

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235343                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                 | (X3) DATE SURVEY<br>COMPLETED<br><br>07/28/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Kith Haven                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>G 1069 Ballenger Highway<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |                                                 |
| F 0741<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake Number 3033712. Based on interview and record review, the facility failed to ensure that 3 residents (Resident #102, Resident #103 and Resident #104) had behavioral interventions and residents' responses to interventions documented for 3 residents reviewed for behaviors. Findings Include: Resident #102: Review of the Face Sheet, Nursing notes dated 7/26, and care plans dated 12/23, revealed Resident #102 was [AGE] years old, alert with confusion, admitted to the facility on [DATE], and dependent on staff for Activities of Daily Living (ADL). The residents diagnoses included stroke with hemiplegia and hemiparesis of the right side, anxiety, adjustment disorder, major depression, mild intellectual disabilities and Asperger's syndrome with behaviors. Review of the residents Behavioral care plan dated 12/29/23, stated Document behaviors, and (residents) response to interventions. During an interview done on 7/27/26 at 3:26 p.m., the Director of Nursing stated It (document behaviors, interventions and resident response to interventions) should be on the behavior symptoms task charting (in PCC-Point Click Care). Review of the resident's POC Response History documentation, dated 6/26, revealed only one behavior (resist care) on 7/4/26, and a review of the daily Behaviors PCC task charting, dated 6/26, revealed there were no behaviors all month. No documentation of interventions used regarding the behavior, nor the residents response to the intervention was found. Resident #103: Review of the Face Sheet, Nursing notes, dated 6/26 and care plans dated 5/26 to 6/26, revealed Resident #103 was [AGE] years old, alert and his own person, admitted to the facility on [DATE], and dependent on staff for ADL's. The resident's diagnoses included, diabetes, major depression, adjustment disorder with anxiety, seizures, abusive language, chronic lung disease and dependent on renal dialysis. Review of the resident's Behavioral care plan, dated 6/28/26, stated Document behaviors, and (the resident) response to interventions. Review of the resident's POC Response History documentation, dated 6/26, revealed no documentation at all of behaviors (on 6/12/26, the resident had documented behaviors in the nursing notes), no documented interventions and no resident response to the interventions. During an interview done on 7/27/26 at 11:50 a.m., Resident #103 acknowledged on 6/12/26, he was upset with a staff member because they hurt his leg. Resident #104: Review of the Face Sheet, Nursing notes, dated 7/26, and care plans, dated 11/24, revealed Resident #104 was [AGE] years old, had a guardian and was admitted to the facility on [DATE]. The resident's diagnoses included, colon cancer, psychotic disorder, anxiety, epilepsy, depression and Dementia. Review of the resident's behavioral care plan dated 11/4/24, stated attempt non-pharmacologic interventions, document behaviors, and (the resident) response to interventions. Review of the resident's Behavior sheet, dated 7/26, revealed behaviors and interventions that had been documented, however no documentation of residents response to interventions was found. During an interview done on (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

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| F 0741<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | 7/27/26 at 3:00 p.m., Social Worker C stated, They (staff) are supposed to document behaviors, behavior interventions and residents response. During an interview done on 7/27/26 at 3:40 p.m., the Administrator stated, There is an opportunity for improvement. Review of the facility Behavioral Management Program, dated 4/20/23, stated The facility staff will utilize tasks in PCC (Point Click Care) to document behaviors exhibited by the resident, including new, existing and escalating behaviors, as well as the effectiveness of interventions (frequency of the behavior exhibited, interventions, effectiveness of non-pharmacological interventions). |                                                                                          |                                                 |