

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 01/13/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and recorded review, the facility failed to ensure that one resident's (Resident #104) Behavior Care Plan, dated 01/14/25, had interventions which were implemented consistently for Resident #104, who had a history of poor impulse control and aggression, of 4 residents reviewed. Findings Include: Resident #104:Review of Face Sheet, care plans dated 1/2025, nursing progress notes dated 1/7/26 and 1/8/26, revealed Resident #104 was [AGE] years old, alert and able to make own decisions, admitted to the facility on [DATE], required staff to assist with Activities of Daily Living, had a below knee left leg amputation, was wheelchair bound, and received dialysis treatments. The residents' diagnosis included end stage 5 kidney disease, alcohol use, post-traumatic stress disorder, anxiety disorder, schizoffective disorder, chronic migraine, diabetes, depression disorder, and heart failure.Review of the resident's potential for aggression care plan dated 1/14/25, revealed staff were to avoid confrontation, and adjust plan of care to reduce incidents of aggression where possible.During an interview done on 1/13/26, at 8:00 a.m., the Director of Nursing said on 1/8/26, at 11:41 a.m., and per observation of the facilities video of the incident on 1/8/26, revealed Resident #104 exited the building to go on LOA (On leave of Absence-outside to smoke). The facility was aware Resident #103 was already outside smoking (on LOA). When Resident #104 wheeled past Resident #103, Resident #103 hit Resident #104 with his grabber. The two residents then were hitting each other and Resident #104 hit Resident #103's face; his ring cut the side of his (Resident #103) face. Resident #104 then started coming back onto facility through the main door with Resident #103 following him. The police were contacted and took Resident #103 in handcuff's (Fought with police) to jail. Resident #104 will be discharged back to his apartment next week (1-19-26); neither resident will be re-admitted to the facility.Review of the contracted mental health note dated 1/13/26, stated Today's visit was requested by the medical team due to a physical altercation occurring between this patient (Resident #104) and another resident (Resident #103). The provider discussed the incident at length with the facility Administrator today as well as with the NP (nurse Provider). Apparently, the altercation began the day prior (on 1/7/26) with the other resident (Resident #103) accusing this patient (Resident #104) outside the building with an object (grabber), the patient then hitting the other resident (Resident #103 hit Resident #104 with grabber, then Resident #104 hit Resident #103 in face). The other resident (Resident #103) came back into building and made several verbal threats. Police were called; there was much confusion.During an interview done on 1/13/26 at 11:00 a.m., the Administrator and Director of Nursing/DON said Resident #104 had been put on 15-minute checks on 1/7/26, due to the argument between both residents regarding resident #104 stealing Resident #103's planner. Review done on 1/13/26, of the resident #104's facility 15-minute check sheet dated 1/7/26 and 1/8/26, confirmed this information. Resident #104 signed out on the LOA sheet to smoke on 1/8/26 at 11:41 a.m., rolled past resident #103 on the sidewalk, when Resident #103 started</p> <p>(continued on next page)</p>		

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>hitting him with his grabber. At this point Resident #104 hit him in the face and wheeled back into the facility and signed back in at 11:47 a.m. The Administrator and DON both said the facility had been aware that Resident #103 had also signed out and was outside prior to resident #104 signing out on 1/8/26. Resident #104's 15-minute check sheet had documented they had observed him at 11:45 a.m., while he was outside. The DON said they should not have let Resident #104 outside to smoke the same time Resident #103 was also outside smoking. The Administrator stated, We did not follow that care plan (the aggression care plan dated 1/25-avoid confrontation and adjust plan of care to reduce incidents of aggression where possible). The DON stated We did not follow it (the aggression care plan dated 1/25). The Administrator and DON both said the facility did not avoid confrontation and adjust Resident #104's plan of care to reduce incidents of aggression when possible. The facility Care Plan policy dated 6/24/21, stated the care plan must be specific, resident centered, how to manage risk factors (includes behaviors-aggression), and have a comprehensive assessment.</p>		