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	03/12/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to advocate for one out of two residents (#29) reviewed for dignity resulting in the resident feeling unheard, decreased self-worth, frustration, decreased quality of life and suffered mental anguish. Findings include: Resident #29 (R29) Review of the medical record reflected R29 was an initial admission to the facility on [DATE]. Diagnoses of Aphasia following cerebral infarction, anxiety, nontraumatic intracerebral hemorrhage in hemisphere, speech and language deficits following cerebral infarction, Dysarthria, Dysphagia, needs assistance with personal care, Chronic Obstructive Pulmonary Disease and unsteady gait. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/20/2024, revealed R29 had a Brief Interview of Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. During an interview on 03/10/25 at 10:30 AM, anonymous interviewee T stated they had concerns regarding a resident that was not being heard and not having his resident rights addressed. Anonymous interviewee T stated R29 was admitted to the facility in September 2024. R29 has a court appointed guardian who R29 no longer wanted this person in that role. R29 is not allowed visits from his fiancé and cannot go back to his apartment. R29 is not being told what his discharge plans are. R29 is so distraught from not being allowed visits that he had make comments about being suicidal. Anonymous interviewee T stated R29 would like his fiancé to become his Durable Power of Attorney (DPOA) and was told he cannot have her. R29 was sent out to the emergency room for suicidal ideations and reported that nobody was listening to him, he didn't have a voice. During an interview on 03/10/25 at 11:02 AM, R29 stated he was not allowed to voice his concerns, wishes or wants, adding nobody will help him get a new guardian. R29 stated he wants to go home and wants his fiancé to be with him. R29 stated he is frustrated and upset that she could not come to the facility to spent time with him. R29 asked writer to help him return a video call to his fiancé, writer pointed to the key to push to return call. R29 also told writer again that he wanted a new guardian. (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: 235451	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Oaks at Battle Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 706 North Avenue Battle Creek, MI 49017	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed R29 was sent out to the emergency room for suicidal ideation on 03/06/25 .Resident verbalized wanting to kill himself with a knife after not being able to see his girlfriend. Resident was not able to see his girlfriend for reasons that his DPOA/Guardian has put in place. Resident can speak with her on the phone but not have visits. Resident was sent to ED and returned to the facility and cleared of all suicidal ideations. Social Service Director (SSD) is working with resident and had completed a wellbeing check. Resident denied thoughts of suicidal ideations and has returned to baseline . Record review revealed there was not any follow up by social work following the date of his emergency room visit until this date of 03/10/25. During an interview on 03/11/25 at 3:31 PM, Licensed Practical Nurse (LPN) Q stated the guardian won't let the fiancé come into the facility to visit, only facetime and phone calls. LPN Q stated it was too bad because it helped having her at the facility with him. During an interview on 03/11/25 at 3:37 PM, Social Worker (SW) H stated she did not meet with R29 at his admission, she had not started working there yet. Writer asked SW H if she had met with him after she had started working there. SW H stated R29 wanted to be discharged back to his old apartment. SW H stated he had a guardian, who was his sister, and she didn't feel he would be safe there, and wanted to find a different apartment. SW H stated the guardian did not like R29's girlfriend and stated that the girlfriend had a disability who still wanted to help take care of him. SW H added that R29 wanted to be with his girlfriend. SW H stated they still assist him with calling his girlfriend throughout the day. SW H stated sometimes he told them he didn't want his sister to be his guardian. Writer asked SW H about following R29 wishes, and what did he want. SW H stated they have discussed discharge planning, and he shouldn't be going to an apartment at all. SW H stated she was ware of residents having rights, but probably didn't know all of them. Writer asked SW H if she knew he had rights and he could ask the court to re-assign to another guardian. SW H stated she was unaware of that process but maybe the previous social worker could assist her with that. Writer asked SW H how long the sister would be a temporary guardian per the court papers. SW H stated she didn't know that or how long that would last. SW H stated R29 just had his 1st quarterly assessment, and he attended. SW H stated that R29 didn't voice