

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Pinnacle Care of Battle Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 675 Wagner Drive 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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 1194799 and 2564904. Based on observation, interview and record review, the facility failed to protect the resident's (R1's) right to be free from sexual abuse by R2. Findings include: R1: Review of the medical record reflected R1 admitted to the facility on [DATE], with diagnoses that included Parkinson's and dementia. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/9/25, reflected R1 scored zero out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and required supervision or touching assistance for walking. On 9/10/25, at 9:12 AM, R1 was observed lying in bed, awake. She acknowledged having friends at the facility but did not know their names. R2 denied concerns pertaining to interactions with other residents. R2: Review of the medical record reflected R2 admitted to the facility on [DATE], with diagnoses that included Alzheimer's. The Annual MDS, with an ARD of 6/20/25, reflected R2 scored nine out of 15 (moderate cognitive impairment) on the BIMS, did not walk and required substantial/maximal assistance for transfers. On 9/10/25, at 8:25 AM, R2 was observed seated in a wheelchair, in his room. R2 denied having any interactions with female residents, including touching. R2 denied having been talked to about his interactions with other residents. R1's medical record included a Progress Note for 6/24/25 at 6:33 PM, which reflected she set off the door alarm when entering the North unit. R1 stated her boyfriend lived over there, and she was going to see him. According to the note, R1 was redirected to her unit. R1's medical record included a Progress Note for 6/25/25 at 4:09 AM, which reflected that at approximately 7:55 PM (on 6/24/25), a Certified Nurse Aide (CNA) reported R1 was observed in R2's room, with her shirt lifted above her breasts. R2's medical record included a Progress Note for 6/24/25 at 9:20 PM, which reflected a CNA observed R1 in R2's room. R1's shirt was up, her breasts were exposed, and R2 was touching R1's breasts. In a phone interview on 9/9/25 at 2:26 PM, CNA C reported that when walking by R2's room, she observed R1 in the room, with her back towards the door and her shirt lifted up. CNA C observed R2 touching R1's chest. CNA C reported she was unsure of what to do and left the unit to notify Registered Nurse (RN) D of the observation. When CNA C and RN D returned together, R1 continued to be in R2's room and was redirected out at that time. CNA C stated she received education, from RN D, that she should have removed R1 from R2's room at the time of her observation. CNA C was unaware of any further incidents between R1 and R2 since 6/24/25. In a phone interview on 9/9/25 at 2:52 PM, RN D recalled a CNA running up to her, stating R1 was in R2's room. Upon responding to R2's room, R1 was seated on R2's bed, fully clothed at that time. RN D was unaware of any further incidents between R1 and R2 since 6/24/25. R1's medical record included a Social Services Progress Note for 6/26/25, which reflected R1 could not recall the incident. R2's medical record included a Progress Note for 6/26/25, which reflected the Social Worker met with R2 to discuss the incident on 6/24/25. According to the note, R2 stated no harm was done. R1's Care Plan reflected an intervention, dated 7/1/25, that she was unable to consent to any sexual relations due to dementia and would require the consent of her Guardian. R2's Care Plan reflected an intervention, dated 7/1/25, that he may be verbally and physically sexually inappropriate with women. R1's medical record included a Progress Note for 7/5/25 at 2:23 PM, which reflected that around 10:30 AM, Maintenance staff observed R1 and R2 in the main dining room. R2 was observed rubbing R1's leg and buttocks. According to the note, the residents were separated. In an interview on 9/10/25 at 9:38 AM, Licensed Practical Nurse (LPN) F reported being notified, by Maintenance, that R2 was touching R1 on the outside of her pants. LPN F stated she had been aware that R1 had previously been in R2's room (on 6/24/25) but knew nothing more than that. During an interview on 9/10/25 at 10:24 AM, Nursing Home Administrator (NHA) A reported R1 wanted to see her friend and was let into the secure unit by a CNA (on 6/24/25). When walking by R2's room, a CNA observed R1 with her shirt lifted and R2 fondling R1's breasts. NHA A reported they were trying to keep R1 and R2 separated after the incident, and R1 was started on antibiotics for a urinary tract infection. NHA A reported there was a second incident (7/5/25), when Activities staff took R2 to the dining room, to go outdoors for a smoke break. While staff were gathering other residents, R1 went in the dining room and approached R2. R2 was observed touching R1's leg and buttocks, on the outside of her clothing.</p>		