STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235536	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Care of Battle Creek	675 Wagner Drive Battle Creek, MI 49017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2630915Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from resident-to-resident physical and verbal abuse for 2 (Resident #103 and Resident #104) of 4 residents reviewed for abuse, resulting in Resident #103 experiencing physical contact with facial laceration and verbal threats by Resident #104. Resident #103(R103)Review of the Face Sheet and Minimum Data Set (MDS) dated , 8/18/25 reflected R103 was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that traumatic brain injury, intermittent explosive disorder, psychologic disorder, anxiety and depression. The MDS reflected R103 had a BIM (assessment tool) score of 13 which indicated his ability to make daily decisions was cognitively intact.Resident #104(R104)Review of the Face Sheet and Minimum Data Set (MDS) dated , 8/18/25 reflected R104 was a [AGE] year-old male admitted to the facility on [DATE], with vascular dementia, irritability and anger, anxiety and depression. The MDS reflected R104 had a BIM (assessment tool) score of 15 which indicated his ability to make daily decisions was cognitively intact.Review of the Facility Reported Incident, dated 9/17/25, reflected R103 and R104 were involved in a witnessed resident to resident altercation.During an observation and interview on 1/22/26 at 11:40 a.m., R103 was in the hall self-propelling in wheelchair. R103 appeared slightly anxious but appeared to calm and pleasant with general routine to conversation. R103 reported feels safe at facility and reported was not afraid of anyone at facility. During an observation and interview on 1/22/26 at 11:50 a.m., R104 was lying in bed and appeared calm and pleasant. R104 reported felt safe at facility and reported everyone treated him with dignity and respect. During an interview and record review on 1/22/26 at 12:06 p.m., Social Worker (SW) C reported was aware of Resident-to-Resident altercation on 9/17/25 and reported prior Nursing Home Administrator (NHA) G was only witnessed staff at the time of the altercation and completed most of investigation. SW C reported no prior altercations between R103 and R104 and none since. SW C reported did follow up with R103 after incident with no changes in baseline and verified after reviewing Progress Notes. SW C reported R104 was arrested and was currently in the facility. SW C reported had been a lot of staff turnover since September, and she was the only staff who was still employed that was involved in the incident.Review of NHA G witness statement, dated 9/17/25, reflected, At approximately 1:30 p.m. on 9/17/25 I was in the main dining room for a resident activity. While speaking with residents about planning for Halloween, I observed [named R103 and R104] in an altercation. [named R103] was ambulating in his wheelchair and bumped into [named R104] wheelchair. [NAME] swung back with his right arm and a closed fist, making contact with the right side of [named R103] face near his mouth. [named R103] yelled out as I ran over to separate them. Both residents were agitated and I took [named R103] out into the hallway to calm down. I contacted his nurse to assess his face for injury. [named R103] was observed to have a small open area on his bottom lip, and blood in his mouth. [named R103] went with his nurse and I (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approached [named R104]. When I asked him what happened, he stated, He ran into my chair. When I asked why he would become physically violent with someone over an accident, he stated it was a good reason to hit him. I notified the resident that I would need to contact the local police and he stated, I don't give a fu--, [explicit language] Resident was laughing regarding the situation.Officers notified me that [named R104] has multiple outstanding warrants and they would need to take him to jail.Review of the facility 5-day investigation, dated 9/24/25, reflected the facility was able to substantiate abuse had occurred, along with injury to R103.

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2668291Based on observation, interview and record review the facility failed to allow one Resident (Resident #105) to return to the facility after being hospitalized immediately upon the first available bed and failed to implement required discharge policies and procedures, resulting in increased likelihood of anxiety, stress and uncertainty about placement.Review of the Face Sheet and Minimum Data Set (MDS) submitted 10/16/25, reflected R105 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included progressive neurologic disorder, dementia with agitation, and adjustment disorder with anxiety. The MDS reflected that R105 had a BIM (assessment tool) score of 9 which indicated his ability to make daily decisions was moderately impaired. Continued review of the MDS reflected R105 had no history of hallucinations or delusions and 1 of 3 days with verbal behavioral symptoms directed towards other and other behavioral symptoms directed towards self-including hitting, verbal behaviors, and pacing. Review of the Complaint filed with the State of Michigan, dated 11/14/25, reflected an allegation that indicated the facility had refused to readmit R105 after hospital admission. Review of R105 Electronic Medical Record (EMR) on 1/22/26 reflected R105 was not currently a resident at the facility and had been transferred to hospital on [DATE]. Continued review of the EMR reflected R105 orders and Care Plans were discontinued on 1/19/26. During an observation on 1/22/26 at 10:40 a.m., this surveyor observed five open beds on South halls of facility. Review of R105 Progress Notes, dated 11/13/25 at 4:58 p.m., reflected, Resident is exit seeking and not easily redirectable, trying to walk out of doors. Spoke to the dpoa [durable power of attorney], we are sending resident out for his safety. (Last documented note was 11/6/25 related to placement of wander guard.) Review of R105 Nurse Progress Note, dated 11/14/25 at 1:24 p.m., reflected, Resident arrived via police officer admitted under the care [named physician]. Resident readmitted from [named local hospital]. With a diagnosis of dementia. Review of R105 Social Work Progress Noted, dated 11/14/25 at 4:24 p.m., reflected, Due to residents exit seeking behavior we have placed resident on 1:1 supervision for resident safety. Spoke to guardian and attempted to send resident to [named psychiatric hospital] for psych eval.[evaluation] At this time they could not do the eval, suggesting for us to send to [named hospital] if behavior continues or worsens. Review of R105 Progress Note, dated 11/14/25, reflected, resident placed on 1:1. resident able to be redirected by staff. Review of R105 Elopement Evaluation Progress Note, dated 11/14/25, reflected, Elopement Evaluation: Wandering behavior a pattern or goal-directed: Yes. Wanders aimlessly or non-goal-directed: Yes. Wandering behavior likely to affect the safety or well-being of self / others: Yes. Wandering behavior likely to affect the privacy of others: No. Recently admitted or re-admitted (within past 30 days) and has not accepted the situation: Yes. Elopement Score: 7.0 Review of the Nurse Progress Note, dated 11/15/25 at 4:45 p.m., reflected, resident continues on 1:1, pleasant this shift and able to be redirected when needed. continues on ATB[antibiotics] for tooth infection, no adverse reaction noted. no c/o [complaint of] tooth pain this shift. wand guard in place to wrist. Review of R105 Electronic Medical Record (EMR), dated 11/14/25 through 12/27/25, reflected no evidence of documented behaviors with several Progress Notes that R105 continued to have 1:1 supervision and was pleasant and cooperative. Review of R105 Nurse Progress Notes, dated 12/27/25 through 12/28/25, reflected three entries with increased agitation and exit seeking behaviors. Continued review of the note, dated 12/28/25 at 12:50 p.m., reflected provider had been contacted after failed attempts to redirect R105 related to agitation, exit seeking and physical aggression toward staff. Review of EMR reflected no evidence of required Transfer Notice or Bed Hold policy provided to R105 or (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible party after R105 transfer to the hospital on [DATE]. Review of R105 Behavior Care Plans, dated 10/14/25, reflected goal of fewer episodes of physical and verbal aggression and interventions that included, Monitor behaviors episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes (dated 10/16/25). During an interview on 1/22/26 at 12:06 p.m. Social Worker (SW) C, reported R105 was currently admitted to [named Psychiatric Hospital]. SW C reported prior Nursing Home Administrator (NHA) D whose last day of employment was 1/19/26, had reported facility would not take R105 back because of safety risk to self and other residents. SW C reported R105 Psychiatric Hospital staff had reached out to the facility Director of Nursing (DON) B and asked SW C to communicate other options for placement to Psychiatric Hosptial staff for R105. SW C reported she was told other facilities were better equipped to care for R105 related to behaviors. SW C reported R105 had prior history of transfer to the hospital related to aggressive behaviors and exit seeking and reported had actually left hospital without staff knowledge and was escorted back to facility on 11/14/25(same time complaint was filed related to allegation of facility refusal to re-admit resident to facility.) by local police. SW C reported had emailed Ombudsman on 12/31/25 list of residents that had transfers and discharges that included R105's hospital transfer with anticipated return to facility on 12/28/25. SW C reported was responsible for completing Discharge Summary but had not yet completed because just found out 1/20/26 that R105 was not returning to the facility. SW C reported R105s personal items were still in his room on 1/16/26 and currently had been packed up and were waiting pickup. SW C reported was unsure if R105 or responsible party had been provided Transfer Notice and was unsure if facility followed appropriate discharge process. During an interview on 1/22/26 at 1:05 p.m., Director of Nursing (DON) B reported had worked at facility for about one month and reported R105 was on 1:1 supervision because he was aggressive with staff and had frequent attempts to leave the facility and was not him own responsible party. DON B verified R105 was transferred to the hospital on [DATE] and had not returned. DON B reported had planned to return to the facility but had been gone greater than the 10 day Bed Hold and guardian had not arranged to hold R105 bed and facility was getting close to not having available beds. DON B reported facility had not planned for R105 to be gone for that length of time. DON B verified the current census was 62 and the facility had at least 72 beds available total. DON B reported was unsure if Transfer Notice and Bed Hold had been provided to R105 responsible party and reported both should have been and medical record should show evidence of both. DON B reported would expect both Transfer Notice and Bedu Hold to be provided to responsible party at time of transfer to hospital. During an interview on 1/22/26 at 2:31 p.m. Business development staff (BD) D reported R105 had been gone longer than 10 days and responsible party declined to pay to hold the bed, so facility does not need to hold the bed for the hospitalized resident. BD D reported the facility has bagged R105 personal items and are awaiting responsible party to pick up. BD D reported R105 was not allowed to return to the facility because the clinical team, that included DON B, had made that decision related to R105 aggressive behaviors at the time of the hospital transfer on 12/28/26. BD D reported R105's bed had already been spoken for and awaiting authorization and reported was only male room available. BD D was unable to say when arrangements were made for new admission and planned to follow up. During a telephone interview on 1/22/26 at 3:37 p.m. Psychiatric Hospital Case Worker (CW) E verified R105 was a current patient and awaiting discharge. CW E reported had contacted facility on 1/19/26 to inform facility R105 was ready to discharge back to the facility (less than 30 days since admission), and was informed there were no beds available and would provide list of other possible options for R105. CW E reported had attempted to reach out to other facilities with no (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	return calls and have been unable to find placement for R105 at current point in time. During a telephone interview on 1/22/26 at 3:48 p.m., Ombudsman F reported had communicated with facility staff in past related to concerns with appropriated discharge for R105. Ombudsman F reported R105 had reported concerns that facility had been threatening to not allow R105 to return to the facility and Ombudsman F assured R105 the facility could not do that without completing a Involuntary Discharge and verified the facility had not started that process for R105. Ombudsman F reported did not feel that R105 was being treated as though the facility was his home and given choices about making his own schedule and felt that made R105 upset. During an interview and record review on 1/22/26 at 4:20 p.m. BD D reported facility had no available male beds and reported secure memory unit was not appropriate for R105 according to clinical team. BD D reported had last spoke with R105 Psychiatric hospital on 1/13/26 and was not ready for discharge at that time and reported was unaware R105 was ready for discharge on [DATE]. BD D reported resident awaiting authorization for only male bed on unsecure unit was promised the bed on 1/21/26(two days after R105 denied re-admission related to no beds available). BD D reported R105 prior bed had been empty from 12/28/25 to current. Review of the provided bed board reflected 1 room with 2 beds available and BD D reported those were reserved for Medicare not Medicaid residents and R105 was Medicaid. Continued review of the bed board reflected R105 prior room remained empty along with several listed as offline and one room with no water and seven open beds on secure memory unit. Review of the, Facility Bed Hold and Return to Facility Policy and Procedure, dated 2025, reflected, Purpose: To ensure that residents being transferred to a hospital or placed on therapeutic leave are informed as to the facility's bed-hold and return policy.Before a resident is transferred to a hospital or the resident [NAME] on therapeutic leave, the Facility must provide written information to the resident or the representative regarding the Facility's bed-hold and return policy.The facility will permit residents to return to the Facility after they are hospitalized or placed on therapeutic leave.A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the Facility to his/her previous room if available or immediately upon the first availability of a bed in a semi-private room.If the Facility determines that a resident who was transferred with the expectation of returning to the facility cannot return to the facility, the Facility must comply with the requirements of its Resident Transfer and Discharge Policy and Procedure. Review of the State Operations Manual, dated 7/23/25, reflected, Facilities are required to determine their capacity and capability to care for the residents they admit. Therefore, facilities should not admit residents whose needs they cannot meet based on the Facility Assessment requirements at S483.71. For residents the facility has admitted , S483.15(c)(1)(i) provides that The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless. This means that once admitted , residents have a right to remain in the facility unless the discharge or transfer meets one of the specified exceptions in SS483.15(c)(1)(i)(A)-(F). Discharging a resident is a violation of this right unless the facility can demonstrate that one of the limited circumstances listed in the regulation is met.Without an assessment of the resident's status and needs at the time of proposed return to the facility, there can be no determination of (A), the resident's needs cannot be met, or (C) and (D), that the safety or health of individuals would be endangered.Facilities must develop and implement policies for bed-hold and permitting residents to return following hospitalization or therapeutic leave. These policies apply to all residents, regardless of their payment source. The facility policies must provide that residents who seek to return to the facility within the bed-hold period defined in the State plan are allowed to return to their previous room, if available. Additionally, residents who seek to return to (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility after the expiration of the bed-hold period or when state law does not provide for bed- holds are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room provided that the resident.The policies must also provide that if the facility determines that a resident cannot return, the facility must comply with the requirements at 42 CFR 483.15(c).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2668291. Based on interview and record review, the facility failed to notify the resident and/or resident's representative of the facility policy for bed hold and a written reason for the transfer, for one (Resident #105) of three reviewed for hospitalization.Review of the Face Sheet and Minimum Data Set (MDS) submitted 10/16/25, reflected R105 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included progressive neurologic disorder, dementia with agitation, and adjustment disorder with anxiety. The MDS reflected that R105 had a BIM (assessment tool) score of 9 which indicated his ability to make daily decisions was moderately impaired. Continued review of the MDS reflected R105 had no history of hallucinations or delusions and 1 of 3 days with verbal behavioral symptoms directed towards other and other behavioral symptoms directed towards self-including hitting, verbal behaviors, and pacing. Review of the Complaint filed with the State of Michigan, dated 11/14/25, reflected an allegation that indicated the facility had refused to readmit R105 after hospital admission. Review of R105 Electronic Medical Record (EMR) on 1/22/26 reflected R105 was not currently a resident at the facility and had been transferred to hospital on [DATE]. Continued review of the EMR reflected R105 orders and Care Plans were discontinued on 1/19/26.Review of R105 Nurse Progress Notes, dated 12/27/25 through 12/28/25, reflected three entries with increased agitation and exit seeking behaviors. Continued review of the note, dated 12/28/25 at 12:50 p.m., reflected provider had been contacted after failed attempts to redirect R105 related to agitation, exit seeking and physical aggression toward staff. Review of EMR reflected no evidence of required Transfer Notice or Bed Hold policy provided to R105 or responsible party after R105 transfer to the hospital on [DATE].During an interview on 1/22/26 at 1:05 p.m., Director of Nursing (DON) B reported had worked at facility for about one month. DON B verified R105 was transferred to the hospital on [DATE] and had not returned. DON B reported was unsure if Transfer Notice and Bed Hold had been provided to R105 responsible party and reported both should have been and medical record should show evidence of both. DON B reported would expect both Transfer Notice and Bed Hold to be provided to responsible party at time of transfer to hospital. During an interview on 1/22/26 at about 2:15 p.m., DON B reported was unable to locate evidence R105 responsible party was notified and received written notice of transfer or bed hold policy after 12/28/25 transfer to the hospital.