

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/13/2025
NAME OF PROVIDER OR SUPPLIER  Christian Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2053 South Sheridan Drive Muskegon, MI 49442	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (continued on next page)

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/13/2025
NAME OF PROVIDER OR SUPPLIER  Christian Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2053 South Sheridan Drive Muskegon, MI 49442	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake 2572210. Based on interview and record review, the facility failed to report verbal abuse and intimidation from a staff member to the State Agency for 1 Resident (Resident #2) of 3 residents reviewed for reporting. Findings include: Resident #2 (R2) Review of Resident #2's admission Record revealed R2 was a [AGE] year-old female originally admitted to the facility on [DATE] with pertinent diagnoses of Sepsis, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and major depressive disorder. A review of the facility's Abuse, Neglect and Exploitation policy and procedure, revised 6/25/2025, defined Abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or an enabled through the use of technology. During an interview on 8/12/25 at 2:27 PM, the NHA (Nursing Home Administrator) was asked to provide any incident, accident, concern or grievance forms that were generated for R2 during the resident's stay. The NHA revealed he only had one form involving the resident for an incident on 7/20/25. Review of R2's incident report form revealed #2804 Alleged Abuse dated 7/20/2025 at 8:40 AM. The report was for an incident that occurred in R2's room and it was prepared by the DON (Director of Nursing). During an interview on 8/12/25 at 2:27 PM, the NHA revealed that they had not reported the incident to the State Agency and that the DON would need to provide any further information. Review of R2's #2804 Alleged Abuse report under Resident Description revealed, R2 had an interaction with CNA B (Certified Nursing Assistant) and felt the aide had an attitude towards her because she did not want to get out of bed and CNA B said that makes her job more difficult and that was not appropriate for her to say to R2. The report also reflected that CNA B came back to R2's room again after being asked not to and stood with her hands on her hips and was speaking loudly. Further review of #2804 Alleged Abuse report reflected LPN C (Licensed Practical Nurse) was made aware of how she (the resident) felt, and LPN C removed CNA B from her section and CNA I took over. When LPN C spoke with the resident the resident stated that not working with CNA B was a good intervention. LPN C asked if she felt safe and R2 stated she does as long as CNA B doesn't care for her. Further review of the report revealed an investigation was conducted. The report contained interventions, and interviews with staff, family and residents. During a phone interview on 8/13/25 at 11:44 AM, Certified Nurse's Aide (CNA) I revealed, she went into (R2's) room for something and R2 was upset and teary. CNA I stated R2 was emotional, was upset and did not want CNA B coming back into the room. CNA I told her she would just help take care of her for the rest of the day. She stated the nurse went in behind her and talked with her and she took care of R2 the rest of the day. During an interview on 8/12/25 at 1:39 PM, LPN C revealed that R2 had told her one of girls had told her she was making their job harder. LPN C stated she switched out CNA B for CNA I. LPN C further revealed that R2 would not tell her about her hurt feelings. During an interview on 8/12/25 at 1:43 PM, CNA B stated the resident (R2) told her to leave her alone she was tired. CNA B revealed she went back in to get her up for breakfast and the resident refused. She went back in again after breakfast and R2 did not want to get up because she was still tired. CNA B stated she had to get R2 cleaned up because she was soaked and that she ended up putting a brief on her because when she is in bed she can soak through everything. CNA B revealed she then went back into R2's room after her care to give her water, and she was crying. She (R2) kept saying I'm tired, can't you understand. CNA B stated she was told by another aide that R2 did not want her back in her room but that she went back to drop off a condiment that was missing on R2's lunch tray and R2 told her to get out because she wasn't supposed to be in her room. During an interview on 8/13/25 at 12:32 PM, Ombudsman J confirmed that she had received a call/complaint from the resident about an incident that happened in the building but was unable to connect with R2. During an Interview on 8/13/25 at 3:44 PM, R2's Sister L revealed R2 was currently in the hospital. When asked if she knew of an incident that happened back in July involving an aide. R2's Sister L stated she came up to the building on that day because her sister called her because she was afraid. R2 had told her that someone had come in and tried to get her up and dressed at like 5:00 in the morning on the weekend and that R2 told the aide she was not getting her up. R2 then revealed to her sister that the next aide came in and was upset</p>		