he wanted to go home to her. During an interview on 03/12/25 at 8:31 AM, SW H stated the previous social worker now worked in another area of the facility, and she was off work today. During an interview on 03/12/25 at 10:02 AM, Director of Nursing (DON) B stated the expectation was they would investigate getting him another guardian, and knew he wanted to be discharged , and his sister didn't think it would be a safe choice. DON B stated they didn't think he was ready for discharge yet, just went to Neuropsychologist and would look for the report. DON B acknowledged he did have rights and would work on steps to help him on the situation. DON B stated she didn't know if a different guardian would provide anything different than the one he had. Writer asked DON B why that would stop him from asking for a different guardian, if that is his wish. It shouldn't matter on the reason, he still has rights. DON B stated she was unsure if it had been started, and was not aware she was a temporary guardian. DON B stated the social worker did know about residents' rights. DON B stated SW H knew about federal regulations and residents' rights. During an interview on 03/12/25 at 10:47 AM, previous SW R stated they can assist with that paperwork for R29. Previous SW R stated the guardian was following the recommendations given to her by the court and didn't know that a new guardian would change any of the things that she had done. Previous (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SW R stated that she had called the court advocate to come speak with the resident, and she would say that the guardian who was working with him now had the best interest for him. Previous SW R stated R29 has not voiced to her that he wanted a new guardian, again stated the current guardian was following the recommendations from the court. Previous SW R stated he talked about going home, but his apartment lease was up, and they need to find him an apartment. Previous SW R stated the court advocate made rounds to speak to residents. Previous SW R could call her to come meet with this resident. Previous SW R stated she had not started the process with R29 at this time. Also stated there were other family and friends who were not happy with his guardians' decisions, and she had encouraged them to apply for guardianship. Writer asked previous SW R about the temporary guardianship status, and she didn't know what the process was for that time frame. Previous SW R stated she did know R29 had resident rights. Record review revealed the facility staff had not assisted R29 to exercise his rights.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review the facility failed to ensure that the Notice of Medicare Non-Coverage (NOMNC) was provided for two Residents (#2 and #179) and a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) was provided for three Residents (#2, #178, and #179) out of three reviewed for Beneficiary Notification. Findings Included: Resident #2 (R2) Review of the medical record revealed R2 was admitted to the facility 10/02/2024 with diagnoses that included chronic kidney disease, hyponatremia (low sodium level) type 2 diabetes, atrial fibrillation, chronic obstructive pulmonary disease (COPD), anemia (low red blood cells), hyperlipidemia (high fat content in blood), depression, chronic pain, and gastro-esophageal reflux disease. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) 01/06/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 13 (cognitively intact) out of 15. In an interview on 03/12/2025 at 10:25 a.m. Licensed Nursing Home Administrator (LNHA) A explained that she could not verify that R2 had a Notice of Medicare Non-Coverage (NOMNC) and a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) that was to be completed 12/02/2024 for the change in payor source date of 12/04/2024. LNHA A could not explain why the NOMNC and SNFABN was not completed as required. Resident # 178 (R178) Review of the medical record revealed R178 was admitted to the facility 02/12/2025 with diagnoses that include congestive heart failure (CHF) atrial fibrillation, kidney failure, type 2 diabetes, chronic respiratory failure, morbid obesity, depression, anxiety, atrial fibrillation, vitamin D deficiency, hypotension (low blood pressure), mitral valve insufficiency, aortic valve insufficiency, and hyperlipidemia (high fat content in blood). The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/18/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 13 (cognitively intact) out of 15. In an interview on 03/12/2025 at 10:25 a.m. Licensed Nursing Home Administrator (LNHA) A provided a Notice of Medicare Non-Coverage (NOMNC) for R178 that was completed 02/16/2025 for an effective date of 02/18/2024. LNHA A explained that she could not provide a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) for R218. LNHA A could not explain why the SNFABN was not completed as required. Resident #179 (R179) Review of the medical record revealed R179 was admitted to the facility 09/28/2024 with diagnoses that included left artificial knee joint, spondylosis lumbar region (age related war and tear of the spinal disks in the back), type 2 diabetes, hyperlipidemia (high fat content in blood), depression, anxiety, hypertension, insomnia, gastro-esophageal reflux, and chronic pain. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/04/2024, demonstrated a Brief Interview for Mental Status (BIMS) of 14 (cognitively intact) out of 15. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/12/2025 at 10:25 a.m. Licensed Nursing Home Administrator (LNHA) A explained that she could not verify that R179 had a Notice of Medicare Non-Coverage (NOMNC) and a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) that was to be completed 10/08/2024 for the change in payor source date of 10/10/2024. LNHA A could not explain why the NOMNC and SNFABN was not completed as required.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review, the facility failed to ensure resident medical records were secured and held confidential for 1 resident (R8) of 17 residents sampled, resulting in exposed resident medical information. Findings include: On 3/10/25 at 7:55 AM, the medication cart was observed in the hallway outside of R8's room, with the computer screen open with R8's profile in focus and visible for anyone that walked in the hallway. No nurse was present at that time. LPN E returned to the cart, when asked if she would normally lock her computer screen when she walks away she reported that the screen normally locks on it's own after three seconds. On 3/10/25 at 7:58 AM, LPN E was observed walking away from the medication cart for a second time without locking the computer screen, leaving resident information exposed. LPN E was observed walking into and out of two resident's rooms before returning to the medication cart. On 3/10/25 at 8:01 AM, LPN E was observed walking away from the medication cart for a third time, without locking the computer screen. LPN E walked down the hallway and retrieved a portable vital signs cart. When questioned a second time about the computer screen being left open with resident information exposed LPN E reported that settings on the computer must have changed over the weekend causing it to not automatically lock the screen. On 3/12/25 at 1:22 PM, during an interview with director of nursing (DON) B, she reported that the expectation is that no protected health information is left open/exposed on an unattended computer screen and that staff should be locking their screen or closing the laptop when leaving the computer unattended. Review of the facilities admission packet documented in part .You have a right to personal privacy and confidentiality. This includes your accommodations, medical treatment, written and telephone communications, personal care, visits and meetings with family and other residents .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a person centered care plan for targeted behaviors for the use of psychotropic medications for one Resident (Resident 20) of 17 residents reviewed for care plans. Findings include: Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] reflected Resident 20 (R20) was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease with late onset, unspecified dementia with psychotic disturbance and depression and was admitted on an anti-psychotic medication. R20 scored 6 out of 15 (severe cognitive impairment) on the Brief Interview Mental (BIMS). The mood and behavior section of the MDS revealed R20 had no mood, behavior concerns and no hallucinations or delusions. The 11/20/24 MDS reflected R20 had no mood problems, no hallucinations, no delusions and wandered 1 to 3 days a week. R20 was observed throughout the survey R20 was well groomed, smiling and engaged with peers easily. Review of R20's pharmacy recommendations dated 1/06/25 and 3/04/25 revealed the facility needed to establish a behavioral monitor for the use on an anti-psychotic medication and address the use of the medication in the care plan. The recommendation also advised to include the behaviors that were being treated , the non-drug interventions used to treat R20's behaviors along with potential side effects. Review of R20's care plans dated 12/09/24 reflected R20 was at risk for adverse consequences related to anti-psychotic medication with a goal of R20 not having adverse effects of the medication. There was no care plan in place to address the targeted behaviors or what symptoms the antipsychotic medication was to manage, there was nothing in place to address what non-pharmalogical interventions had been tried or how any behaviors were being monitored. Review of R20's cognition and mood combination care plan dated 12/09 revealed R20 had impaired memory and altered mood with a goal of R20 remaining safe and not injure herself due to poor decision making, the interventions some of the interventions were adjust her hearing aid and redirect if she becomes agitated and obverse for wandering into others rooms. On 03/11/25 03:22 PM during an interview with Social Worker (SW) H she reported R20 was on an anti-psychotic medication because she had a diagnosis of dementia and some behaviors when queried what R20's behaviors were SW H stated she didn't know. When queried what was developed and implemented for a person centered care plan in relation to R20's prescribed an anti-psychotic medication, SW H stated R20 wandered. On 03/11/25 04:19 PM during an interview with Director of Nursing (DON) B R20's use of anti-psychotic medication use was discussed along with R20's care plans. DON B was offered no explanation as to why R20 did not have a person centered care plan that addressed the need for an anti-psychotic medication. Of note, DON B wandering was not an acceptable use of an anti-psychotic medication.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that meaningful activities were provided for one resident (R26) out of two resident who are dependent on staff for transferring and mobility and the likelihood for depression, feelings of melancholy using the reasonable person concept. This deficient practice resulted in the potential for boredom, lack of stimulation and loneliness. Findings Include: Resident #26 (R26) Review of the medical record reflected R26 was an initial admission to the facility on [DATE]. Diagnoses of a Stroke, Hypertension, Coronary Artery Disease, Hemiplegia on right side, Malnutrition, Depression and Anxiety. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/21/2024, revealed R26 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. Under section GG0100, Activities of Daily Living (ADL) Assistance reveals R26 requires minimal/moderate assist with all care and minimal assist setting up for meals. During an interview on 03/10/25 at 9:30 AM, R26 stated he doesn't get to activities because it takes a lot to get him up and ready to go. R26 stated he would like to participate in some of the activities offered but it a time thing, staff do not come in and get him up in his chair in time to go to the dining room for meals or the activities that take place. During an interview and observation on 03/11/25 at 10:53 AM, R26 stated this was not a good time to visit as he is waiting for a CNA to get him cleaned up and in his chair for lunch in the dining room. R26 still had his breakfast tray sitting on his over the bed table, he was sipping the last bit of water out of his white foam water glass from earlier this morning. Did not observe an activity calendar visible in R26's room. Writer did not observe a CNA current working in this hall outside of his room. During an observation on 03/11/25 at 11:26 AM, CNAs were providing personal care, door closed. During this same observation on 03/11/25 at 12:00 PM, CNAs were still providing care, door closed. During an observation on 03/11/25 at 1:25 PM, R26 was sitting in the dining room alone in his wheelchair, slumped forward in his wheelchair sleeping. R26's lunch was sitting in front of him, plate uncovered and no longer warm, pork chop, rice, apple pie and root beer. During an interview on 03/11/25 at 2:28 PM, Life Enrichment Director (LED) S was asked where she documented activity participation's and involvement. LED S stated they used a program called life loop, documentation is not in electronic medical records, only assessments and care plans are in electronic medical record. Record review revealed R26's participation in activities from 11/01/24 through today 03/11/25, showed the report of 5 activities attempted, R26 declined 3 activities, no other attempts were (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented. Documentation also showed that the resident had a personal visitor on 02/28/25 and was marked it down as an activity. R26 had a phone call in 2/18/25 and was marked as an activity. R26 had a personal visitor on 01/26/25 and was marked as an activity. Activity log reported R26 has a rehab specialty cart (cart with books, magazines and word cross books) on 03/1/25 and a 1:1 visit on 03/2/25. No other documentation to reveal R26 was engaged in any stimulating activity from 11/01/24 until 03/01/25. During an interview on 03/12/25 at 9:53 AM, DON B stated the expectation would be to involve R26 in 1 on 1 program, getting him up in time to participate in activities, allowing time to engage with other residents during meals in the dining room.