STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	**5/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE CARE OF BATTLE CREEK	**675 WAGNER DR BATTLE CREEK, MI 49017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Pinnacle Care of Battle Creek was surveyed for an Abbreviated survey on 5/17/23. Intakes: MI00134409, MI00135891, MI00136339, MI00135521, MI00134124. Census=58	F0000		
F0584 SS= E	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as	F0584	F Tag 584 Element 1 The window screen with the large hole was replaced, 1 commode, 1 walker and 1 wheelchair will remain in the room. The 2nd of each has been removed. The pop and soft drinks were removed from the floor. The bags of clothes were removed from the floor. The drywall was repaired, the chipped paint was removed and repainted. The broken mirror was removed. The mouse trap was removed. The tree branches outside were removed outside of room #130. The temperature in the dining room was adjusted to meet regulatory compliance. The Maintenance Director checked the HVAC System and found it to be in need of repair. The Maintenance Director contacted A 1. For repair. The repairs and removals will be completed by June 19, 2023. Element 2 The facility has determined that all residents have the potential to be affected. Element 3 The Preventative Maintenance Policy and Safe/Clean/Comfortable Homelike Environment Policy was reviewed and deemed appropriate. The facility has provided in service education programs for Maintenance and all direct care personnel addressing policies and procedures. The administrator in serviced the Maintenance Director on Preventative Maintenance and the	6/19/2023

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

Electronically Signed | 06/05/2023

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.

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	evidenced by: This citation pertains to intake MI00134124. Based on observation, interview and record review, the facility failed to maintain comfortable temperatures between 71 degrees Fahrenheit to 81 degrees Fahrenheit in the dining room and create a homelike environment in resident rooms, in two of three residents interviewed for environment (Resident #12 & #13), and as reported in resident council, resulting in an uncomfortable environment. Resident #12 (R12) R12's Minimum Data Set (MDS) assessment dated 3/22/23, introduced a Brief Interview for Mental Status (BIMS), a brief performance-based cognitive screener for nursing home residents, score of 13 (13-15 Cognitively Intact). During an interview on 5/16/23 at 7:35 AM, R12 stated she had seen a mouse in her room night, sometimes she saw the mouse during the day. A trap was observed on the floor in the room. A large hole, approximately 8 inches by 3 inches, was noted on the side of the window screen. R12 stated her room was cluttered with 2 bed side commodes, 2 walkers, 2 wheelchairs, cans of pop and soft drinks stored on the floor, and clothes in bags on the floor. Resident #13 (R13) R13's MDS dated 5/01/23 revealed a BIMS score of 13 (13-15 Cognitively Intact). On 5/16/23 at 7:35 AM, R13's bed was placed against the wall, the drywall was ripped in approximately six areas, with brown paper		facility staff on maintaining a Homelike Environment by June 19, 2023. Element 4 Management staff or designee will audit 3 times weekly for 4 weeks. Findings will be reported to the QAPI Committee monthly. The Administrator is responsible for maintaining compliance. The date of compliance is June 19, 2023.	

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	exposed. Chipping paint, and several screw holes that were observed. R13 stated the resident that was in the room prior had several items hanging on the wall and asked jokingly if it looked nice. A broken mirror was observed fixed to the wall under the over-the-bed light. In review of Resident Council Minutes dated 3/08/23, a resident expressed concern she was afraid that tree branches were going to come through her window. The Resident Council Investigation form dated 3/09/23 indicated environmental services needed to remove three to four trees in that area. On 5/15/23 at 4:30 PM, three trees were observed behind facility, visible from room 130, that appeared to be dead, without any foliage. Resident Council Minutes dated 5/10/23 indicated the dining room was cold and to turn the air off. Resident Council Investigation form dated 5/12/23 indicated maintenance was educated on temperatures throughout the building. On 5/17/23 at 2:30 PM, Maintenance Staff "D" took the temperature in the main Dining room with a laser thermometer, and it read 67.5 degrees Fahrenheit to 70 degrees when read pointing at the ceiling. Nursing Home Administrator (NHA) "A" was interviewed on 5/17/23 at 3:15 PM and regarding pest recommendations, stated he could not verify things in past, just going forward. NHA "A" stated he was not aware of the dead trees behind the facility. NHA "A" stated the temperature in the dining room was usually colder in the morning and should be at 72 degrees. NHA "A" was notified the temperature obtained on 5/17/23 was in the afternoon, at 2:30 PM.			
F0585	Grievances §483.10(j) Grievances.	F0585	F Tag 585	6/19/2023

