STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235536	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Care of Battle Creek	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 - 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 observations, interviews, and record review the facility failed to protect the resident's (Resident #1) right to be free from physical abuse by Resident #2. Findings Included:This citation pertains to intake number 3032111. Resident #1 (R1): Review of R1's electronic medical record (EMR) revealed R1 was a [AGE] year-old male who was admitted to the facility on [DATE]. Diagnoses included repeated falls and muscle weakness, Resident #2 (R2): Review of R2's EMR revealed R2 was a [AGE] year-old male who was admitted to the facility on [DATE]. Diagnoses included psychotic disturbance, vascular dementia, severe, with behavioral disturbance. Review of a Social Services Quarterly Evaluation dated 6/4/2026 revealed that on 5/4/2026 R2's Brief Assessment of Mental Status (BIMS) score was a 13 out of 15 which indicated R2 was of normal cognitive functioning. Record review of a facility reported incident (FRI) dated 5/23/2026 revealed that on 5/23/2026 R2 was in the hallway in his wheelchair, when R1 also was coming around the corner. R1 was walking with his walker when R2 backed into R1 with his wheelchair and continued to back into R1 until R1 fell to the floor. The FRI report revealed R1 had a laceration 3.8 X 0.1 cm in size to the back of his head that was bleeding. R1 was also noted to complain of right hip pain, an ambulance was called, and R1 was found to have a right hip fracture and a laceration to the back of his head. The report revealed R1 stayed five days in the hospital and required surgery to repair the fractured right hip. The facility investigation summary dated 6/2/2026 revealed R2 was in his wheelchair heading to the dining room and R1 was coming from the dining room, when R2 started talking to R1 who continued to walk in the opposite direction. Then R2 started to reverse in his wheelchair, and R1 put his hand out to R2's back telling R2 not to bump into him. The summary revealed that R2 continued to bump into R1 until R1 fell to the floor. A nurse heard the commotion and upon arriving R2 was moved away from R1, and R1 was observed to be lying on his back with a small amount of blood under his head. The facility investigation summary further revealed that an interview was conducted with R1, and R1 stated that he was walking from the dining room when R2 came around the corner wheeling in his wheelchair. R1's documented interview revealed that R2 started mouthing to me and I kept walking. R1 said in the interview that as he was walking around the corner he felt R2's wheelchair bump into him. R1 stated that he put his hand out trying to tell R2 to stop backing up, but R2 continued to back up, and he lost his balance and fell to the floor. The facility investigation summary revealed that there were no witnesses however the incident was captured on the facility's surveillance camera. The summary also revealed that the facility notified the police who went to the facility and interviewed R2, and R2 was placed on a one-on-one supervision. The summary conclusion revealed that R1 stated that R2 did intentionally back into him causing him to fall, and after staff reviewing the video coverage the conclusion was documented to be that R2 did appear to keep backing up into R1 after being told to stop. The facility concluded that resident to resident abuse was substantiated. Review of the facility incident report dated 5/23/2026 revealed that when R1 was being assessed and prepared for transfer to the hospital R2 was separated from R1 during that time, but R2 attempted to return to R1 several times to begin an altercation again. Review of the hospital records dated 5/26/2026 revealed R1 had a fracture of 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

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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 - Actual harm Residents Affected - Few	right femur and a laceration to the right scalp. The notes revealed that R1 had surgery to repair his fractured right hip on 5/24/2026. In an interview on 6/18/2026 at 12:00 PM, R1 stated that on 5/23/2026 an incident occurred with R2. R1 reported that he was walking down the hall with his walker when R2 approached him from behind and ran into him with the back of his wheelchair. R1 said he pushed R2 off of him and told R2 to stop, but then R2 came back at him even harder and rammed into him with the back of his wheelchair which caused him to fall backwards onto the floor. R1 said he hit his head causing a laceration. R1 stated that he was transferred to the hospital and had to get two staples in his head. R1 also said he fractured his right hip and had to have surgery. R1 revealed his incision scar, which was observed to be on the right hip. R1 described his decline since the event. R1 states that as a result of this he can no longer stand at the bathroom sink and shave or brush his teeth, because he is too weak since the fall. R1 said he could do all that before the fall. R1's laceration to the back of his head was observed with staples in place. In an interview on 6/18/2026 at 12:36 PM, an attempt was made to interview R2 however, R2 became angry and stated that R1 did not have his walker, fell down, and he did not know why R1 fell down. Observation of a surveillance video provided by the facility dated 5/23/2026 at 1:19 PM revealed R1 walking around the corner using his walker, and R2 was observed coming around the same corner in his wheelchair. The video revealed R1 showed up around the corner first followed immediately by R2 who self-propelling was purposefully backwards in his wheelchair next to R1. Then R1 walked behind R2's wheelchair and was observed using his left arm to touch R2's back and attempt to separate himself from R2. The video revealed that at that time R1 was able to turn forward with his back to R2 however, R2 was observed to purposefully continue to move backwards in his wheelchair looking back behind his shoulder at R1. The video revealed R2 with no attempt to move out of the path of R1 and without stopping or slowing down. Then R2 