

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/6/2024
NAME OF PROVIDER OR SUPPLIER PINNACLE CARE OF BATTLE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K0000 SS=	<p>INITIAL COMMENTS</p> <p>On June 5, 2024, a complaint intake MI00144940, Life Safety Code Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Pinnacle Care of Battle Creek was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, subpart 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety code and the 2012 Edition of NFPA 99, Health Care Facilities Code.</p> <p>The complaint alleges 6/5/24, 11:45 pm, during fire watch rounds, fire watcher smelled smoke coming from the Director of Nursing's office and immediately called 911. Sprinkler system turned on and put out fire. Fire was contained to the DON's office. Fire came from vital sign machine that was plugged in.</p> <p>During the investigation on June 6, 2024, it was revealed the facility had responded appropriately to the fire emergency as required by facility policies and procedures. Facility was on current fire watch due to their dialer being inoperable and had logged fire watch rounds as required.</p> <p>The allegations were substantiated with no deficiencies.</p>	K0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/25/2024

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.