STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kith Haven	G 1069 Ballenger Hwy Flint, MI 48504

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Number MI00149971. Based on observation, interview and record review, the facility failed to address hospital discharge recommendations for blood glucose monitoring and insulin administration and follow parameters for insulin administration for two residents (Residents #1 and Resident #3) of three residents reviewed for glucose monitoring. Findings include: Resident #1: A review of Resident #1's medical record revealed an admission into the facility on [DATE] and re-admission on 2/19/25 with diagnoses that included end stage renal disease, dependence on renal dialysis, and type 2 diabetes mellitus with ketoacidosis. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 11/15 that indicated moderate cognitive impairment. The Resident went out of the facility for dialysis treatments. On 3/27/25 at 1:01 PM, an observation was made of Resident #1 dressed and sitting on the side of the bed with their lunch tray on the overbed table. The Resident had Visitor C seated in a chair by the Resident. The Resident answered questions and engaged in limited conversation; the Visitor assisted the Resident with answers. The Resident reported not going to dialysis today but had gone yesterday. The Resident was asked if they ate breakfast at dialysis. The Resident stated, I usually get it when I come back, don't eat at dialysis. When asked about blood sugar monitoring, the Resident reported that it goes up and down. On 3/27/25 at 1:10 PM, an interview was conducted with Resident #1's Nurse D. The Nurse was asked if the resident received insulin with her breakfast yesterday. The Nurse stated, No she was gone to dialysis. The Nurse was asked if the Resident had a blood sugar check after returning from dialysis and before eating breakfast, and the Nurse reported that she receives insulin when her blood sugar is high. The Medication Administration Record (MAR) was reviewed with the Nurse for 3/26/25 with documentation on the MAR of 5 that indicated hold see nurses note. The nurses note revealed, dialysis, and the Resident did not get the blood sugar checked or insulin given as per sliding scale. The Nurse reported that the Resident does come back and either eats a sack lunch or will get a tray and stated, Eats either her sack or the tray, it's either/or. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the orders revealed the Resident had a recent hospitalization where the Resident was sent out to the hospital from dialysis. The Progress Note dated 2/10/25 at 12:50 PM revealed, Dialysis called and they sent patient to hospital for ams (altered mental status) and bs (blood sugar) of over 900. The Resident was readmitted to the facility on [DATE]. A review of Resident #1's discharge hospital records of the Discharge Summary Notes revealed .Labs showed hyperglycemia with BG (blood glucose) >920 and acidosis PH 7.19 with pseudohyponatremia of 122 and AG of 19 with lactic acid of 4.2. She was started on insulin drip and fluid per DKA protocol . DKA (diabetic ketoacidosis-a complication of diabetes that can be life-threatening when there is a lack of insulin causing blood to become acidic). A review of Resident #1's discharge hospital records revealed medication list that had the directions, START taking these medications: insulin aspart U-100 100 unit/mL (milliliter) vial, Commonly known as: Novolog. Inject 0-8 Units into the skin 3 (three) times daily before meals. A review of Resident #1's discharge hospital records revealed a FAX Cover Sheet dated 2/20/25 with a Medication List: START taking these medications insulin aspart . Inject 0-8 Units into the skin 3 (three) times daily before meals: 100-140= 0 Units Subcutaneous; 141-200= 1 Unit Subcutaneous; 201-250= 2 Units Subcutaneous; 251-300= 3 Units Subcutaneous; 301-350= 4 Units Subcutaneous; 351-400= 5 Units Subcutaneous. A review of the medical record revealed an order dated 3/14/25 for Insulin Aspart Subcutaneous Solution Cartridge 100 Unit/ML (Insulin Aspart). Inject as per sliding scale, three times a day before meals with the sliding scale of 100-140= 0U (unit), 141-200=1 U, 201-250=2 U, 251-300=3 U, 301-350= 4 U, 351-400=5 U. The medication was started on 3/15/25 but was not given in the morning on the Resident's dialysis days. The Resident went out to dialysis on Monday, Wednesday, Friday. Further review of the medical record revealed a lack of documentation of why the hospital discharge recommendations for medication were not followed, no progress note made that the recommendation was discussed with the doctor upon readmission. On 2/27/25 at 2:11 PM, an interview was conducted with Director of Nursing (DON) regarding Resident #1's hospitalization with treatment for DKA and the discharge orders for insulin sliding scale. The resident's return on 2/19/25 but the insulin sliding scale not ordered until 3/14/25 was reviewed with the DON. The notation on the hospital records of Physician Assistant A for 3/14/25 was reviewed. The DON was unsure why the medication orders from the hospital discharge were not followed and reviewed the medical record and revealed no documentation of why. The DON indicated that if the hospital discharge instructions were not going to be followed, there should be documentation of the rational and the nurse should document discussions with the practitioner if it had occurred. The lack of following the physician order to monitor the blood glucose and give insulin as needed per sliding scale with meals was reviewed with the DON and Nurse B who had been the interim DON prior to the DON. It was determined that the Resident ate breakfast when they returned from dialysis. The DON reported the Nurse should be checking the blood glucose and following the sliding scale for insulin after the resident returned from dialysis. It was reported that when the nurse identified the Resident was out for dialysis treatments, the glucose monitoring and sliding scale insulin would not show back up on the MAR to be given. The medication schedule for the glucose monitoring and insulin was not adjusted to accommodate the Resident's dialysis treatment schedule. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/25 at 10:37 AM, an interview was conducted with Physician Assistant (PA) A regarding Resident #1's order for blood glucose monitoring and sliding scale insulin. The hospital records were reviewed with the written note sent 3/14/25 and the PA signature. The PA reported that she had came upon a pile of paper in the office that had not been reviewed and that it could have been it that pile. The PA indicated that the medication orders should be addressed when the Resident came back form the hospital. When asked if the recommendations were not going to be followed, the PA indicated that there should be documented rational why it will not be followed. A review of facility policy titled, Diabetic Management, revised 9/22/23, revealed, . Evaluation: Upon admission the interdisciplinary team evaluates the diabetic resident and implements a plan of care to ensure: orders are received and are accurate related to blood glucose monitoring and anti-diabetic agents. Blood glucose orders should include parameters to follow and when to notify the physician . Blood glucose measurements are taken per the physician order . Anti-diabetic agents (insulin or oral anti-diabetic agents) are administered per physician order . 49944 Resident #3 (R3): R3 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include type 2 diabetes, anxiety, depression and alcohol abuse. On 03/28/25, record review revealed a physician's order Insulin Glargine, inject 10 units, subcutaneously two times a day for diabetes mellitus (DM). Hold for blood glucose (BG) less than 100. The start date for this order 03/09/2025. On 03/28/25, record review of the medication administration record (MAR) for March 2025 revealed that on three occasions the 10 units of insulin glargine was given outside of the parameters of administration. -03/14/25- Blood glucose was 79 and the medication was administered. -03/18/25- Blood glucose was 57 and the medication was administered. -03/22/25- Blood glucose was 71 and the medication was administered. Record review of the policy titled, Diabetic Management, revealed: Evaluation: -Orders are received and are accurate related to blood glucose monitoring and anti-diabetic agents. Blood glucose orders should include parameters to follow and when to notify the physician. Routine Care: -Blood glucose measurements are taken per the physician order. Results outside of ordered parameters are communicated to the physician immediately.

Printed: 07/31/2025
Form Approved OMB
No. 0938-0391

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 This Citation pertains to Intake Number MI00151298. Based on interview and record review the facility failed to update care plans and implement interventions to prevent falls for one resident (Resident #2) of three residents reviewed for incidents and accidents, resulting in repeated falls. Findings include: Resident #2 (R2): R2 is [AGE] years old and was initially admitted to the facility on [DATE] with diagnoses that include above the knee amputation on the right leg, dementia, anemia and chronic obstructive pulmonary disease. R2 has a brief interview for mental status (BIMS) score of 5, indicating severe cognitive impairment. On 3/28/2025, a review of falls was completed for R2, it was revealed that R2 had sustained multiple falls in the facility. -On 1/5/25 at 04:03 AM, R2 was observed lying on his left side on the floor beside his bed. The fall was unwitnessed, and the care plan intervention was to perform a three-day sleep study. Results of the sleep study were unable to be located in the electronic medical record. -On 1/31/25 at 11:30 PM, R2 was observed holding onto the bed post and sliding off the left side of the bed, the care plan was not updated with a new intervention. -On 2/28/25 at 11:30 AM, R2 was found lying on the floor next to the bed. The care plan was not updated after the fall. -On 2/28/25 at 05:30 PM, R2 was observed sitting on his bottom next to his bed with his back up against the other bed (bed 2) in the room. The care plan was updated to perform checks on R2 every 15 minutes. Documentation of the 15-minute checks could not be located in the electronic medical record. -On 3/3/25 at 02:15 AM, R2 was observed on the floor, laying on his left side. The care plan was not updated in the electronic medical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/28/25 an interview was conducted with the Director of Nursing (DON). The DON was asked what the expectation is with updating care plan after falls. The DON stated, this will require education for the nursing staff, at the time of the fall I expect the nurse to put something (an intervention) in right away, the next day we can review the falls with the team and see if we can come up with an intervention based on what the root cause of the fall is. Going forward these incident forms will be filed in one spot so we can find them and ensure they get updated. The electronic medical record has a nice system in place to keep track of incidents and we plan to fully use that going forward. The DON was asked if they think the interventions should be meaningful and pertaining the fall. The DON stated, yes, the interventions should be meaningful and relevant to the fall. Review of the policy titled, Incidents and Accidents for Guests/Residents or Visitors, revealed: Policy: Incidents or accidents involving a guest/resident or visitor will be documented and reported to meet the regulatory requirements. The administrator and the director of nursing will be notified as outlined in this policy. Procedure: 7. For incident and accidents involving guests/residents, pertinent clinical information and observations must be recorded in the medical record. Documentation: 5. Record the relevant facts regarding the guest/resident in the medical record, e.g. where guest/resident was found, evaluation conducted, care provided, follow-up care provided, etc.