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents prescribed anti-psychotic medication had an adequate indication for use, clinical rational to support continued use, as well as identify and monitor resident specific specific behaviors and approaches and non-pharmacological approaches for one resident (Resident #20) of five residents reviewed for unnecessary medications. Findings include: Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] reflected Resident 20 (R20) was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease with late onset, unspecified dementia with psychotic disturbance and depression and was admitted on an anti-psychotic medication. R20 scored 6 out of 15 (severe cognitive impairment) on the Brief Interview Mental (BIMS). The mood and behavior section of the MDS revealed R20 had no mood, behavior concerns and no hallucinations or delusions. The 11/20/24 MDS reflected R20 had no mood problems, no hallucinations, no delusions and wandered 1 to 3 days a week. R20 was observed throughout the survey R20 was well groomed, smiling and engaged with peers easily. Review of R20's pharmacy recommendations dated 1/06/25 and 3/04/25 revealed the facility needed to establish a behavioral monitor for the use on an anti-psychotic medication and address the use of the medication in the care plan. The recommendation also advised to include the behaviors that were being treated , the non-drug interventions used to treat R20's behaviors along with potential side effects. Review of the Interdisciplinary Team (IDT) note dated 12/18/24 revealed R20 had experienced hallucinations and dysuria. A urinalysis was completed, R20 was found to have a urinary tract infection and was treated with antibiotic. There was no mention if the hallucination was distressing nor was there any further documentation in R20's medical record that R20 had any further hallucinations or delusions. Review of the Nurse practitioner notes dated 1/24/25 revealed the provider saw R20 due to a possible Gradual Dose Reduction (GDR) of R20's anti-psychotic medication and was amenable to try alternative therapy. The same progress note reflected R20 was administered Seroquel for night time agitation and psychosis, and that the facility staff had been educated on close monitoring. The progress note did not include what the alternative therapy was. Review of the Nurse practitioner notes dated 1/27/25 revealed R20's family reported that R20 had an allergy to alprazolam (a medication to treat anxiety) and that Seroquel (an anti-psychotic) medication had best helped R20 maintain good mood or behavior for quality of life. The progress note reflected use of Seroquel was revisited at that time and Gradual Dose Reduction (DR) benefits outweigh the risk continuing therapy of psychiatric medication. No additional information was provided as how the anti-psychotic best helped R20 and what the symptoms of R20s mood and behavior were. Review of the Clinically At Risk (CAR) notes dated 2/08/25 Initial CAR note: Resident is being picked up on CAR for use of psychotropic medications. Resident has order for Seroquel and Sertraline. Resident has a diagnosis of Depression and Psychosis. Seroquel started on 1/27/25 after failed GDR. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sertraline increased on 1/24/25. Resident presents as stable of symptoms, behaviors, and mood at this time. No side effects noted at this time. Non- pharmacological interventions listed in care plan, current care plan reviewed and remains appropriate. Will continue to review CAR monthly with IDT. CAR Note dated 3/7 CAR NOTE: Revealed R20 was followed by CAR for psychotropic medication use. Resident continued on Seroquel tablet; 50 milligram (mg) ,1 tablet; oral and sertraline tablet; 100 mg; 1 tab. No issues or concerns at this time. On 03/11/25 at 03:22, PM during an interview with Social Worker (SW) H she reported R20 was on an anti-psychotic medication because she had a diagnosis of dementia and some behaviors when queried what R20's behaviors were SW H stated she didn't know. SW H then reported R20 had a failed GDR in January and Seroquel had to be restarted, when asked to elaborate on how the GDR was determined to have failed, SW H stated she assumed R20 had more behaviors but she really wasn't sure as no one had informed her why the medication was restarted. When asked what non-pharmalogical interventions were in place, tried failed etc SW H offered R20 had a care plan for exit seeking. When queried if R20 had been evaluated by the Psychiatry group that visits the facility, SW H stated no because R20 was a hospice resident and hospice residents were not allowed to see the psychiatrist due to reimbursement issues. When asked about behavior management and how behaviors were tracked and monitored SW H stated they had CAR meetings and psychotropic medication use was discussed in those meetings. SW H reviewed R20's electronic medical record during the interview and reported the failed GDR was evidence by the Nursing progress note dated 1/25/25. Review of nursing progress note dated 1/25/25 revealed R20 paced up and down the 100 and 200 hall that afternoon without her walker and R20 had to be reeducated on the importance of the walker. The progress note did not reflect R20 was distressed, exit seeking, delusional or hallucinating, combative a danger to herself or others. Of note, review of the January 2025 Medication Administration Record reflected R20 was administered Seroquel on 1/24/25 at night, thus the event of R20 pacing up and down the 100 and 200 hall had not missed/had the Seroquel GDR implemented. On 03/11/25 at 04:11 PM, during an interview with Certified Nursing Assistant (CNA) O she reported regularly working with R20 who had no mood or behavior concerns. When queried if R20 had hallucinated CNA O reported Oh ya once a long time ago. Was R20 distressed or upset? Oh no not at all, if anything she was happy she was seeing a little girl. On 03/11/25 at 04:19 PM, during an interview with Director of Nursing (DON) B R20's use of anit-psycotic medication use was discussed, DON B was unable to identify benefit of use, what is prescribed for, targeted behaviors, how and where behaviors were monitored , nonpharmilogical interventions implemented or what the failed GDR was based on. DON B agreed wandering and dementia did not justify use. Documentation was requested at this time to support the use of Seroquel, none was provided by end of the survey on 3/12/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235451	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Oaks at Battle Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 706 North Avenue Battle Creek, MI 49017	

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review the facility failed to ensure that food was served and held at a palpable temperature. Resulting in the potential to affect all residents (total facility census of 70) that consume food from the kitchen. Findings Included: Resident #173 (R173) Review of the medical record revealed R173 was admitted to the facility 02/14/2025 with diagnoses that included prosthetic left hip joint, fracture of left femoral neck, type 2 diabetes, hypertension, hyperlipidemia (high fat content in blood), depression, anemia (low red blood cells), osteoarthritis (type of arthritis occurs when tissue at end of bones wears down), unilateral inguinal hernia, and pain in left hip. The Minimum Data Set, with an Assessment Reference Date (ARD) of 02/20/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 9 (moderate cognitive impairment) out of 15. During observation and interview on 03/10/2025 R173 was observed lying down in bed. R173 explained that five out of seven days the food was cold. R173 explained that the food that should have been hot was cold and the food that should have been cold was warm. On 03/12/2025 at 12:19 a.m. R173 was observed to arrive in the dining room. R173 was provided a food tray which appeared to contain one fried chicken sandwich and fixed vegetables. Assistant Dietary Manager (ADM) L was asked to check the temperature of R173's lunch tray. ADM L was observed to check the temperature of the mixed vegetables, and it was observed to have a temperature of 113 degrees F (Fahrenheit). ADM L was observed to check the temperature the chicken sandwich and it was observed to have a temperature of 101 degrees F. ADM L explained that the mixed vegetables should have been at least 165 degrees F and the fried chicken should have been 165 degrees F. ADM L explained that R173 would be provided another lunch tray. On 03/12/2025 at 12:22 a.m. entered the kitchen with Assistant Dietary Manager (ADM) L and observed a tray of fried chicken setting on the top of the steam table. ADM L was observed to obtain a temperature for the fried chicken, that she reported to be 101 degrees F (Fahrenheit). ADM L explained that the chicken should be at least 165 and informed staff to remove fried chicken and re heat the fried chicken. ADM L was observed to obtain a temperature for the mixed vegetable, located in a tray on the steam table, that was reported to be 145 degrees F. ADM L explained that the mixed vegetables should have had a temperature of 165 degrees F and that those mixed vegetables would be re-heated. When asked how many Residents had received the fried chicken and mixed vegetables ADM L responded at least half of the facility to that point.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment effecting 70 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and plumbing water leaks. Findings include: On 03/10/25 at 07:35 A.M., An initial tour of the food service was conducted with Dietary [NAME] C. The following items were noted: 1 of 2 True 2-door reach-in cooler doors were observed to not automatically close completely after opening, creating an air gap (approximately 1-2-inches wide between the refrigeration unit frame and the door gasket seal). The 2022 FDA Model Food Code section 4-501.11 states: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened. The can opener assembly was observed soiled with accumulated and encrusted food residue. Dietary [NAME] C indicated the can opener assembly had been used for the morning Breakfast Meal preparation. Dietary [NAME] C also stated: I didn't work this past weekend. The exterior surfaces of the Cleveland steamer were observed soiled with accumulated and encrusted food residue. The top surface of the Cleveland steamer was also observed coated with accumulated (dust, dirt, debris). The exterior surfaces of the South Bend convection oven(s) were observed soiled with accumulated and encrusted food residue. The top surface of the South Bend convection oven(s) were also observed with accumulated (dust, dirt, debris). One metal oven rack was further observed resting upon the top surface of the South Bend convection oven(s). The Globe stand mixer was observed soiled with accumulated and encrusted food residue. The backsplash plate, metal guard assembly, and spindle gear assembly were also observed soiled with accumulated and encrusted food residue. The Globe stand mixer frame legs and support table surface were additionally observed with accumulated and encrusted food residue. The Pitco fryer interior cabinet surfaces and exterior unit surfaces were observed soiled with accumulated and encrusted grease/dirt deposits. Main Dining Room: The beverage island base cabinet doors and interior cabinet surfaces were observed soiled with accumulated and encrusted food residue (soda syrup concentrate), creating door opening and closing concerns. 200 Hall Nourishment Room: The dustpan caddy was observed heavily soiled with accumulated and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	encrusted dust/dirt/food residue. The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. The Berner mechanical Air Curtain, located above the food service rear entrance/exit door, was observed soiled with accumulated and encrusted dust/dirt deposits. Large pockets of accumulated dust/dirt were also observed within the interior mechanics of the Berner Air Curtain. The flooring/wall surfaces, located adjacent to the Pitco fryer unit, were observed soiled with accumulated and encrusted grease/dirt deposits. Private Dining Room: The hand sink basin and vanity surface were observed soiled with accumulated and encrusted dirt/food residue. 200 Hall Nourishment Room: The two top sliding cabinet drawers were observed soiled and in disarray. Miscellaneous items (cloth napkins, salt packets, pepper packets, ketchup cups, metal meal knifes, metal meal spoons, metal meal forks, etc.) were also observed stored within the soiled cabinet drawers. The 2022 FDA Model Food Code section 6-501.12 states: (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing. The two-compartment vegetable preparation sink faucet assembly was observed leaking water from the spout. Dietary [NAME] C stated: I am not sure if maintenance is even aware of the problem. Dietary [NAME] C also stated: The sink faucet has been leaking for about a month. Main Dining Room: The hand sink basin goose neck faucet assembly was observed loose-to-mount. The 2022 FDA Model Food Code section 5-205.15 states: A plumbing system shall be: (A) Repaired according to LAW; and (B) Maintained in good repair. Dry Storage Room: The Sugar storage bin clear plastic protective cover was observed three-quarters open, exposing the food product (sugar) to potential external contaminants. The 2022 FDA Model Food Code section 3-307.11 states: FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306. On 03/11/25 at 08:50 A.M., An interview was conducted with Food Service Director D regarding the facility maintenance work order system. Food Service Director D stated: We have the TELS program., referring to the Direct Supply TELS software system for initiating and tracking facility maintenance work orders. On 03/12/25 at 09:00 A.M., Record review of the Policy/Procedure entitled: Kitchen Cleaning (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procedures dated (no date) revealed under Mixer: Procedure: (1) Disassemble removable parts. (2) Wash all non-electrical parts in the three-compartment sink. (3) Wash non-removable parts of the mixer with a solution of pot & pan detergent. (4) Wash handle and underneath where paddle attaches. (5) Rinse with fresh water and wipe dry. (6) Using a different wiping cloth, apply sanitizing solution to the mixer. (7) Allow to air dry. (8) Reassemble. On 03/12/25 at 09:15 A.M., Record review of the Policy/Procedure entitled: Kitchen Cleaning Procedures dated (no date) revealed under Can Opener: Procedure: (1) Remove handle from base. (2) Exercise caution near the blade. It is sharp and can cause injury. (3) Wash handle in the three-compartment sink. (4) Wash base with a solution of pot & pan detergent. (5) Rinse with fresh water and wipe dry. (6) Using a different wiping cloth, apply sanitizing solution to the base. (7) Allow to air dry. (8) Place handle back into base.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to practice effective infection prevention standards related to hand hygiene, 1) adhere to infection control practices, during medication administration with three of four nurses; and 2) facility failed to maintain infection control practices, in one of two wounds, Resident #59 (R59). Findings Included: Resident #59 (R59) Review of the medical record reflected R59 was an initial admission to the facility on [DATE]. Diagnoses of Congested Heart Disease, Chronic Kidney Disease, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease and Diabetes. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/2024, revealed R59 had a Brief Interview of Mental Status (BIMS) of 13 (cognitively intact) out of 15. Under section GG0100, Activities of Daily Living (ADL) Assistance reveals R59 requires set up/moderate assist with all care. During an interview and observation on 03/12/25 at 9:37 AM of Wound Care (WC) Nurse N perform wound care on both of R59's feet. Observed WC nurse N donning a gown and gloves. WC Nurse N had gathered wound care supplies prior to donning. Supplies were visible in a container prior to entering the room. WC Nurse N washed his hands once in the room and then put gloves back on. Observation of the bottom sheet at the foot of the bed dirty from betadine leaking through the dressing. Observed blood on the bottom sheet at the head of bed from R59 scratching. Observed WC Nurse N remove the dirty dressing from right foot, laid the now soiled scissors on the bed sheet beside the resident's right foot. WC Nurse N did not change gloves or hand sanitize before reaching into the container of clean dressing supplies with the same gloves he removed the dirty dressing with. WC Nurse N cleaned the right foot great toe with betadine and applied Medi-honey to the top of the great toe on the right foot, then covered with border dressing, wrapped it with rolled gauze dressing. WC Nurse N set the box of rolled tape on the dirty bed sheet beside the right foot. WC Nurse N then cut the tape from the roll with the dirty scissors, then laid the dirty scissors back down on the bed beside the right foot. WC Nurse N went to the left foot to perform wound care on the heel of the left foot. WC Nurse N did not wash hands or hands sanitize between completing wound care on the right foot and moving to the left foot. WC Nurse N removed the soiled dressing from the left foot with the same dirty scissors and laid them back down on the dirty sheet by R59's feet. WC Nurse N placed a bath towel under R59's left foot due to the supplies used. WC Nurse N used the same gloves to touch the wound and measure it. WC Nurse N used the same gloves to clean wound with a wound cleanser. Observation of black eschar on the heel of the left foot. WC Nurse N grabbed the box of rolled tape from sitting on the dirty bed sheet. WC Nurse N grabbed a cup with betadine-soaked gauze from his clean container of supplies, wearing the same soiled gloves and placed the soaked gauze over the heel eschar and wrapped the foot with a rolled gauze dressing. WC Nurse N then removed his gloves and washed his hands in the resident's bathroom. WC Nurse N put on new gloves and cut tape off from the roll of boxed tape, with the dirty scissors that were still laying on the bed, and secured the rolled gauze dressing in place while laying the dirty scissors (continued on next page)

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	235451	A. Building B. Wing	03/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	back on the soiled bottom sheet of the bed. WC Nurse N then doffed his gown and gloves, picked up the box of rolled tape and the dirty scissors and placed them back in the container of clean dressings and carried the container out of the room. During an interview on 03/12/25 at 10:14 AM, writer asked Director of Nursing (DON) B what her expectations were for providing wound care. DON B stated she needed to pull the policy and look at it first. During an interview on 03/12/25 at 11:21 AM, Infection Preventionist Registered Nurse (IPRN) P stated her expectations for wound care would be, prior to entering the room, either enhanced barrier or transmission-based precautions, the nurse would gown up, wash their hands before putting on gloves, make sure the necessary supplies were there. Nurses can get the supplies from one of the treatment carts on each hall so they can have the cart outside of the room or go to the gather the supplies and go to the room. Writer asked IPRN P what the expectations were for using soiled Instruments. IPRN P stated nurses need to clean scissors between each person but not between wounds. Writer asked IPRN P her expectations from removing soiled dressings, then cleaning wounds and applying new clean dressings with the same soiled gloves. IPRN P stated they should probably change the gloves, but if it isn't soiled, they don't have to. During this same interview, writer asked IPRN P what her expectations were on infection control while passing medications. IPRN P stated nurses should be washing their hands or hand sanitizing frequently and appropriately. IPRN P stated if the nurses come out of a room, and touch another item or environment, they need to perform hand hygiene. IPRN P stated they used to have more wall mounted sanitizers before remodeling. IPRN P stated she asked the nurses if they had hand sanitizer in their pockets or the top drawer of the medication cart. Writer asked IPRN P why they did not use them during medication administration if they had them. CDC Clinical Safety; Hand Hygiene for Health Care Workers Immediately before touching a patient. Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or patient's surroundings. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal. Resources; https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf