

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  04/29/2026
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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This Citation Pertains to Intake# 2985732Based on observation, interview and record review, the facility failed to protect the resident's (Resident #101) right to be free from abuse by Resident #102 of 3 residents reviewed for abuse, resulting in resident #101 needing hospital treatment for assault, facial contusion and closed head injury. Findings Include: Review of Resident #101's medical record revealed Resident #101 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: history of a stroke, Dementia, diabetes, history of seizures, cognitive communication deficit, anxiety, and hypertension. The MDS assessment dated [DATE] revealed the resident had moderate cognitive decline with a Brief Interview for Mental Status/BIMS score of 8/15 and needed some assistance with care. Review of Resident #102's Face sheet and MDS assessment revealed Resident #102 was initially admitted to the facility on [DATE] and had a most recent readmission on [DATE] with diagnoses: history of a gunshot wound to the back, paraplegia, history of traumatic brain injury, psychotic disorder with delusions and hallucinations, schizophrenia, depression, anxiety, adjustment disorder with mixed disturbance of emotions and conduct, history of alcohol abuse, frontotemporal neurocognitive disorder, dementia, colostomy and urinary retention. The MDS assessment dated [DATE] revealed the resident had full cognitive ability with a BIMS score of 15/15 and needed some assistance with care. A review of a Facility reported incident indicated on 3/24/2026 at approximately 11:00 AM, Certified Nursing Assistants/CNAs B and G entered the room of Residents #101 and #102 each noticed Resident #101 had blood on his face and his right eye and lip were swollen, he had bruises on his face and blood on his teeth. When CNA B asked Resident #101 what happened, he pointed to Resident #102 and said, He did it. We got in a fight. Review of the Facility reported incident investigation revealed that Nurse H said that CNA G came to the Nurses desk and said it looked like the residents had been fighting (Resident #101 and #102). When Nurse H entered the room, she asked Resident #101 if he was Ok and he said No that he wanted to go home. When she asked Resident #101 what happened he said he and his neighbor had a fight and he demonstrated how he put up his hands to try and keep Resident #102 off him. Nurse H said she assessed Resident #102 at that time, and he had no new wounds. The Facility reported incident for Resident #101 and #102 indicated both residents were transferred to the hospital on 3/24/2026: Resident #101 for injuries and Resident #102 for his aggressive behavior. A review of the Hospital emergency room discharge document revealed Resident #101 was treated in the emergency room on 3/24/2026 at 12:23 PM for Assault with a Facial contusion and Closed head injury. A review of a Wound Picture for Resident #101 that was taken after he was assaulted by Resident #102 indicated he had multiple red, raised, abraded areas on his forehead. His right eye was almost swollen shut with abrasions and swelling underneath, and his lips were swollen, red and had abrasions. Further review of the medical record for Resident #101 revealed the following: 3/24/2026 at 12:07 PM, a Nurses Note Approximately 1120 am, a CNA came to me and stated that the resident in 313 had attacked the other resident and that he was bleeding. Called to room by staff; I observed the resident (R101) bleeding from the mouth, bruising to the right eye, bruising to the forehead and right jaw. Resident was visually (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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Is currently on 15 minute checks.Further review of Resident #102's medical record revealed the following:3/24/2026 at 11:15 AM, a Nurses Note This writer was called to room [ROOM NUMBER], with a complaint that (Resident #102) had beat up on his roommate. Upon arrival to the room the roommate was sitting on the edge of his bed with bruising and swelling to his right eye, red marks on his forehead, and blood and swelling around his mouth. When questioned, (Resident #102's) 1st response was, I didn't do anything. Upon further questioning he stated, He keeps scratching my mother f.) falls up. Physical exam was completed by NP (Nurse Practitioner I) and wound care nurse. No new injuries were present, only the MASD (moisture associated skin damage) that he is currently being treated for. Residents were kept apart, staff remained with both until EMS/PD arrived.3/24/2026, Encounter note Date of Service 3/24/2026 . (Resident #102) . He is being seen today after staff reported that he was in an altercation with his roommate where he was the aggressor. Upon entering the room, (Resident #102) was in his bed. When asked what happened. He stated, He kept scratching my balls and wouldn't stop so I hit him. Upon assessment with wound care nurse, there are open areas to his testicles due to moisture-related breakdown, but they have been present for a few weeks now. He also stated You can turn those microphones off that I know you all have. I'm done with them all. EMS and the police were contacted, and both parties were sent to the hospital for further assessment . Reported to be aggressive against his roommate by punching him in the face. Sent to the hospital under MD certification for psych evaluation.3/18/2026 at 4:02 PM, Psychology Follow-up visit (by Social Worker), . History of delusions, hallucinations, and extreme paranoia. admitted to multiple skilled nursing facilities over the last several years. Since admission to current facility, has had increased behaviors. rejection of care, yelling, abusive language, and threatening behaviors. History of strange and inappropriate behaviors, refusal of care, and suspected drug-seeking behavior from prior facilities. Risk Assessment: Episodes of psychosis with inappropriate and refusal behaviors. Poor judgment, poor insight, poor impulse control.3/2/2026 at 5:40 PM, SBAR Summary for Providers, The Change in Condition/ reported on this CIC Evaluation are: Behavioral symptoms. The resident appears to be under the influence. He is loud and obnoxious, blinking his eyes when eye contact is made, talking to himself and unable to self-propel in his WC (wheelchair) properly. At this time the resident has escalated with his behaviors and making threats to harm other residents.3/2/2026 at 4:47 PM, Social Services Note, SW was informed that resident return from his LOA (leave of absence) appeared to be intoxicated yelling/screaming, abusive languages, thinking disorganized, irrelevant conversation, illogical flow of ideas. while in his wheelchair running into the wall. speech was slur, rambling, difficult focusing his attentions. notified guardian via telephone regarding resident behaviors. Guardian stated resident has history: domestic violence.A review of Resident #102's Care Plans from 10/29/2025 after admission does not mention the resident's history of violent and aggressive behavior towards others.A Care Plan titled (Resident #102) has a history of substance abuse. Potential Heroin. date initiated 3/2/2026 was updated on 4/2/2026 with intervention Close observation such as q (every) 15 (minute), 1:1, as needed, date initiated 3/2/2026 and revised 4/2/2026.A Care Plan titled (Resident #102) has the potential for fluctuation in mood r/t: Mood affective disorder. Hostility. created on 10/29/2025 and revised 4/2/2026. There was no intervention to address preventing Hostility towards other residents and staff until 4/13/2026: Should (Resident #102) be expressing a desire to harm self or others provide 1:1 monitoring, follow suicide protocol and report to physician immediately. The interventions (continued on next page)</p>		

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