

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  08/14/2025
NAME OF PROVIDER OR SUPPLIER  Kith Haven		STREET ADDRESS, CITY, STATE, ZIP CODE  G 1069 Ballenger Highway 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 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.  (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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This Citation Pertains to Intake Numbers: 2575687, 2577971, and 2580349. Based on interview and record review, the facility failed to develop and implement policies and procedures to ensure effective and appropriate communication and documentation for transfer to the hospital and failed to ensure readmission to the facility for one (#701) of three Residents reviewed for discharge rights and planning. Findings include: Review of documentation revealed three separate intakes with allegations pertaining to the facility refusing to readmit Resident #701 back to the facility after being in the hospital. Per the intake information, Resident #701 had a legal Guardian, was a long-term Resident of the facility, and was not provided with a bed-hold policy and/or eviction notice prior to being transferred to the hospital. An interview was completed with Resident #701's Guardian Representative Witness A on 8/12/25 at 10:38 AM. Witness A was queried regarding Resident #701's transfer to the hospital on 7/22/25 and revealed they received a phone call from the facility Administrator the day after Resident #701 had been sent to the hospital. When asked why they were not informed prior to the Resident being transferred, Witness A stated, They often forget to call. It is what it is. Witness A added that the facility did not call their cell phone or their office and did not leave a message. When queried what the Administrator told them when they called, Witness A replied, (The Administrator) said (Resident #701) was petitioned and (the hospital) decided they were not going to keep (Resident #701) and sent them back (to facility) but then (Resident #701) eloped. When queried why Resident #701 was petitioned and sent to the hospital, Witness A responded they were told that (Resident #701) was aggressive and wouldn't get off the elevator. Witness A then stated, I think (Resident #701) had some aggression and I don't know if they were trying to leave or something but it didn't seem like something that was really petition-able but I did not argue with them (facility staff). Witness A revealed the hospital evaluated Resident #701 and determined the Resident did not need inpatient mental health treatment and discharged them back to the facility via a transportation van. Witness A stated, (Resident #701) got mad and out (of the transport van) in the middle of [NAME]. When asked what happened after Resident #701 got out of the back of the van, Witness A stated, (Resident #701) went missing. Witness A continued, They (Administrator) called me to tell me (the Resident) was missing but that it wasn't their fault because they discharged (Resident #701) and that was the (transport companies) fault. Witness A verbalized they were only concerned with finding the Resident and bringing them back to the facility. When queried what happened, Witness A stated, So like 12 hours later, (Resident #701) was found on the side of the road with a crack pipe, passed out. With further inquiry, Witness A stated, The Administrator called me and said they found (Resident #701) and the police wanted them to just take (the Resident) back to the facility. Witness A verbalized they told the Administrator they wanted the Resident to go to the hospital be checked out and that Resident #701 could return to the facility after that. Witness A stated the Administrator responded, We discharged (Resident #701) and Witness A said they told the Administrator, I understand but, in the morning, you can do a readmit and (the Administrator) said we'll get (the Resident) to the hospital to be checked out. Witness A verbalized they did not know what the concern was as the Administrator agreed Resident #701 should be evaluated at the hospital. When asked about the Administrator telling them Resident #701 had been discharged, Witness A responded that they understood that to mean that the Resident was discharged from the computer when they were sent to the hospital and would need to be readmitted which is difficult to do during the night shift. When queried why Resident #701 did not return to the facility, Witness A revealed Resident #701 was evaluated in the Hospital ER and medically cleared to return to the facility but when the hospital called the facility to send the Resident back, the facility informed the hospital they were not taking (Resident #701) back. When queried why the facility would not take Resident #701 back, Witness A revealed they contacted the facility and the facility refused to take (Resident #701) back. Witness A verbalized they told the facility staff they were dumping (Resident #701) and they said that was not what they were doing. Witness A continued, I said (Resident #701) doesn't have a place to do and lives with you guys. Witness A stated they told the facility that not taking Resident #701 back did not seem right. When asked how the facility staff responded, Witness A verbalized the Director of Nursing (DON) told them that the facility discharged (Resident #701) to the hospital and we (guardian) were okay with that. Witness A reiterated they were not notified of the Resident's transfer and specified they were fine with the Resident going to the hospital ER for treatment not as a new placement. Witness A said they told the DON It wasn't like you discharged (Resident</p>		