never completed oral care on R8 and did not provide any type of oral care for R8 today, because he thought only the nurses were to do it. CNA J and this surveyor observed R8's mouth, CNA J stated it should not look like that, it seems like she has a lot of secretions built up and stuck in her throat, and she needs to be cleaned up. In an interview and observation on 4/6/2026 at approximately 3:20 PM., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) H accompanied this surveyor to R8's room. Both DON and ADON H reported they were concerned about the overall appearance of R8. ADON H and DON were both informed of this surveyor's earlier observation of R8, and the interview with CNA J, as well as the multiple staff who entered the Staff Breakroom while R8's call light was on. ADON H appeared visibly upset and reported they would take care of R8 cares and oral cares. The DON responded with concern and stated, the staff failed R8 by ignoring her call light and did not provide proper care and services, which is unacceptable care for any resident. This surveyor informed DON and ADON H that CNA J openly admitted to lying in an interview with this surveyor about completing earlier care for R8 and turning off a resident call light without meeting the needs of residents, because he did not know what to do. DON and ADON H both began to gown up and proceeded to start care on R8. ADON H stated she would be speaking to CNA J and the staff once R8's care was complete.

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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 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 (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	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 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: (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	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 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 4/6/2026 at 1:17 PM observed the large stand mixer covered with a plastic bag. DM A was asked why the bag was covering the mixer and they stated that the bag meant that the mixer had been cleaned and covered to show that it was ready to use again. The covering was removed and food debris was noted on the protective wire bowl guard and on the underneath splash zone area where the beater is attached to the unit.According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. On 4/7/2026 at 10:04 AM observed upon opening the door to the exterior walk-in freezer that the stainless-steel covering on the interior of the door is completely missing and the foam insulation underneath is completely exposed. According to the 2022 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications.

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Christian Park Health Care Center	2415 5th Avenue South Escanaba, MI 49829

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain general repair of patient equipment and the premises resulting in an increased potential for contamination and a possible decrease in satisfaction of living affecting all residents of the facility. Findings Include:On 4/7/2026 at 8:25 AM in room [ROOM NUMBER] Bed A, observed that the headboard was broken away from the bed and sitting askew with the left corner of the headboard sitting on the floor. During this observation, resident 1 stated that they had requested this be repaired three to four months ago and nothing had been done yet. On 4/7/2026 at 09:29 AM observed duct tape on the handle of the hopper water hose that is used to rinse out soiled linens. During this observation, Maintenance Director (MD) E stated that the duct tape was to give the handle some traction so it would hang in the bracket above the bowl without falling out. On 4/7/2026 at 10:04 observed peeling sealant on exterior soffits on the two hundred wing and just to the left of the emergency exit door on the three hundred wing. Paint was noted missing from the area below the exterior window frames below four sets of windows.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Medication Regimen Reviews (MRRs) were addressed by the physician in a timely manner and maintained in the clinical record for three Residents (#5, #45, and #52) of five residents reviewed for MRRs.Findings include:Resident #45 (R45) Review of R45's admission Minimum Data Set (MDS) assessment, dated 6/25/25, revealed R45 was admitted on [DATE] with active diagnoses that included the following, in part: Non-Alzheimer's dementia, anxiety disorder, and restlessness and agitation, Resident R45 scored a 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition, with no documented behaviors. Medications administered upon admission included an antipsychotic and antidepressant. Review of R45's MRR Recommendations (to Physician), provided by the facility, revealed the following, in part: Review of R45's Electronic Medical Record (EMR) revealed MRR documentation was not present or not addressed by the physician for the following months: July 2025 August 2025 September 2025: Resident has received buspirone 20 mg (milligrams) BID (twice daily) for anxiety since at least 3/2025. Resident also receives trazodone. Please consider a gradual dose reduction (GDR) to buspirone 15 mg BID. If GDR is clinically contraindicated at this time this contraindication may be documented by including medical rational for the contraindication below in lieu of performing a GDR. The Physician Response, Signature, and Date were absent any documentation and unaddressed by the physician. October 2025 MRR Date: 10/15/26 Resident (R45) receives risperidone for 'anxiety'. Anxiety is generally not considered an acceptable antipsychotic use per CMS F330/F758. Please clarify the diagnosis for the use of the antipsychotic agent in the directions of the order and reissue as a new order. OR please taper and discontinue if no valid diagnosis exists for this order. Physician/Prescriber Response, Signature and Date were blank: absent any physician documentation. November 2025: MRR Date: 11/19/25 This notated MRR Recommendation, with the same recommendation as issued 10/15/25, was provided to this Surveyor on 4/8/26 at 7:33 a.m., by Unit Manager/RN K. The 11/19/25 MRR Recommendation was signed by the physician on 2/10/26, nearly 3 months following the pharmacy recommendation, and noted by nursing staff on 3/7/26 and 3/9/26. December 2025 January, February and March 2026: MRR Dates: 1/20/26, 2/17/26 and 3/17/26 Pharmacy Recommendations to the Physician revealed the following, repeated information: Anxiety is generally not considered an acceptable antipsychotic use per CMS F330/F758. Please clarify the diagnosis for the use of the antipsychotic agent in the directions of the order and reissue as a new order. OR please taper and discontinue if no valid diagnosis exists for this order. Physician/Prescriber Response, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Signature and Date were blank: absent any physician documentation. Resident #52 (R52) Review of R52's MDS assessment dated [DATE], revealed R52's admission to the facility with diagnoses that included anxiety disorder and depression, in part. R52 scored 15 of 15 on the BIMS, reflective of intact cognition. Review of R52's Electronic Medical Record (EMR) revealed the MRR documentation was not present or not addressed by the physician for the following months: August 2025 September 2025: Resident has received buspirone 20 mg (milligrams) BID (twice daily) for anxiety since at least 3/2025. Resident also receives trazodone. Please consider a gradual dose reduction (GDR) to buspirone 15 mg BID. If GDR is clinically contraindicated at this time this contraindication may be documented by including medical rational for the contraindication below in lieu of performing a GDR. The Physician Response, Signature, and Date were absent any documentation and unaddressed by the physician. October 2025 November 2025 December 2025 January 2026 March 2026 During an interview on 4/8/26 at 7:18 a.m., the DON stated, There was a break in the (MMR) process. When there was an interim DON there was a break in the process of getting these (MMRs) taken care of. The DON acknowledged that not all MMR documentation was present for R45 or R52 in the medical record. Review of the Timeliness of Medication Regimen Review Reports, policy, last revised 9/7/23, revealed the following, in part: Policy: The pharmacist will review and report any medication irregularities at least once a month. 1. With new admissions the consultant pharmacist will complete a MRR and provide a report via secure email within 72 hours to the Director of Nursing/designee. 2. Clinically significant medication issues . must be communicated to the prescriber or designee and resolved by 11:59 p.m. the following day. 3. The consultant will provide monthly MRR reports addressed to the Medical Director, Director of Nursing, and Attending Physician within 3-5 days of completion via secure e-mail or hard copy. 4. The attending physician is expected to review the resident's individual MRR and document and sign (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that he/she has reviewed the pharmacist' identified recommendations within 14 days of receipt. 5. The attending Physician does not respond to the resident's MRR report within 14 days, the Director of Nursing will notify the physician of pending MRR reports. 6. If by the 21st day, the attending physician has not yet responded to the resident's individual MRR report, the Director of Nursing will notify the Medical Director to review and respond to the pending MRR reports. 7. If the medical Director is also the attending physician, the Director of Nursing will escalate the issue to the facility Administrator. 8. When the consultant pharmacist identifies a recommendation that requires immediate or urgent action, the pharmacist will notify the director of Nursing and the assigned nurse at the time the recommendation is identified. Resident #5 (R5) Review of R5's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 8/6/21, with diagnoses that included Non-Alzheimer's dementia and schizophrenia. R5 scored 0 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment. Review of R5's Electronic Medical Record (EMR) did not contain MRR for the following months: August 2025 October 2025 November 2025 December 2025 February 2026 March 2026 During an interview on 4/8/26 at 7:34 a.m., the Director of Nursing (DON) reported, I cannot find MRR's for the months of August, October, November, and December of 2025.and I cannot find the MRR's for February or March of 2026 for R5. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/8/26 at 2:42 p.m., the DON and Nursing Home Administrator (NHA) acknowledged the facility did not have the MRR's for R5.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate advanced directive information was in place for one Resident (7) of two residents reviewed for accuracy of advanced directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time).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 #7 (R7)Review of an admission Record revealed R7 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: right femur fracture.Review of a Minimum Data Set (MDS) assessment for R7, with a reference date of 2/9/2026 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated R7 was mild cognitive impairment.Review of R7's Electronic Medical Record (EMR) on 4/07/2026 at 11:05 AM., read in part on the face page of the EMR R7 was listed as (Advance Directives) Full Code by Default .Review of R7's EMR in the Documents (various original paper form documents uploaded to view) Advance Directives original signed document had R7 listed as a No Code or Do Not Resuscitate In an interview/record review on 4/07/2026 at 3:40 PM., Assistant Director of Nursing (ADON) H reported R7 should be a Do Not Resuscitate his EMR in both areas of his medical chart. ADON H reported it was not clear at this time and would have to look into it.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure unnecessary psychotropic medications were not administered for an extended duration and without appropriate indications for use for 2 Residents (R45 & R59) of 5 residents reviewed for unnecessary medications/chemical restraints. This deficient practice resulted in administration of antipsychotic medications for an extended duration, administration of antipsychotic medication without appropriate diagnoses for use, and lack of timely gradual dose reductions (GDRs). Findings include:Resident R45Review of R45's admission Minimum Data Set (MDS) assessment, dated 6/25/25, revealed R45 was admitted on [DATE] with active diagnoses that included the following, in part: Non-Alzheimer's dementia, anxiety disorder, restlessness and agitation, Resident R45 scored a 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition, with no documented behaviors. Medications administered upon admission included an antipsychotic and antidepressant. Review of R45's quarterly MDS assessment, dated 10/9/25, revealed diagnoses that included anxiety disorder and non-Alzheimer's dementia. Psychotic Disorders was documented no. BIMS remained cognitively intact with a 15 of 15 score. Medications continued to include an antipsychotic and an antidepressant. Antipsychotics were routinely administered with no GDR and no documented contraindication for a GDR. Review of R45's quarterly MDS assessment, dated 12/23/25, revealed diagnoses that included non-Alzheimer's dementia and anxiety disorder. Psychotic Disorders was documented no. BIMS score was 13 out of 15, reflective of intact cognition. Medications included antipsychotic and antidepressants. Antipsychotics were administered routinely with no GDR and no documented contraindication for a GDR in the medical record. Review of R45's quarterly MDS assessment, dated 4/1/26, revealed diagnoses that included non-Alzheimer's dementia and anxiety disorder. BIMS score was not completed for this assessment. Behaviors were also not assessed. Medications included antipsychotic, anti-anxiety and antidepressant. The Antipsychotic Medication Review revealed antipsychotics were administered on a routine basis, and a GDR was attempted on 3/15/26. No documentation by the physician was documented as clinically contraindicated. Review of R45's 9/18/25 Nursing Notes revealed Resident (R45) noted to have increased anxiety at times, worried about her breathing, worrying about her husband and things such as lunch etc. I spoke with PA (physician assistant) regarding this, new order to increase Risperdal (antipsychotic medication). Resident aware. Review of R45's MRR Recommendations (to Physician), provided by the facility 4/8/26 at approximately 1:10 p.m., revealed the following, in part:MRR Date: 10/15/26 Resident (R45) receives risperidone for 'anxiety'. Anxiety is generally not considered an acceptable antipsychotic use per CMS F330/F758. Please clarify the diagnosis for the use of the antipsychotic agent in the directions of the order and reissue as a new order. OR please taper and discontinue if no valid diagnosis exists for this order. Physician/Prescriber Response, Signature and Date were blank: absent any physician documentation.MRR Date: 11/19/25 This notated MRR Recommendation, with the same recommendation as issued 10/15/25, was provided to this Surveyor on 4/8/26 at 7:33 a.m., by Unit Manager/RN K. The 11/19/25 MRR Recommendation was signed by the physician on 2/10/26, nearly 3 months following the pharmacy recommendation, and noted by nursing staff on 3/7/26 and 3/9/26.MRR Dates: 1/20/26, 2/17/26 and 3/17/26 Pharmacy Recommendations to the Physician revealed the following, repeated information: Anxiety is generally not considered an acceptable antipsychotic use per CMS F330/F758. Please clarify the diagnosis for the use of the antipsychotic agent in the directions of the order and reissue as a new order. OR please taper and discontinue if no valid diagnosis exists for this order. Physician/Prescriber Response, Signature and Date were blank: absent any physician documentation.Review of a 9/18/25 Physician Visit with a Chief Complaint of Anxiety, revealed the following, in part: [R45] is having anxiety that is not controlled with her current (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dose of Risperdal. I will increase her Risperdal to 1 mg BID (milligram twice a day). May consider Buspar (anti-anxiety medication) in the future .Behavior/Psychiatric: Positive: Normal mood and affect, Cooperative . Completed by Physician Assistant O.Review of Psychiatric Follow up Visit for R45 on 2/19/26 revealed the following, in part: [R45] .history of dementia and anxiety . BIMS score is 15 (intact cognition). [R45] . is overdue for Gradual Dose Reduction (GDR) for Risperdal, and the indication for starting Risperdal is unclear. Facility staff report no problematic behaviors. The patient denies hallucination, paranoia, or nightmares. She is described as pleasant but experiences episodes of anxiety. Risperdal is not used for managing her anxiety, and adjustments to her anxiety medications could be considered if necessary . During an interview on 4/8/26 at 1:15 p.m., the Director of Nursing (DON) and DON/Registered Nurse (RN) N provided a copy of R45's Risperdal (antipsychotic) medication orders and changes which were listed on 22 separate lines within R45's Risperdal Order Review listing within the Electronic Medical Record (EMR). The DON and DON N provided and confirmed the following Risperdal medication information in writing:6/19/25 admission order (for behaviors exhibited in the acute care hospital prior to admission) 1 mg (milligram) at HS (hour of sleep). 0.5 mg in AM.6/24/25 No dose change. Changed indication for use (to anxiety).9/18/25 1 mg BID (daily dose increased). During an interview at this same time, DON N and the DON said Risperdal continued prescribed for the diagnosis of anxiety.1/19/26 No dose change (1 mg BID). 2/21/26 1 mg at HS. 0.5 mg at AM. (Same order as that ordered 6/19/25).3/7/26 Diagnosis changed from anxiety to restlessness and agitation.3/8/26 0.5 mg BID (Diagnosis of restlessness and agitation.)3/10/26 1 mg at HS 0.5 mg at AM.3/16/26 No dose change.3/24/26 0.5 mg BID 3/28/26 No dose change (0.5 mg BID). During an interview at this same time, when asked if anxiety was an appropriate indication for use for R45's Risperdal, DON N stated, I agree anxiety is not an appropriate diagnosis . When asked how pharmacy recommendations to the physician will be monitored for appropriate antipsychotic documentation and usage, the DON stated, (We will have) a different process to review (the MRRs) timely, contact the physician and get that process in place (including ensuring consents for psychotropics were obtained prior to administration.)During a telephone interview on 4/8/26 at 4:07 p.m., Consultant Pharmacist P was asked about R45's Pharmacy Recommendations to the Physician related to R45's antipsychotic medication - Risperdal. Consultant Pharmacist P stated, I have not always gotten back the physician recommendations. That has been a struggle for the physician. I don't know if it is the physician not answering, or if the facility is breaking down in communication. Antipsychotic (medication) is an automatic resubmit and I bring it up every month and say here is an antipsychotic diagnosis that did not get answered each month . I told them month in and month out that these reports (needed to be addressed) . Review of the Psychoactive Medication Management policy, last revised 1/28/26, revealed the following, in part: The facility does not use chemical restraints which are defined by federal regulations as drugs used for discipline or convenience and not required to treat medical symptoms .When pharmacological interventions are indicated, the licensed staff will verify that the physician order includes the appropriate clinically supported diagnosis and/or behavior symptoms .Residents receiving psychoactive medications upon admission, those with new psychoactive medications orders or an increase in the dose of the medication, will have a psychotropic medication informed consent completed. Before initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase .Review of the Risperdal Black Box Warning and Indications for Use, revised 1/2025, revealed the following, in part: WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS . Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. RISPERDAL is not approved for use in patients with dementia-related psychosis. (5.1) ---RECENT MAJOR CHANGES---- Warnings and Precautions (5.6) 1/2025 ----INDICATIONS AND USAGE---- RISPERDAL is an atypical antipsychotic indicated for: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treatment of schizophrenia (1.1) As monotherapy or adjunctive therapy with lithium or valproate, for the treatment of acute manic or mixed episodes associated with Bipolar I Disorder (1.2) Treatment of irritability associated with autistic disorder (1.3) .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to implement its Abuse Program Policy and Procedure and immediately protect other this and other residents from neglect, for 1 Resident (#8) from 4 residents reviewed for abuse/neglect. This deficient practice resulted in the potential for continued resident abuse/neglect. Findings include:Review of a facility Abuse Prohibition Policy dated 10/14/2022 read in part: Policy-Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment. Allegations of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator and reported to the appropriate state agencies.Neglect is the failure of the facility, its employees or service providers to provide goods and services to a guest/resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware, or should have been aware of, goods or services that a guest/ resident(s) requires but the facility fails to provide them to the guest(s)/resident(s), resulting in physical harm, pain, mental anguish or emotional distress. Alleged violations of neglect include cases where the facility demonstrates indifference or disregard for guest/resident care, comfort or safety, resulting in physical harm, pain, mental anguish or emotional distress. Further review of the facility policy revealed:G. Reporting abuse and facility Response to the allegation1. The staff will report any allegations or suspicions of mistreatment, abuse, neglect, exploitation, misappropriation of property, and injuries of unknown source to the Administrator immediately.2. The Administrator or designee will notify the guest's/resident's representative. Also, any State or Federal agencies of allegations per state guidelines (2 hours if abuse allegation or serious injury; all others not later than 24 hours). At the conclusion of the investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective action.3. Substantiated complaints against nurse aides for acts of guest/resident abuse, mistreatment, neglect or misappropriation of a guest's/resident's property shall be reported to the state Nurse Aide Registry when the facility has knowledge. Nurses will be reported to the State Board of Nursing for violations that are substantiated. The facility has the obligation to report to state nurse aide registry or licensing authorities any knowledge it has of court actions against an employee that would make them unfit for service.4. In cases of abuse, neglect, misappropriation of guest/resident property, and exploitation, the Quality Assurance Performance Improvement Committee will review the circumstances to determine if changes in policies and procedures are necessary to provide further preventative measures. All cases will be reviewed at the QAPI meetings.Resident #8 (R8)Review of an admission Record revealed R8 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral palsy, anxiety and difficulty swallowingReview of a Minimum Data Set (MDS) assessment for R8, with a reference date of 1/14/2026 revealed a Brief Interview for Mental Status (BIMS) score of 99/15 which indicated R8 was severely cognitively impaired.Review of R8's Care Plan read in part: FOCUS: R8 was unable to tolerate nutritionally adequate food and/or fluids by mouth requiring the use of a feeding tube R/T (related to) dysphagia, quadriplegic cerebral palsy, seizures, epilepsy and Nothing BY Mouth Diet order. Date Initiated: 01/27/2025 .INTERVENTIONS: ORAL HYGIENE: Resident is dependent on staff for oral hygiene and requires one person assistance. Date Initiated: 01/29/2025 .Review of R8's Care Plan read in part: FOCUS: R8 was at risk for pain r/t Chronic Physical Disability = cerebral palsy, scoliosis and contractures Date Initiated: 01/28/2025.INTERVENTIONS: Observe and report any (signs/symptoms) of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Report abnormal findings to the physician. Date Initiated: 01/28/2025.During initial pool observations on 4/6/2026 at 2:42 PM., a crying/moaning sound was coming from a resident's room and could be heard from the middle of the unit, from approximately 25 feet or more away. This surveyor proceeded down the unit to find the resident who could be heard crying. This surveyor reached the end of the unit to the last room on the right-hand side and the resident in the first bed was noted to be R8. This surveyor knocked but there was no answer and crying was still heard. This surveyor announced self and entered the room. In the first bed, R8 was observed lying on her right side with a pillow underneath her left side. R8 was hooked up to a feeding tube which was running. R8 continued crying, moaning and thrashing her head back and forth. This surveyor approached the right side of the bed and observed R8's hair matted to the back of her head and it appeared greasy and unkempt. R8 was noted to have tears coming from her eyes. There were dried crusted tears in which the white substance (aqueous layer-watery part from lacrimal glands, containing salts, proteins, and enzymes) from the tears was noticed to be dry on her right temple and upper cheek, there was also a collection of wet tears on her left inner eye canthus (the corner of the eye nearest the nose where the upper and lower eyelids meet, playing a key role in tear drainage). R8 appeared sweaty and her bed linens were strewn about the bed. R8 appeared to be restless, tense and it seemed as though she was trying to swallow. R8 had a copious (abundant) amount of secretions in her mouth, her tongue was moving back and forth and sticking in and out. R8 was still crying and there was a noticeable rattle-gurgling sound from her throat. This surveyor made their presence known, although R8 was unable to answer questions, or make any verbal contact she appeared to be calming down, she began pushing her head back into her pillow with less thrashing. R8's front upper and bottom teeth had a thick dry, stuck on plaque, tarter and sputum in layers approximately three quarters of an inch thick. R8's teeth could not be seen. R8's mouth, lips and chin also had areas of wet and dry crusted sputum-secretions. R8's call light was noted to be clipped to the pillow behind her out of reach. R8 was noted to have limited range of motion with her upper extremities, and her arms were contracted inward up near her chest. R8 continued to cry and moan, as well as continued distress and thrashing of her head. At approximately 2:47 PM, this surveyor pressed R8's call light to note call light wait times. This surveyor noted R8's roommate was in her bed asleep, her call light was a round pad type, R8s call light was a button press style. This surveyor noted approximately 2-3 Certified Nurse Aides (CNA) staff members enter the room directly across from R8. The sign on the door read Employee Breakroom This surveyor looked outside R8's bedroom doorway above the door to ensure the call light had triggered properly for staff to respond timely. The call light was on and was lit up. At this time, which was 3:04 PM., no staff were noted on the unit. R8 appeared to have noticed this surveyor when reapproaching the right side of her bed, taking note of the bedside table which held a basin full of mouth swabs, suction pieces individually wrapped and various other oral-mouth care items. This surveyor took note of R8's garbage next to her bed, noted it was a clear garbage bag with nothing in it and the bathroom garbage was also empty.On 4/6/2026 at 3:10 PM., CNA J was observed entering R8's room and walked in front of this surveyor (standing 1-foot away from the foot of R8's bed). CNA J walked around R8's bed on the right side, and shut the call light off. CNA J did not make eye contact, look at or say anything to R8. CNA J then walked over to R8's roommate who was asleep. CNA J asked the roommate if she needed anything, no answer or sound was made by R8's roommate and her eyes remained closed. CNA J walked past this surveyor, not looking at R8 and exited the room.This surveyor then approached CNA J, and in an interview/observation on 4/6/26 at 3:12 PM., was asked what he completed in R8's room. CNA J stated I saw the call light on and know that R8 cannot use her call light, so I went over to bed 2 and asked her what she needed. She (R8's roommate) said she hit the call light by accident. when further prompted, CNA J responded by stating I am assigned to both residents in R8's room, I did not look closely at R8, and I have not done cares on her since this morning CNA J was asked what R8's baseline for breathing, oral-mouth appearance, hair, toileting and her typical behaviors were. CNA J (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated R8 cries out when something was wrong or she is uncomfortable and/or in pain. CNA J stated I didn't look at her or check on her when I turned the call light off, I did not notice the 2 call lights were not the call lights for the residents. CNA J stated I lied, R8's roommate did not say anything to me when I asked her if she needed anything, she was asleep. I did not do anything to assist R8 when it was clear she was uncomfortable, and I lied to you when you (this surveyor) asked me, because I don't know the answers to the questions you were asking about R8. CNA J reported he should have looked at R8's Kardex, and/or gotten assistance from the nurse on duty to ensure R8 was okay. CNA J reported he has never completed oral care on R8 and did not provide any type of oral care for R8 today, because he thought only the nurses were to do it. CNA J and this surveyor observed R8's mouth, CNA J stated it should not look like that, it seems like she has a lot of secretions built up and stuck in her throat, and she needs to be cleaned up.In an interview and observation on 4/6/2026 at approximately 3:20 PM., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) H accompanied this surveyor to R8's room. Both DON and ADON H reported they were concerned about the overall appearance of R8. ADON H and DON were both informed of this surveyor's earlier observation of R8, and the interview with CNA J, as well as the multiple staff who entered the Staff Breakroom while R8's call light was on. ADON H appeared visibly upset and reported they would take care of R8 cares and oral cares. The DON responded with concern and stated, the staff failed R8 by ignoring her call light and did not provide proper care and services, which is unacceptable care for any resident. This surveyor informed DON and ADON H that CNA J openly admitted to lying in an interview with this surveyor about completing earlier care for R8 and turning off a resident call light without meeting the needs of residents, because he did not know what to do. DON and ADON H both began to gown up and proceeded to start care on R8. ADON H stated she would be speaking to CNA J and the staff once R8's care was complete. In an observation and interview on 4/8/26 at 9:00 AM., CNA J was noted on the 500 unit. CNA J approached this surveyor and apologized for lying in his interview yesterday. CNA J stated after I left from work, I reflected on what I had done, and I was wrong for lying. I should have checked on (R8) more often and asked for help or just said I didn't know the answers to your questions. CNA J reported he had not been removed from the unit, or from providing care to residents.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to investigate a report of neglect for 1 Resident (#8) of 4 residents reviewed for abuse/neglect, resulting in the potential for continued abuse and/or neglect of residents residing in the facility to go unrecognized.Findings include:Review of a facility Abuse Prohibition Policy dated 10/14/2022 read in part: Policy-Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment. Allegations of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator and reported to the appropriate state agencies.Neglect is the failure of the facility, its employees or service providers to provide goods and services to a guest/resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Alleged violations of neglect include cases where the facility demonstrates indifference or disregard for guest/resident care, comfort or safety, resulting in physical harm, pain, mental anguish or emotional distress. Further review of the facility policy revealed:Investigation.1. Allegations by anyone who becomes aware of verbal, physical, mental, sexual or emotional abuse and mistreatment, neglect, exploitation, involuntary seclusion or misappropriation of property must immediately report it to his/her Administrator.2. The Director of Nursing or designee will complete an assessment of guest(s)/resident(s) and document findings in the medical record.3. An Incident Report (and/or grievance forms per state specific requirements) will be completed.4. The licensed nurse will:a. Notify the physician if requiredb. Notify the family member/responsible party/emergency contact/legal guardian (not necessarily all individuals)1. A preliminary, on-site investigation will be initiated within twenty-four (24) hours of any report.F. Protection of Guests/Residents during the Investigation1. If the accused is an employee of the facility, he/she will be suspended until the investigation has been completed.Resident #8 (R8)Review of an admission Record revealed R8 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral palsy, anxiety and difficulty swallowing.Review of a Minimum Data Set (MDS) assessment for R8, with a reference date of 1/14/2026 revealed a Brief Interview for Mental Status (BIMS) score of 99/15 which indicated R8 was severely impaired.Review of R8's Care Plan read in part: FOCUS: R8 was at risk for pain r/t Chronic Physical Disability = cerebral palsy, scoliosis and contractures Date Initiated: 01/28/2025.INTERVENTIONS: Observe and report any (signs/symptoms) of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Report abnormal findings to the physician. Date Initiated: 01/28/2025.Review of R8's Kardex (CNA care guide) read in part: MONITORS: Observe and report any s/sx (signs/symptoms) of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Report abnormal findings to the physician.During initial pool observations on 4/06/2026 at 2:42 PM., a crying/moaning sound coming from a resident's room could be heard from the middle of the unit. At the very end of the unit last room on the right in the first bed, it was noted R8. R8 was crying, moaning and thrashing her head back and forth. R8's hair was matted to the back of her head, her hair was greasy and she appeared unkempt. R8 was noted to have tears coming from her eyes. R8 was sweaty and her bed linens were strewn about the bed. R8 appeared to be restless, tense and it seemed as though she was trying to swallow. R8 had a copious (abundant) amount of secretions in (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her mouth. R8 continued crying and there was a noticeable rattle-gurgling sound from her throat. R8's front upper and bottom teeth had a thick dry, stuck on plaque, tarter and sputum in layers approximately three quarters of an inch thick. R8's mouth, lips and chin also had areas of wet and dry crusted sputum-secretions. R8's call light was noted to be clipped to the pillow behind her out of reach. At approximately 2:47 PM, this surveyor pressed R8's call light to note call light wait times. This surveyor noted R8's roommate was asleep in her bed. In an interview/observation on 4/6/26 at 3:12 PM., CNA J stated I saw the call light on and know that R8 cannot use her call light, so I went over to bed 2 and asked her what she needed. She (R8's roommate) said she hit the call light by accident. CNA J reported he did not look closely at R8 and had not done cares on her since this morning. CNA J stated I lied, R8's roommate did not say anything to me when I asked her if she needed anything, she was asleep. CNA J reported he did provide care to R8 when she was uncomfortable, he should have looked at R8's Kardex, and/or gotten assistance from the nurse on duty to ensure R8 was okay. CNA J reported he has never completed oral care on R8 and did not provide any type of oral care for R8 today. CNA J stated her mouth should not look like that, it seems like she has a lot of secretions built up and stuck in her throat, and she needs to be cleaned up. In an interview and observation on 04/06/2026 at approximately 3:20 PM., Director of Nursing (DON) and Assistant Director of Nursing (ADON) H accompanied this surveyor to R8's room. Both DON and ADON H reported they were concerned with the overall appearance of R8. This surveyor explained the earlier observation/interview with CNA J. ADON H appeared visibly upset and reported she would take care of R8 cares and oral cares. DON responded with concern and stating failure on CNA J part to ensure goods and services were provided was not acceptable care for any resident.In an observation and interview on 4/8/26 at 9:00 AM., CNA J was noted on the 500 unit where R8 resides. CNA J approached this surveyor and apologized for lying in his interview yesterday. CNA J stated after I left work, I reflected on what I had done, and I was wrong for lying. I should have checked on (R8) more often and asked for help or just said I didn't know the answers to your questions. CNA J reported he had not been removed from the unit, or from providing care to residents.In an interview on 4/8/2026 at 3:22 PM., ADON H reported after the incident of alleged neglect for R8 on 4/6/26 regarding CNA J failing to provide care for R8, she and DON informed the Nursing Home Administrator (NHA) of the concerns this surveyor had. ADON H reported she was unsure if NHA reported anything to the State Agency. ADON H reported she did not complete an Incident Report or provide education on Abuse to all staff.In an interview on 4/8/26 at 4:10 PM., NHA and DON were seated in NHA office. NHA was asked if an incident report or a Facility Incident Report (FRI) was completed and/or R8s alleged neglect was reported to the state agency. NHA stated I was unaware that the incident happened like it did, and the word neglect was never said. DON reported she informed the NHA of what occurred in R8's room on 4/6/26 after she and ADON H had provided care to R8. DON reported she did not fill out an Incident Report. NHA stated I was only told that the CNA had lied to the surveyor. NHA reported the incident was not reported or investigated as an allegation of abuse/neglect. Review of the State Operations Manual read in part: 483.12(c)(3) Prevent further potential abuse, neglect. While the investigation is in progress. Prevention .the facility must immediately put effective measures in place to ensure that further potential abuse, neglect. Does not occur while the investigation is in process. Examples of instances where the facility failed to provide protection include, but are not limited to: The alleged perpetrator continues to have access to the alleged victim and/or other vulnerable residents.

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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.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain a PASARR (Preadmission Screening/Annual Resident Review) prior to admission for one Resident (#3) of two residents reviewed for PASARR screening.Findings include:Resident #3 (R3)Review of Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE] with diagnoses that included: anxiety disorder, depression, bipolar disorder, and schizophrenia. R3 scored 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition.Review of R3's Electron Medical Record (EMR) revealed a PASARR was not completed until 2/21/26.During an interview on 4/7/26 at 2:22 p.m., the Director of Nursing (DON) reported, PASARR's are completed when the residents are admitted to the facility. The DON acknowledged the PASARR had not been completed upon admission.During an interview on 4/8/26 at 2:42 p.m., the DON and Nursing Home Administrator (NHA) acknowledged the concern regarding PASARR's not being completed and the NHA offered Past Non-Compliance (PNC).During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included.On 1/24/26 the facility identified PASARR's were not completed upon admission and annually since October of 2025. The facility audited all residents regarding PASARR completion. Education was provided to the admissions coordinator and the Social Services Designee. A spreadsheet was created to indicate when the PASARR was completed and when the annual PASARR was due. Audits were completed to ensure completion. The facility date of compliance was 2/24/26.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide oxygen services per standards of practice for two Residents (#65 & #83) of four residents reviewed for respiratory care.Findings include: Resident #83 (R83) Review of R83's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 5/19/25, with diagnoses that included respiratory failure and Chronic Obstructive Pulmonary Disease (chronic inflammatory lung disease that causes obstructive airflow from the lungs, making breathing difficult). R 83 scored a 00/15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment. Review of physician orders revealed R83 to be administered oxygen at 4L/min (liters per minute) via nasal cannula for SOB [shortness of breath]. Review of R83's care plan last revised 3/30/26, read in part . R83 to have supplemental O2 [oxygen] 4L as ordered. During an observation on 4/7/26 at 8:49 a.m., R83 sat in a wheelchair in the dining room and received oxygen from an oxygen tank with a flow rate set at 3L. During an observation on 4/7/26 at 4:18 p.m., R83 sat in a wheelchair in the dining room and received oxygen from an oxygen tank with a flow rate set at 2L. During an interview on 4/7/26 at 4:20 p.m., Registered Nurse (RN) I reported, The orders have not been changed but I am monitoring his oxygen sats (saturation) .the NP [nurse practitioner (NP) talked about possibly lowering the flow rate so I lowered the flow rate of oxygen, but there is no order from the NP yet. During an interview on 4/7/26 at 4:32 p.m., the Director of Nursing (DON) reported, The oxygen flow rate should not be changed unless there is an order from the NP or physician. During an interview on 4/8/26 at 2:42 p.m., The DON and Nursing Home Administrator (NHA) acknowledged the RN should not have changed the flow rate without having an order from the NP or physician. Resident #65 (R65) Review of an admission Record revealed R65, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: chronic obstructive pulmonary disease. Review of a Minimum Data Set (MDS) assessment for R65, with a reference date of 1/9/26 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated R65 was cognitively impaired. (continued on next page)

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

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 4/7/2026 at 10:31 AM., Resident #65 was awake in his bedroom sitting in his wheelchair. R65's Oxygen (O2) tubing dated 3/27/26. In an interview on 4/7/26 at 11:10 AM., Assistant Director of Nursing (ADON) H reported oxygen tubing should have a physician's order to change the tubing weekly and as needed. Review of Resident #65's Physicians Order read in part: Order Summary: 2/10/26 O2 2L/min via nasal cannula for SOB (Short of breath) every day and night shift Review of R65's Physicians Orders revealed R65 has no order to change oxygen tubing and or clean oxygen concentrator weekly. Review of R65's Care Plan read in part: R65 has a potential for difficulty breathing and risk for respiratory complications R/T (related to) Emphysema/COPD., SOB: on exertion, Date Initiated: 11/17/2025 .

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure resident medications were securely stored in locked compartments for all Residents residing on the 200 Hall. This deficient practice resulted in the potential for tampering and/or diversion of resident medication. Findings include:During an observation on 4/7/26 at 5:05 p.m., the 200 Hall medication cart, staffed by Licensed Practical Nurse (LPN) R, was observed unlocked, facing outward into the hall, as LPN R entered room [ROOM NUMBER]. Dietary Manager (DM) A was present near the nurse's station and was motioned to the 200 Hall medication cart by this Surveyor. The 200 Hall medication cart verified as unlocked, when it was opened in front of DM A. DM A stated, That is not good. The 200 Hall medication cart was then closed awaiting the return of LPN R. Following exit from room [ROOM NUMBER], when asked if it was acceptable to have the medication cart unlocked and unsupervised, LPN R stated, Absolutely not. During an observation on 4/8/26 at 8:50 a.m., two inhalers, one green and white, the other red, were left on top of the 300 Hall medication cart while LPN S entered R70's room to administer morning medications. Upon return from R70's room, when asked if it was acceptable to leave Resident medications out on top of the medication cart, LPN S stated, No, absolutely not. When queried regarding whose inhalers had been left on top of the medication cart, LPN S reported they belonged to Resident #7 (R7). One was a Symbicort inhaler, the other Spiriva.During an interview on 4/8/2026 at 7:28 a.m., when asked about the security of medications in the medication carts, the Director of Nursing (DON) said the medication carts need to be locked and not left open unsupervised. Review of the Medication/Treatment Cart Use policy, last revised 8/15/23, revealed the following, in part: .The medication/treatment cart and its storage bins are kept locked until the specified time of medication/treatment administration. If an emergency occurs during the medication/treatment pass, the nurse securely locks the medication/treatment cart before attending to the emergency situation. During routine administration of medications, the cart may be kept in the doorway of the resident's room with: Drawers unlocked and facing inward, and within sight of the nurse. No medications are kept on top of the cart. The cart must be clearly visible to the person administering medications, and all outward sides must be inaccessible to persons passing by .