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SS= F	§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program		Element 1 The Grievance process will be posted throughout the facility, by the Social Service Office, The Administrator□s, each Nursing station and the Front lobby. Resident Council was held by the Activities Director for any grievances and concerns. Staffing, Call lights, receiving showers, Residents getting up, Kitchen running out of food, removing dead tree branches from resident room areas. Any other concerns that were identified will be addressed by June 19, 2023. Element 2 The facility has determined that all residents have the potential to be affected. Element 3 The Grievance Policy has been reviewed and deemed appropriate. The facility will provide in service education programs for all personnel addressing policies and procedures, regulations and facility expectations of staff to assure that grievances and concerns have been received and completed by June 19, 2023. Element 4 The Social Service Director or designee will audit 3 times weekly for 4 weeks for Grievances. Findings will be reported to the QAPI Committee monthly. The Administrator is responsible for maintaining compliance. The compliance date is June 19, 2023.	

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	or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement			

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	agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00134124. Based on observation, interview, and record review, the facility failed to resolve resident grievances, in 3 of 3 residents reviewed for staffing concerns (Resident #6, #12, & #13), and as reported in resident council minutes, resulting in unresolved concerns and dissatisfaction. Findings include: Resident #6 (R6) R6's Minimum Data Set (MDS) assessment dated 3/20/23 indicated he admitted to the facility on 2/14/20, had a Brief Interview for Mental Status (BIMS), a short performance-based cognitive screener for nursing home residents, score of 14 (13-15 Cognitively Intact); had no physical, verbal, or other types of behaviors during the look-back period; did not reject care, and was independent in locomotion on and off the unit. On 5/17/23 at 11:45 AM, R6 was observed sitting in the dining room. R6 stated there was not enough staff and it was an ongoing problem. R6 stated the south hall was short-staffed that morning. Resident #12 (R12) R12's MDS assessment dated 3/22/23, introduced a BIMS score of 13 (13-15 Cognitively Intact).			

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On 5/16/23 at 7:35 AM R12 stated the nurse assistant would answer the call light and then she had to wait for them to hunt down the nurse. R12 stated she had asthma, and it took 45 minutes to 1 hour to get assistance. R12 stated there were not enough nurse assistants, at times they had one nurse assistant, and if they were giving a shower, no one would answer her call light.

Resident #13 (R13)

R13's MDS dated 5/01/23 revealed a BIMS score of 13 (13-15 Cognitively Intact).

During an interview on 5/16/23 at 7:35 AM, R13 stated the call light response time was 45 minutes to 1 hour at times and felt neglected when that happened.

Resident Council Minutes (RCM) dated 1/11/23 revealed there was not enough staff. Resident Council Investigation Form (RCIF) dated 1/11/23 indicated staff numbers were sufficient and the concern was resolved.

RCM dated 2/8/23, under "old business" indicated old business was not accepted, and staffing was still an issue. RCM also indicated residents were not getting up when they wanted to. RCIF dated 2/09/23 indicated audits and education would continue, and the concern was not resolved.

RCM dated 3/08/23 indicated call lights were taking too long to be answered and a concern regarding dead tree branches. RCIF form dated 3/09/23 indicated 3 to 4 trees needed to be removed from the area.

RCM dated 4/05/23 indicated concerns related to call light response and not receiving showers.

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	RCIF dated 4/06/23 indicated the concerns were resolved. RCM dated 5/10/23 indicated concern regarding call light response. The same minutes indicated the dining room was cold, the kitchen was running out of food, and not getting up when they wanted to. The facility did not provide a response to the call light concern reported on 5/10/23.			
F0610 SS= D	Investigate/Prevent/Correct Alleged Violatio §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00135409. Based on observation, interview, and record review, the facility failed to initiate a thorough investigation following an abuse allegation, in 3 of 7 residents reviewed for abuse (Resident #6, #7 & &15), resulting in the potential for abuse and residual effects. Findings include: In review of the facility 5-day follow-up	F0610	F Tag 610 Element 1 Residents #6, #7 #15 were interviewed for any concerns. Resident council will be held to address any other concerns with other residents by June 9, 2023. Element 2 The facility has determined that all residents have the potential to be affected. Element 3 The Abuse, Call Light, Medication Administration Policy was reviewed and deemed appropriate. The facility will provide in service education programs for all personnel addressing policies and procedures, regulations and facility expectations of staff to assure that Abuse Investigation process is completed thoroughly by June 19, 2023. Element 4 The Administrator or designee will audit 3 times weekly for 4 weeks for Abuse Allegations and completion of investigations. Findings will be reported to the QAPI Committee monthly. The Administrator is responsible for maintain compliance. The compliance date is June 19, 2023.	6/19/2023

