STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235656	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Care Nursing Center	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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to 2628080.Based on observation, interview and record review, the facility failed to prevent the physical restraint of 1 Resident (R200) out of 3 reviewed for restraints. Findings include:Review of a Facility Reported Incident (FRI) 5-day investigation reflected the incident occurred on 8/10/25 at approximately 8:30 AM. R200 was observed in the dining room with a gait belt around his waist and his wheelchair.R200A review of R200's admission Record, dated 9/25/25, revealed R200 was an [AGE] year-old resident initially admitted to the facility on [DATE] with multiple diagnoses that included Alzheimer's Disease and Dementia.A review of R200's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 7/19/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 3 which revealed R200 was severely cognitively impaired.During an interview on 9/26/25 at 9:27 AM, Registered Nurse (RN) D revealed that on the day of the incident the resident had been jumping up and down, he was wandering, agitated, combative, and had urinated on another resident's room floor. RN D stated she had given R200 his medication at the nurse's station and then walked him with his gait belt on and his wheelchair down to the dining room for breakfast. RN D stated staff had asked if they could leave the gait belt on R200 so they could assist him better to help prevent a fall. RN D stated it wasn't even 10 minutes later when CNA E asked if I had saw the gait belt on R200. I thought she meant around his waist, I had not seen it around the wheelchair until she brought it to my attention. The gait belt was around R200 and his wheelchair. I told the aides to take it off him immediately, because it was being used as a restraint. R200 seemed fine, he was just at the table eating breakfast. I then called and left messages for the DON and the Unit Manager (UM) J and reported what happened. I talked to the Nursing Home Administrator (NHA). RN D stated a skin assessment was completed on R200 with no concerns. She stated she had not talked to R200's family or physician about the incident. RN D clarified she had three aides in the dining room besides CNA E and none of them admitted to restraining R200 with a gait belt. RN D revealed she reported the incident because she considered it to be abuse.During an interview on 9/26/25 at approximately 3:00PM, CNA E revealed that she had been on light duty, so she came in at 8:00 AM that day and was told to go assist R200 because he was being combative. I went into the dining room, said good morning to him and saw the gait belt around him. I saw him from the front and thought he had it on for safety reasons. He was eating just fine by himself, so I left to grab some paperwork. When I came back, I noticed the gait belt was around him and his wheelchair. I went to RN D and asked if she knew that R200 had a gait belt on and that it was a restraint/abuse. RN D saw it on and told (CNA I) to take the gait belt off R200.During a phone interview on 9/25/25 at 2:59 PM, R200's wife (Wife A) revealed her husband has dementia. Wife A was asked if she had been notified about an incident that happened in the facility dining room during breakfast on 8/10/25 where R200 was found tied with a gait belt to his wheelchair. Wife A stated NO, and I would remember being told about that.During an interview on 9/26/25 at 12:13 PM, CNA I revealed, R200 was in a mood that day. I did not see a gait belt around the wheelchair; I was told about it but did not see it. He was having major behaviors that morning. He was not sitting in his (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair at all because he kept getting up. CNA I revealed she had been interviewed and had received education by administration because a Gait belt wrapped around the wheelchair (and resident) is considered a restraint and needs to be reported because it's a type of abuse. Review of Nursing Home Guide: Restraints education provided to facility staff from 8/22/25 - 9/16/25 revealed the following is considered a physical restraint, Lap belts, bed rails, locked chairs, wrist/ankle ties.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2628080.Based on observations, interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Social Security Act regarding reportable incidents for 1 Resident (Resident#200) of 4 residents reviewed for reporting. Findings include: A review of R200's admission Record, dated 9/25/25, revealed R200 was an [AGE] year-old resident initially admitted to the facility on [DATE] with multiple diagnoses that included Alzheimer's Disease and Dementia.Review of R200's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 7/19/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 3 which revealed R200 was severely cognitively impaired.Review of a Facility Reported Incident (FRI) 5-day investigation reflected the incident occurred on 8/10/25 at approximately 8:30 AM. (Name of R200) was observed in the dining room with a gait belt around his waist and his wheelchair. Further review of the report indicates the DON (Director of Nursing), Physician and Family were notified of the incident on 8/10/25 at 9:46 AM and the NHA (Nursing Home Administrator) was notified at approximately 10:00 AM. Law Enforcement was noted as Not Applicable (N/A). In addition, the FRI revealed the incident was reported to the State Survey Agency on 9/16/25 at 8:15 PM (37 days after the incident occurred).During an interview on 9/25/25 at 9:40 AM, the NHA stated, The incident on 8/10/25 had been reported late because of problems with the new system.During a meeting on 9/25/25 at approximately 1:11PM, Survey Manager (SM) K revealed she had not been notified by the facility (through email, phone call or text) that they were having problems reporting a FRI's.During an interview on 9/25/25 at 1:55 PM, NHA stated he got a call via the phone on 8/10/25 and someone reported to me about the gait belt being used as a restraint. When the NHA was asked if he reported the incident to the police he stated, No, was I supposed to? I guess I didn't look at it like it was abuse. Maybe I should have.During a second interview on 9/26/25 at 2:53 PM, the NHA stated I don't know why I didn't report [the incident timely]. I usually do report them. The NHA further stated that he did not notify Law Enforcement that a resident R200 was restrained in a wheelchair because he did not believe that it was reportable.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 enabled through the use of technology.Further review of the facility's Abuse, Neglect and Exploitation policy and procedure, revised 6/25/2025, defined Willful means the individual must have acted deliberately, not that individual must have intended to inflict injury or harm.A review of the facility's Reporting of Incidents policy and procedure, revised 2/2024, reflected, 3. A reasonable suspicion of a crime against a resident, possible incidents of abuse, neglect, mistreatment, exploitation, or resident property or injuries of unknown origin reported to the Administrator will be evaluated and the following will be considered when making a decision regarding reporting to the State Agency and Local Law Enforcement. a. Allegations involving alleged abuse must be reported immediately but not more than 2 hours after the allegation is made. c. Allegations not involving abuse or a reasonable suspicion of a crime without bodily injury must be reported no later than 24 hours after the allegation is made or suspicion is formed. d. Any reasonable suspicion of a crime against a resident will also be reported to the local Law Enforcement Agency in addition to the State Agency. Further review of the facility's Reporting of Incidents policy and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure, revised 2/2024, reflected, 5. The Administrator will complete the 24-hour report via the online reporting system established by [Name of State Survey Agency]. The following statement was reviewed on the bottom of the first page NOTE: WHEN IN DOUBT AS TO WHETHER THE INCIDENT/OCCURRENCE IS REPORTABLE TO THE STATE AGENCY/LAW ENFORCEMENT AGENCY THE FACILITY SHOULD REPORT THE EVENT.

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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 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** This citation pertains to intake 2628080Based on interview and record review, the facility failed to complete and report a thorough investigation for an allegation of abuse for 1 Resident (R200) of 3 residents reviewed. Findings include: A review of the facility's Abuse, Neglect and Exploitation, policy and procedure, reviewed/revised 6/25/2025, revealed Abuse means 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 caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.Further review of the facility's Abuse, Neglect and Exploitation, policy and procedure, reviewed/revised 6/25/2025, reflects under section V, Investigation of Alleged Abuse, Neglect and Exploitation that A. An immediate Investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: . 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Review of a Facility Reported Incident (FRI) 5-day investigation reflected the incident occurred on 8/10/25 at approximately 8:30 AM. (Name of R200) was observed in the dining room with a gait belt around his waist and his wheelchair. Further review of the report indicates the DON (Director of Nursing) Physician and Family were notified of the on 8/10/25 at 9:46 AM and the NHA (Nursing Home Administrator) was notified at approximately 10:00 AM. Law Enforcement was noted as Not Applicable (N/A). In addition, the FRI revealed the incident was reported to the State Survey Agency on 9/16/25 at 8:15 PM.R200A review of R200's admission Record, dated 9/25/25, revealed R200 was an [AGE] year-old resident initially admitted to the facility on [DATE] with multiple diagnoses that included Alzheimer's Disease and Dementia. Review of R200's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 7/19/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 3 which revealed R200 was severely cognitively impaired.A review of R200's medical record failed to reveal any information related to the incident that occurred on 8/10/25.In an interview on 9/25/25 at 2:20 PM, R200's daughter (Daughter B) revealed she is usually at the facility visiting her father daily. During the interview she stated, No, I was not made aware of an incident where my dad was tied with a gait belt to his wheelchair during breakfast and I would remember if someone told me something like that. Daughter B further stated, My mom would have definitely told me about this (the incident).During a phone interview on 9/25/25 at 2:59 PM, R200's wife (Wife A) revealed her husband has dementia pretty bad. Wife A was asked if she had been notified about an incident that happened in the facility dining room during breakfast on 8/10/25 where R200 was found tied with a gait belt to his wheelchair. Wife A stated NO, and I would remember being told about that. I know they did not call my (oldest) daughter because she would have called me and her sister right away. During an interview on 9/26/25 at 9:27 AM, Registered Nurse (RN) D revealed that on the day of the incident the resident had been jumping up and down, he was wandering, agitated, combative, and had urinated on another resident's room floor. RN D stated she had given R200 his medication at the nurse's station and then walked him with his gait belt on and his wheelchair down to the dining room for breakfast. RN D stated staff had asked if they could leave the gait belt on R200 so they could assist him better to help prevent a fall. RN D stated it wasn't even 10 minutes later when CNA E asked if I had saw the gait belt on R200. I thought she meant around his waist. I had not seen it around the wheelchair until she brought it to my attention. The gait belt was around R200 and his wheelchair. I (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told the aides to take it off him immediately because it was being used as a restraint. R200 seemed fine, he was just at the table eating breakfast. I then called and left messages for the DON and the Unit Manager (UM) J and reported what happened. I talked to the Nursing Home Administrator (NHA). RN D stated a skin assessment was completed on R200 with no concerns. She stated she had not talked to R200's family or physician about the incident. RN D clarified she had three aides in the dining room besides CNA E and none of them admitted to restraining R200 with a gait belt. RN D revealed she reported the incident because she considered it to be abuse.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2628080Based on interview and record review, the facility failed to ensure the medical records for 1 of 3 residents (R200) was complete and accurate.Findings include:R200A review of R200's admission Record, dated 9/25/25, revealed R200 was an [AGE] year-old resident initially admitted to the facility on [DATE] with multiple diagnoses that included Alzheimer's Disease and Dementia.A review of R200's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 7/19/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 3 which revealed R200 was severely cognitively impaired.A review of the Facility Reported Incident (FRI) revealed the incident occurred on 8/10/25 at approximately 8:30 AM. [Name of R200] was observed in the dining room by staff with a gait belt around his waist and his wheelchair.A review of R200's Electronic Medical Record (EMR), dated 8/07/25 to 9/22/25, failed to reflect documentation (e.g., a progress note, a physician note, assessment) that indicated on 8/10/25 R200 was observed being restrained by a gait belt to his wheelchair while he was in the dining room eating breakfast.During an interview on 9/26/25 at 3:23 PM, the NHA (Nursing Home Administrator) revealed he did not see any documentation in R200's EMR that he had been being restrained by a gait belt to his wheelchair while he was in the dining room eating breakfast on 8/10/25. The NHA further revealed they had completed an incident report. A copy of the incident report was requested from the NHA.A review of R200's incident report, dated 8/10/25 at 9:39 AM, revealed, It was reported to me [Unit Manager (UM) J] via Phone by nurse [Name of RN D] that resident had been progressively combative over the weekend peaking on Sunday, hitting, kicking, walking in the hallways and urinating, staff assisted him to a wheelchair and he was attempting to get out of w/c and hit staff. He was assisted to the dining room to eat and that is when it was observed by [Name of CNA E] that there was a gait belt around the resident's chair. In addition, the following statement on bottom of page one of the incident report revealed, Privileged and Confidential - Not part of the Medical Record - Do not Copy.