STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235451	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Battle Creek	706 North Avenue Battle Creek, MI 49017

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 0600 Level of Harm - Minimal harm or potential for 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. This citation pertains to Intakes: 2790134Based on observation, interview, and record review the facility failed to provide an environment free from physical and verbal abuse for two Residents (#29, #95) of two residents reviewed for abuseFindings Included:Resident #29 (R29)Review of the medical record revealed R29 was admitted to the facility 01/02/2025 with diagnoses that included kidney disease, type 2 diabetes, morbid obesity, hyperlipidemia (high fat concentration in blood), depression, anxiety, chronic pain, tachycardia, and heart disease. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/06/2026, revealed R29 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15.Resident #95 (R95)Review of the medical record revealed R95 was admitted to the facility 08/12/2025 with diagnoses that included kidney disease, type 2 diabetes, atrial fibrillation, dysphagia (difficulty swallowing), dementia, muscle weakness, anemia (low red blood cell count), osteoarthritis (degenerative joint disease), hypothyroidism (low thyroid hormone), osteoporosis (brittle/weak bones), sleep apnea, stroke, anxiety, depression, and heart disease. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/17/2026, revealed R95 had a Brief Interview for Mental Status (BIMS) of 14 (cognitively intact) out of 15. R95 was discharged from the facility 03/21/2026.Review of Michigan-Facility Reported Incident (MI-FRI) 00063304 revealed that on 01/25/2026 at 01:15 p.m. R29 and R95 were in their room. R95 had wheeled to R29's side of the room and pulled R29's hair. On 06/02/2026 at 11:28 a.m. during observation and interview R29 was observed sitting up in her room. R29 explained that she remembered the day that R95 had come to her side of the room and pulled her hair. R29 explained that she was just sitting and watching TV and R95 grabbed her hair and shouted, now we are going to talk. R29 explained that she does not remember any events that had led to this interaction. R29 explained that the staff assisted R95 to let go of her hair and staff removed R95 from the room. R29 explained that it did hurt when R95 pulled her hair, and she explained that the pain was a 10 out of 10.During an interview on 06/04/2026 at 03:43 p.m. Licensed Practical Nurse (LPN) P explained she recently became an LPN. LPN P explained that she remembered the incident between R29 and R95 on 01/25/26. LPN P explained that she was working as a certified nurse aide at that time. LPN P explained that she had entered R29's and R95's room because the call light had been activated. LPN P explained that once she entered into the room R95 was sitting in her wheelchair at the entrance to the bathroom. LPN P explained that R29 requested to use the bathroom but explained that she could not get into the bathroom because R95 was blocking the entrance. LPN P explained that she had asked R95 to move but she had refused. LPN P explained that she turned away form the residents and that is when R95 moved her chair toward R29 and grabbed her hair. LPN P explained that another certified nursing aide came in and assisted R95 to let go of R29's hair. LPN P explained that R95 was removed from the room.During a telephone interview on 06/05/2026 at 08:54 a.m. Certified Nursing Aide (CNA) Q explained that on 01/25/2026 she was walking by the room of R29 and R95. CNA Q explained that she heard yelling. CNA Q explained when she entered the room she observed R95 was pulling R29's hair and LPN P was attempting to separate the residents. CNA Q explained that she assisted in getting R95 to let go of R29's hair and R95 was removed from the room.During a telephone interview (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 06/05/026 at 10:02 a.m. Licensed Practical Nurse (LPN) R explained that on 01/25/2026 she was walking by the room of R29 and R95 and heard yelling. LPN R explained that she entered the room and observed R95 pulling the hair of R29. LPN R explained that she assisted R95 to let go of R29's hair. LPN R explained that she then assisted R95 out of the room. LPN R could not recall if other staff was present in the room.During an interview on 06/05/2026 at 10:18 a.m. Nursing Home Administrator (NHA) A explained that on 01/25/2026 that she had received an allegation that R95 had pulled R29's hair. NHA A explained that pulling a resident hair would be defined as abuse. NHA A explained that at the conclusion of the facilities 5 day investigation she had substantiated that R95 had pulled R29's hair and therefore the facility had substantiated that resident to resident abuse had occurred.