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	investigation dated 11/07/22 at 10:00 AM, Nursing Home Administrator (NHA) "A" reported R7 and R6 were yelling at each other. R7 attempted to hit R6. Staff intervened and separated both residents. In review of investigation information provided by facility regarding a facility reported altercation dated 11/07/22, there was one statement that was dated 11/09/22, 2 days following the altercation, written by Social Worker (SW) "H". There were no witness statements from the staff that intervened and separated both residents in the investigation file. SW "H" statement dated 11/09/22, titled "interview: Social Worker with [resident name (R6)]", revealed R6 continued to report the same events that occurred on 11/07/22; R7 was in the dining room, R7 was already agitated because the residents were coming in from smoking and there was cold air being let in, that caused R7 to yell obscenities. R7 went over to talk to R15, who was not talkative, R7 was upset R15 did not talk to him. R7 " ...rams his foot pedal into things as he moves". R6 told R7 that R15 did not talk much, R7 told R6 to shut up and threatened R6. R7 moved closer to R6 while yelling, and R7 got behind R6, pushed R6 and caused his wheelchair to move. R6 locked his wheelchair breaks, R7 swung his elbow at R6 and continued to swing at R6. R6 grabbed R7's arm to stop him from swinging at him. Kitchen staff came out of the kitchen and told the residents to stop. SW "H" was interviewed on 5/17/23 at 9:12 AM and reviewed her witness statement from the 11/07/23 altercation. SW "H" stated the statement was from an interview with R6 and did not witness the altercation. SW "H" stated R7 had history of yelling out and had a diagnosis of a traumatic brain injury. SW "H" stated she did not			

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	know if R7 pushed/rammed his wheelchair into R15. SW "H" was not able to verify R15 was followed for the potential for residual effects, and stated there were no notes in R15's medical record. SW "H" stated R7 would always need re-direction to keep him busy. SW "H" stated she met with R6 daily regarding issues that come up. Resident #6 (R6) R6's Minimum Data Set (MDS) assessment dated 3/20/23 indicated he admitted to the facility on 2/14/20, was 56 year's old, had a Brief Interview for Mental Status (BIMS), a short performance-based cognitive screener for nursing home residents, score of 14 (13-15 Cognitively Intact); had no physical, verbal, or other types of behaviors during the look-back period; did not reject care, and was independent in locomotion on and off the unit. Progress note dated 11/07/22 at 10:58 AM revealed R6 reported an incident that occurred on 11/07/22 in the dining room; R6 reported he was not hurt, was not afraid, and would continue normal routines. During an observation and interview on 5/17/23 at 11:45 AM, R6 was observed sitting in a wheelchair in dining room and was painting a cross. R6 stated he recalled the incident that happened in the dining room on November 7, 2022. R6 stated R7 was angry about the cold air coming into the dining room after residents came into the dining room following a smoke break. R7 started yelling and then turned his aggression toward R15, when R15 did not talk to him. R6 stated he had been abused before and couldn't set there and do nothing. R6 told R7 that R15 didn't talk much and R7 rammed his wheelchair into R15's wheelchair and then approached R6. R6 stated R7 came up behind him and swung his			

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arm. R6 stated he grabbed R7's arm and told him that if he didn't stop, he would break his arm. Some kitchen staff came out of the kitchen and R6 stated he let go of R7's arm. R6 stated he immediately went across the hall and report the incident to NHA "A", because he knew that resident to resident contact needed to be reported. R6 stated R15 seemed more distressed by R7's verbal yelling more than him bumping his chair. R6 stated R15 was trying to move away from R7, but R7 had blocked him in. R6 stated there was a hospitality aide that observed the altercation in the dining room. R6 stated had not had any altercations with R7 since 11/07/22.

Resident #7 (R7)

R7's MDS dated 2/17/23 revealed he admitted to the facility on 5/15/19, was 35 year's old, had a BIMS score of 00 (00-17 Severely cognitively impaired), had physical behaviors 1 to 3 days, zero verbal behaviors, and other behaviors not directed toward other 1 to 3 days during the 7-day look-back period.

R7's care plan dated 3/09/20 indicated he had episodes of socially inappropriate behavior for programs, such

as using abusive language, using sexually explicit language, and making loud disruptive sounds.

R7's care plan dated 5/21/19 revealed he had a behavior problem, at times may be sexual inappropriate to staff and attempt to grab them. Often will masturbate. Will touch staff inappropriately such as try to put my hands down their pants, or up their shirt. At times may yell out profanities at other residents. Will also yell for staff when need help. Will bang/hit on my wall. Will use swear words in my everyday language.

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	Resident #15 (R15) R15's MDS assessment dated 9/01/22 indicated he admitted to the facility on 5/01/19, was 78 year's old, had a BIMS score of 00 (00-07 Severely Impaired), was able to hear adequately, was usually understood (difficulty communicating some words or finishing thoughts but able if prompted or given time), and usually understood (may miss some part/intent of message, but comprehended conversation) others. The same MDS assessment revealed R15 did not have behaviors during the 7-day look-back period and required limited assistance in a wheelchair for locomotion on and off the unit. MDS assessment dated 11/22/22 indicated R15 was discharged from the facility and admitted to the hospital. Nursing Home Administrator (NHA) "A" was interviewed on 5/17/23 at 3:01 PM and stated he did not remember the person that reported the altercation on 11/07/22 and there was a lack of witnesses to interview. NHA "A" stated he got most of the information for his investigation from R6 himself. NHA "A" stated he did not know R15 had been in the dining room at the time of the incident and confirmed R15 was not seen by social services for identification of possible residual effects.			
F0725 SS= E	Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F0725	F Tag 725 Element 1 Residents #6, #12, #13, were interviewed for any concerns. Resident council will be held to address any other concerns with other residents by June 9, 2023. Element 2 The facility has determined that all residents have the potential to be affected. Element 3	6/19/2023

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	134140	A. BUILDING _____ B. WING _____	5/17/2023

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	diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00134124 and intake MI135521. Based on observation, interview, and record review, the facility failed to ensure enough staff were on duty to meet resident needs, in 3 of 3 residents reviewed for staffing concerns (Resident #6, #12, & #13), and as reported by resident council, resulting in excessive wait times for medications, dissatisfaction in care, and the potential for abuse. Findings include: Resident #6 (R6) R6's Minimum Data Set (MDS) assessment dated 3/20/23 indicated he admitted to the facility on 2/14/20, had a Brief Interview for Mental Status (BIMS), a short performance-based cognitive screener for nursing home residents, score of 14 (13-15 Cognitively Intact); had no physical, verbal, or other types of behaviors during the look-back period; did not reject care, and was independent in locomotion on and off the unit.		The Staffing, Call Light and Abuse Policy was reviewed and deemed appropriate. The facility will provide in service education programs for all personnel addressing policies and procedures, regulations and facility expectations of staff to assure that Abuse Investigation process is completed thoroughly by June 19, 2023. Element 4 The Administrator or designee will audit 3 times weekly for 4 weeks for Abuse Allegations and completion of investigations. Findings will be reported to the QAPI Committee monthly. The Administrator is responsible for maintain compliance. The compliance date is June 19, 2023	

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On 5/17/23 at 11:45 AM, R6 was observed sitting in the dining room. R6 stated there was not enough staff and it was an ongoing problem. R6 stated the south hall was short-staffed that morning.

Resident #12 (R12)

R12's MDS assessment dated 3/22/23, introduced a BIMS score of 13 (13-15 Cognitively Intact).

On 5/16/23 at 7:35 AM R12 stated the nurse assistant would answer the call light and then she had to wait for them to hunt down the nurse. R12 stated she had asthma, and it took 45 minutes to 1 hour to get assistance. R12 stated there were not enough nurse assistants, at times they had one nurse assistant, and if they were giving a shower, no one would answer her call light.

Resident #13 (R13)

R13's MDS dated 5/01/23 revealed a BIMS score of 13 (13-15 Cognitively Intact).

During an interview on 5/165/23 at 7:35 AM, R13 stated the call light response time was 45 minutes to 1 hour at times and felt neglected when that happened.

Resident Council Minutes (RCM) dated 1/11/23 revealed there was not enough staff. Resident Council Investigation Form (RCIF) dated 1/11/23 indicated staff numbers were sufficient and the concern was resolved.

RCM dated 2/8/23, under "old business" indicated old business was not accepted, and staffing was still an issue. RCM also indicated residents were not getting up when they wanted to. RCIF dated 2/09/23 indicated audits and

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	education would continue, and the concern was not resolved. RCM dated 3/08/23 indicated call lights were taking too long to be answered. RCM dated 4/05/23 indicated concerns related to call light response and not receiving showers. RCIF dated 4/06/23 indicated the concerns were resolved. RCM dated 5/10/23 indicated concern regarding call light response. The same minutes indicated residents reported they were not getting up when they wanted too. The facility did not provide a response to the call light concern reported on 5/10/23. Director of Nursing (DON) "B" was interviewed on 5/17/23 at 9:41 AM and stated they agency staff use was currently at 22 percent. DON "B" stated they had lots of staff, but their status was "as needed". DON "B" stated staff did not want to change to permanent status because they made more money.			
F0802 SS= F	Sufficient Dietary Support Personnel §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food	F0802	F Tag 802 Element 1 The facility is actively recruiting for a Qualified Dietary Manager that meets CMS regulatory requirements. The 3 Compartment Sink Log, the Dish Machine, The Food Usage and Temp Log Temperature log, are being completed and will be in compliance by June 19, 2023. Element 2 The facility has determined that all residents have the potential to be affected. Element 3 The Dietary Infection Control Policy has been reviewed and deemed appropriate. The facility has provided in service education programs	6/19/2023

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	and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00135521. Based on observation, interview and record review, the facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, in a census of 58 resident, resulting in the increased likelihood for cross-contamination, bacterial harborage and foodborne illnesses. Findings include: In review of the "3 Compartment Sink Log" in the kitchen, the month/year was left blank, the location was also blank. Under the "day" column, the log listed numbers 1 through 31. Across from each day was separated into day, afternoon, and evening data. Data included a column to check the wash temperature was greater than 110-degree Fahrenheit, a column for part per million (PPM) was 150 to 400, and a column for initial of person documenting. Day number 1 through 10 were filled out for day, afternoon and evening. The time was documented in the column for wash temperature greater than 110 degrees Fahrenheit, instead of a temperature. On day 11, the day and afternoon documentation were blank, the evening was documented, with exception of the wash temperature. Day 12 through day 15 was left blank. A column titled manager review weekly was left blank. On the bottom of the same form were instructions "Wash Temperatures: must be > [greater than] 110 degrees. Fill sink with hot soppy water > 110 degrees and record temperature of water".		for the Administrator and Human Resources. Dietary Staff addressing policies and procedures, regulations and facility expectations of staff to assure that Food, Nutrition and Sanitation Policies are followed by June 19, 2023. Element 4 The Administrator or designee will audit weekly until a Certified Dietary Manager/Manager is recruited. Findings will be reported to the QAPI Committee monthly. The Administrator is responsible for maintaining compliance. The compliance date is June 19, 2023.	

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	In review of the "Dish Machine Temperature Log" dated May 2023, Delimed weekly column was left blank, there was no temperature recorded on prior to washing dishes on 5/15/23. In review of the "Food Usage and Temp Log", there were no recorded temperatures from 5/08/23 to 5/15/23. On 5/16/23 at 12:50 PM during an interview with Cook "E" at the same date and time, stated she began making the lunch meal between 9:00 AM and 9:30 AM, to insure it was ready by 11:00 AM. On 5/15/23 lunch was served in the dining room to the first resident at 11:45 AM. In review of the "Food Usage and Temp Log" dated 5/15/23, Chicken 40 pounds of chicken was documented at 120 degrees Fahrenheit, before meal service, in the column for regular diet, in the column for mechanical soft diet and in the column for pureed diet. No time was documented. Cook "F" was interviewed on 5/16/23 at 12:50 PM and stated she was concerned regarding the chicken temperature recorded at 120 degrees on 5/15/23 and verified she did not record that temperature on 5/15/23. Cook "E" was interviewed on 5/16/23 at 12:50 PM and stated she documented the temperature incorrectly on temperature log for lunch on 5/15/23, when she documented 120 degrees 3 times. During an interview with Dietary Aide "G" on 5/16/23 at approximately 1:00 PM, stated she checked the 3 compartment sink and documented on the log form. DA "G" produced log sheet that was filled out on the line for the first day of the month, not on the 16th. Under the column for wash temperature, the time was again documented. There was no documentation of afternoon meal on the 3-compartment sink log. There was no documentation the dishwasher was			

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	checked in morning or afternoon on this same day. During an interview with ES "C" on 5/17/23 at 8:23 AM she had not looked at food temperature logs and did not know what the temperature were supposed to be. ES "C" stated she planned to educate dietary staff before NHA "A" leaves on 5/18/23. ES "C" stated there was a rough patch in the kitchen 2 weeks ago, and a lot of people quit, no dietary staff have been hired in the last 2 weeks. The previous dietary manager's last day was on 5/05/23, she gave a 30-day notice. ES "C" stated in the same interview she had not received any education regarding the kitchen until this week, after the start of the survey. On 5/17/23 at 1:52 PM Registered Dietician (RD) "I" was interviewed and stated she worked at the facility on Wednesday and one weekend day per week. RD "I" stated her role in the building was clinical, with oversight at times as needed and could step into the role of kitchen manager.			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	F Tag 812 Element 1 All food will be dated and labeled, stored properly. Any food not sealed, dated or labeled will be discarded. The logs for Food Temperatures are up to date. The kitchen Area is clean. The Handwashing Station has hand towels, the light switch has been cleaned, the drywall will be repaired, staff are wearing hair nets and beard restraints, meats are being properly stored, refrigerator temperature logs are complete, the trash can near the door and coffee machine lid was cleaned, expired foods were discarded, Ice buildup under first rack in fridge will be removed and cleaned, upper and lower ovens will be cleaned, walk in floor was cleaned, dented cans/products for returns will be stored	6/19/2023

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	This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00134124. Based on observation, interview and record review, the facility failed to effectively store food, clean and monitor food service equipment effecting 58 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage and foodborne illnesses. Findings include: During a tour of the kitchen on 5/15/23 at 9:00 AM, the following was observed: No towels at handwashing sink, Cook "E" was observed using hand sanitizer. The light switch above the sink was heavily soiled and between the sink and soap dispenser, torn drywall was noted, exposing brown paper, approximately 6 inches by 3 inches in size. One dietary staff was noted without a hair net and was not wearing a beard restraint, he was wearing a surgical mask on over his chin. Raw chicken was observed on the preparation table, with liquid juices noted inside the plastic bag that was, inside a cardboard box. Next to the chicken was a cardboard box with frozen vegetables. Cook "E" stated chicken and vegetables were just taken from freezer and was going to be used for lunch on this same day. On the other side of the box of chicken was a Styrofoam food container that contained 2 grilled cheese sandwiches. Cook "E" stated the sandwiches were for a resident that went out for dialysis. The posting in the kitchen indicated a resident went to dialysis on Monday, Wednesday, and Friday at 10:00 AM.		properly off floor, binders will removed from dry storage area. Corrections will be made by June 19, 2023. Element 2 The facility has determined that all resident have the potential to be affected. Element 3 The Food Service, Sanitation, Infection Control Policies has been reviewed and deemed appropriate. The facility has provided in service education programs for the Dietary Staff addressing policies and procedures, regulations and facility expectations of staff to assure that Food, Nutrition and Sanitation Policies are followed by June 19, 2023. Element 4 The Dietary Manager or designee will audit 3 times weekly for 4 weeks. Findings will be reported to the QAPI Committee monthly. The Administrator is responsible for maintaining compliance. The compliance date is June 19, 2023.	

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	A refrigerator that was next to the bread rack had a paper attached to the front with temperatures recorded twice a day. There were no temperatures recorded since 5/12/23. A trash can near door and coffee machine had a lid that was heavily soiled with food on top and bottom of the lid. A refrigerator contained orange juice that was not covered or dated. The freezer contained broccoli in an open plastic bag, in box not sealed. 2 brown bags were observed with no label of the contents. 2 bags of hot dog buns, 6 buns in each bag, were observed in with use by 1/11/23. Ice buildup under first rack was noted. The freezer contained mixed vegetables dated "5/4" and was not sealed/closed. A bag of white rolls was observed not closed/sealed. A freezer was observed with frozen hamburger patties that were not sealed, no date on bag of frozen waffles, hot dogs were not sealed, and no temperature had been recorded on the log on the front of the freezer door since 5/13/23 in the morning. A refrigerator log did not include temperatures in the morning on 5/13/23, or in the afternoon on 5/13/23, and 5/14/23. 2 Tomatoes were observed in a plastic bag, not dated, a bag of Bologna was dated "5/12", hot dogs were not dated, the bottom of the refrigerator was soiled. Tortillas were dated "4/18" and was open. Another bag of opened tortilla was dated "5/8" and were hard near the open area. ½ of a tomato was observed in a bag not dated. Sauces in plastic single use containers were observed on a pink tray that was soiled with spills, no label, no date. The upper and lower ovens were observed			

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	heavily soiled with black debris. The walk-in cooler was observed with a soiled floor, and was heavily soiled in the corner to the right of the door along with a butter packet. Cabbage in box was wilted, Salad mix with use by date of "5/11" were noted. A plastic container of vanilla icing was noted with a use by date of 3/01/23. The temperature log had not been documented on since the afternoon on 5/12/23. The dry storage included three containers, one of each: corn flakes, fruit loops and cheerios with no label or no date. 2 onions were observed with long spouts. A container of croutons was not dated and placed on soiled tray. 7 dented cans were observed on the floor, serving as a door stop. Loose cereal was noted on floor. A bag of elbow macaroni was dated 4/17/23, and not sealed. A container of breadcrumbs was dated "6/15, 12/15". A bag of tortilla chips was not labeled, and not closed. A corn starch box was observed open. A jug of pancake/waffle syrup had a top that was observed opened. Binders were noted in the dry storage area under the cereal that were soiled. Loose cereal was noted on the floor near a mouse trap. During an interview with Environmental Services (ES) "C" on 5/15/23 at approximately 10:00 AM, she stated as of last week she was head of the kitchen. In review of the "3 Compartment Sink Log" in the kitchen, the month/year was left blank, the location was also blank. Under the "day" column, the log listed numbers 1 through 31. Across from each day was separated into day, afternoon, and evening data. Data included a column to check the wash temperature was greater than 110-degree			

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	Fahrenheit, a column for part per million (PPM) was 150 to 400, and a column for initial of person documenting. Day number 1 through 10 were filled out for day, afternoon and evening. The time was documented in the column for wash temperature greater than 110 degrees Fahrenheit, instead of a temperature. On day 11, the day and afternoon documentation were blank, the evening was documented, with exception of the wash temperature. Day 12 through day 15 was left blank. A column titled manager review weekly was left blank. On the bottom of the same form were instructions "Wash Temperatures: must be > [greater than] 110 degrees. Fill sink with hot soppy water > 110 degrees and record temperature of water". In review of the "Dish Machine Temperature Log" dated May 2023, Delimed weekly column was left blank, there was no temperature recorded on prior to washing dishes on 5/15/23. In review of the "Food Usage and Temp Log", there were no recorded temperatures from 5/08/23 to 5/15/23. On 5/16/23 at 12:50 PM during an interview with Cook "E" at the same date and time, stated she began making the lunch meal between 9:00 AM and 9:30 AM, to insure it was ready by 11:00 AM. On 5/15/23 lunch was served in the dining room to the first resident at 11:45 AM. In review of the "Food Usage and Temp Log" dated 5/15/23, Chicken 40 pounds of chicken was documented at 120 degrees Fahrenheit, before meal service, in the column for regular diet, in the column for mechanical soft diet and in the column for pureed diet. No time was documented. Cook "F" was interviewed on 5/16/23 at 12:50 PM and stated she was concerned regarding the chicken temperature recorded at 120 degrees on			

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	134140	A. BUILDING _____ B. WING _____	**5/17/2023**

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	5/15/23 and verified she did not record that temperature on 5/15/23. Cook "E" was interviewed on 5/16/23 at 12:50 PM and stated she documented the temperature incorrectly on temperature log for lunch on 5/15/23, when she documented 120 degrees 3 times. During an interview with Dietary Aide "G" on 5/16/23 at approximately 1:00 PM, stated she checked the 3 compartment sink and documented on the log form. DA "G" produced log sheet that was filled out on the line for the first day of the month, not on the 16th. Under the column for wash temperature, the time was again documented. There was no documentation of afternoon meal on the 3-compartment sink log. There was no documentation the dishwasher was checked in morning or afternoon on this same day. During an interview with ES "C" on 5/17/23 at 8:23 AM she had not looked at food temperature logs and did not know what the temperature were supposed to be. ES "C" stated she planned to educate dietary staff before NHA "A" leaves on 5/18/23. ES "C" stated there was a rough patch in the kitchen 2 weeks ago, and a lot of people quit, no dietary staff have been hired in the last 2 weeks. The previous dietary manager's last day was on 5/05/23, she gave a 30-day notice. ES "C" stated in the same interview she had not received any education regarding the kitchen until this week, after the start of the survey. On 5/17/23 at 1:52 PM Registered Dietician (RD) "I" was interviewed and stated she worked at the facility on Wednesday and one weekend day per week. RD "I" stated her role in the building was clinical, with oversight at times as needed and could step into the role of kitchen manager. The "2017 FDA Model Food Code" section 4-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	5/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE CARE OF BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

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	601.11 states: "Nonfood-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." The "2017 FDA Model Food Code" section 3-401.11 states: raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature and for a time that complies with one of the following methods based on the FOOD that is being cooked: (3) 74oC (165oF) or above for < 1 second (instantaneous) for POULTRY.			
F0925 SS= F	Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00134124. Based on observation, interview and record review, the facility failed to maintain an effective pest control program in 2 of 2 residents interviewed for pests in the facility (Residents in Room 123-1 and 123-2), effecting 58 residents, resulting in the increased likelihood for insect and rodent infestations. Findings include: During an interview on 5/16/23 at 7:35 AM, residents in room 123-1 and 123-2 stated a mouse comes out at night, sometimes will come out during the day, and was about 2 inches in size. A trap was observed on the floor at the foot of 123-2's bed. One resident in room 123 stated the mouse was likely breeding in the trap, and they	F0925	F Tag 925 Element 1 The window screen will be replaced. The mouse trap was removed. Vines will be trimmed away from the building to eliminate rodent activity. The front door seal is being repaired to properly close. Dining door is being repaired to seal properly, the boiler room exit door will be repaired to prevent rodent and pest from entering, door sweeps will be installed. For repair. All repairs will be corrected by June 19, 2023. Element 2 The facility has determined that all residents have the potential to be affected. Element 3 The Pest Control Policy was reviewed and deemed appropriate. The facility has provided in service education for The Maintenance Department in addressing policies and procedures, regulations and facility expectations of Maintenance to assure that Pest Control Procedures are in place per regulatory guidelines by June 19, 2023. Element 4 The Maintenance Director or designee will audit rooms, window screens, building	6/19/2023

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	had never seen anyone check the trap. Room 123 was cluttered, with 2 bed side commodes, 2 walkers, 2 wheelchairs, cans of pop and soft drinks stored on the floor, and clothes in bags on the floor. A large hole was observed in the window screen. Review of a resident concern form dated 3/21/23, a resident that resided in room 123 reported she needed a mouse trap in her room. Corrective action indicated mouse traps were placed even though there was no evidence of mine. Concern form dated 4/06/23 indicated the same resident in room 123 still had a mouse issue. An audit dated 4/07/23 was attached to the concern form dated 4/06/23, indicated no evidence of mice was found in room 123. Pest control receipt with service dated of 3/03/23 indicated vines needed to be trimmed away from the building to help eliminate rodent activity. Interior rodent service was provided to room 111, 115, 183, 127, 129, and 143. The same receipt indicated pest activity was found. The Front Entrance to the facility had an interior exit door that did not close/seal properly, and a gap of ¼ inch or greater existed. Dining interior exit door did not close/seal properly, ¼ inch gap or greater was noted. The boiler room exit door was rusted at the bottom of the door allowing access for rodents and other pests entering. The same receipt indicated there were two doors that separated the boiler room from the interior of the building, and the doors did not have door sweeps. Pest control receipt with service date of 4/17/23 revealed findings that vines that were growing near the entrance doors of the facility could contribute to pest infestations and needed to be cut back away from the facility. On 5/16/23 at 7:35 AM vines were noted around		greenery, door seals, exit doors and door sweeps 3 times weekly for 4 weeks. Findings will be reported to the QAPI Committee monthly. The Administrator is responsible for maintaining compliance. The date of compliance is June 19, 2023.	

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	134140	A. BUILDING _____ B. WING _____	**5/17/2023**

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	front entrance, a gap greater than ¼ inch, in the center of double doors was noted in both the outer and interior doors. Main dining room exit door was observed with gap greater than ¼ inch. On 5/17/23 at 8:23 AM, Environmental Services (ES) "C" was interviewed and stated mouse traps were checked daily. ES "C" stated the entrance door hinges keep coming loose and caused a gap in the doors in the center. ES "C" stated vines were growing up the walls and they had cut those vines back. ES "C" stated she did get a quote to remove the vines and the bushes, but the previous owner did not approve the cost. ES "C" stated resident rooms were cleaned daily. The residents in room 123 ordered snacks in their room and the facility ordered totes to keep the snacks sealed. ES "C" stated the hole in screen was on her list to be repaired. On 5/17/23 at 2:30 PM the door that led to the outside, from the boiler room, was observed to be rusted with daylight coming through under the door, greater than ¼ of an inch. Maintenance staff "E" stated the facility did not install door sweeps, as recommended by the pest control company and stated the boiler door needed a new threshold due to the rust and stated the threshold was on order.			