hit R1 with his wheelchair and upon hitting R1, R2 continued to move his wheelchair again up against R1 until R1 fell down to the floor lying flat on the floor. Review of R2's progress notes revealed a previous resident to resident event on 4/14/2026, (R2 resident's name redacted) had to be removed from BINGO after calling another resident a F**king N**er B**ch. He continued being disrespectful and using foul language., and on 4/15/2026, Resident (R2) was removed from dining room this shift for being disrespectful to residents/staff. Further review of R2's progress notes revealed that on 4/21/2026 R2 was being verbally abusive to other residents while in the hallway. Also, on 5/8/2026 R2's progress notes revealed R2 was in the main dining room being verbally abusive towards other residents. Of note the current NHA was new to the facility during the week of survey and had no further information to provide. In an interview on 6/18/2026 at 12:09 PM with Licensed Practical Nurse (LPN) C stated that R2 had always been aggressive and could not have a roommate because of his aggression. LPN C said R2 was verbally aggressive towards male residents, would poke female residents, and cuss at them. LPN C said that was abuse and management was aware of it. LPN C stated that before the incident on 5/23/2026 there were no interventions in place to stop R2 from verbally or physically abusing other residents.In an interview on 6/18/2026 at 12:59 PM Certified Nurse Aid (CNA) D stated that R2 was verbally aggressive towards residents and sexually towards women. CNA D stated that R2 would instigate pretty much all the fights by verbally saying things to residents like calling them a bitch, or a racial name, but he does know better. CNA D said R2 had always been this way towards other residents. CNA D stated R2 does touch and poke other residents and that management knows about the abuse. Review of R2's care plans revealed that a care plan for behaviors was in place. The care plan was dated 5/21/2019 as the dated the care plan was initiated. The care plan addressed that R2 was physically and verbally aggressive at times, may yell profanities at other residents. The care plan had no interventions for increased supervision related to R2's abusive behaviors towards other residents. The care plan had no new interventions added after each verbal abuse incident that occurred on 4/14, 4/15, 4/21, or 5/8/2026 with R2. The care plan had not been updated since 1/14/2026. The Care Plan meeting IDT note signed by the social worker on 6-3-26 reflected the facility attempted to reach the guardian. Noting R2s guardian no longer wants to be in place.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review the facility failed to ensure required Quality Assurance Performance Improvement (QAPI) committee members attended all QAPI meetings. Findings Included: This citation pertains to intake number 3014134. In an interview on 6/18/2026 at 7:35 AM, Medical Director (MD) E, who was the facility's Physician, stated that he had not been to a QAPI meeting at the facility in so long that he could not recall the last time he was at one. MD E stated that the facility always scheduled the meetings at times he could not attend, and he told them several times the times he was available to attend but they still did not schedule the QAPI meetings around his availability. MD E was very angry while speaking of the concern and stated that all facilities scheduled their QPAPI around the Medical Director's availability, but this facility would not do that, so he was never able to attend.Immediately following the interview with MD E, Administrator A was requested to provide the last year of QAPI sign in logs. Administrator A stated that it was mandatory that MD E be present at all the QAPI meetings. Administrator A said she had only been employed at the facility for one week and said she would have to put a correction plan in place for QAPI. Review of the last years of QAPI sign sheets revealed that on 6/17/2025 MD E did not sign in as attending the QAPI meeting, furthermore, the sing sheet revealed that no infection Control Preventionist (ICP) signed in to the meeting either as in attendance. The ICP is a required committee QAPI member to attend QAPI every time QAPI meets. On 6/27/2025 there was no ICP signature attesting to attendance at the QAPI meeting, on 7/1/2025 there was no ICP signature, on 7/31/2025 there was no ICP signature, on 8/14/2025 there was no ICP signature, on 8/28/2025 there was ICP signature, on 9/25/2025 there was no ICP signature, on 10/21/2025 MD E did not attend the QAPI meeting; his signature was not on the sign in log. The log dated 10/21/2025 only had staff signatures but did not identify the roll of each staff member therefore it was not able to be determined it the ICP attended this meeting, on 11/5/2025 Director of Nursing (DON) B, MD E, and ICP did not sign the sign in log for attendance at the meeting, on 11/17/2025 MD E nor the ICP signed the sign in log indicating they were in attendance. For the month of November 2025, the two meetings listed were Ad Hoc (when necessary) meetings, no monthly QAPI meeting sign in log was received. On 12/3/2025 the sign log revealed that DON B, MD E and ICP did not sign the sign in log that they were in attendance at this monthly QAPI meeting. No sign in log for the month of January 2026 was received in order to show that the required QAPI meeting was held in the month of January 2026. For the QAPI meeting dated 2/26/2026 the sign in log revealed MD E did not sign in that he was in attendance and there was no indication anywhere on the log that an ICP sign in. On 4/30/2026 MD E did not sign the sign in log, and no where did the log indicate that an ICP signed into the meeting, on 5/28/2026 MD E did not sign the sing in log that he was in attendance at the meeting.Per the State Operations Manual, S483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services;(ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist.Review of the facility's Quality Assurance and Performance Improvement (QAPI) policy on page two revealed, The QAA (Quality Assessment and Assurance) Committee shall be interdisciplinary and shall: consist at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist.