STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235343	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kith Haven	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to maintain sanitary conditions in the kitchen and proper cold holding during meal service, resulting in the potential to spread foodborne illness to all residents who consume food from the kitchen.Findings Include:On 3/17/2026 at 12:10 PM, tour of the kitchen was completed with CDM (Certified Dietary Manager) D, and following was observed:Ice Machine:Bin seal/trim was partway detached from the bottom lip of the bin.Inside white flap had orange colored residue spanning the length of it.The inside of the ice bin is blue in color but was peeling and was a white/translucent color.CDM D stated a contracted company empties and cleans the ice machine every 3 months.The bottom of the dolly cart with approximately 35 clean mugs stacked upon it was soiled with debris and other unknown food particles. CDM D stated it is cleaned weekly.The trash can was pushed against the clean and ready for use cookware, multitiered rack. The CDM stated the trashcan should not be there. Deli Cooler:Bottom left and right-side vent grates were riddled with unknown hardened substances.The entirety of the door seals had a black residue lining it.CDM D reported they have tried to clean the bottom grates to no avail. The top of a retractable pen was used to wipe the vent area and the particles loosened. On 3/18/2026 at 12:30 PM, alongside CDM D the 2nd floor dining room was observed as they prepared for lunch service. There was a large gray bin that contained resident beverages (milk and mighty shakes) that was sitting out without any type of cooling process in place for the ready to serve beverages. The dietary aide explained the beverages are brought upstairs based on the resident meal tickets. CDM D stated they are supposed to pour ice atop of the beverages and then bring them to the dining room to maintain the appropriate temperature. CDM D was asked to temp the beverages and the following was indicated:Milk: 48 Juice: 45 CDM D stated the milk, and juice should be 40 and below. The 3rd floor meal service beverages were observed and the juices were not on ice but sitting in a bin, The milk bin had some under the milk under ice and some above them that were not touching the ice. The following temperatures were indicated:Milk: 48 Juice: 42.1 1st floor dining room:Juice temperature: 43 On 3/18/2026 at 3:35 PM, an interview was held with CDM D, she reported the dietary aide stated she forgot to put ice atop the beverages prior to service. They are working on quotes to have the ice bin replaced and a company comes out every three months to clean ice machine and replace the filter. The CDM was asked if kitchen staff ever clean the ice machine if it is soiled and she stated no. She was further asked if they would have observed soiled areas within the ice machine would that have triggered them to clean it and she stated it would not as they would not have noticed it. Review was conducted of Work Orders for cleaning of the ice machine. The following was reviewed:12/23/25: .performed ice machine cleaning on ice machines, bin door messed up and door trim broke on bin, creating health dept (department) issues. (name) to quote new bin. 10/8/2025: .Clean ice machine in kitchen. Review of food/beverages temperature were reviewed for all dining rooms and it was found it was not consistent that dietary staff were temping the beverages being provided to facility residents. The following was reviewed:Breakfast from the Kitchen:3/10/2026Breakfast -no beverage temperatures 3/14/26:Breakfast -no beverage temperatures3/15/2026:BreakfastJuice: 20 Meals served from the kitchen:3/14/2026:Lunch and Dinner - no beverage temperatures 3/15/2026:Lunch and Dinner- no (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

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 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	beverage temperatures3/17/2026:Dinner- no beverage temperatures 2nd Floor: 3/14/2026:Lunch and Dinner: no beverage temperatures3/16/2026:Breakfast and Dinner: no beverage temperatures3/17/2026:Lunch and Dinner: no beverage temperatures 3rd Floor: 3/14/2026:Lunch and Dinner: no beverage temperatures3/15/2026:Lunch and Dinner: no beverage temperatures3/16/2026:Breakfast, Lunch and Dinner: no beverage temperatures3/17/2026:Lunch and Dinner: no beverage temperatures Review was conducted of the facility policy entitled, Food Temperatures, approved 3/11/2026. The policy stated, Food will be maintained at proper temperature to ensure food safety.The temperature of holding cold foods at point of service will be ˆ41 F. According to Food and Drug Administration Food Code, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, Except during preparation, cooking, or cooling, or when time is used as the public health control, time/temperature control for safety food shall be maintained: .at 5 C (41 F) or less. Review was conducted of the facility policy entitled, Nutritional Services Cleaning and Sanitation, last approved 3/11/2026. The policy stated, It is the policy of this facility to maintain the sanitation of the kitchen through proper cleaning and sanitizing.The Nutritional Professional will inspect the kitchen thoroughly to ensure cleaning schedules are completed as assigned.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure interdisciplinary review and revision of comprehensive care plans for one resident (Resident #65) of two residents reviewed. Findings include: Resident #65:On 3/18/26 at 11:55 AM, Resident #65 was observed in their room and an interview was completed. The Resident was noted to have Enhanced Barrier Precautions (EBP) but not Transmission-based isolation precautions in place. When queried if they were receiving any antibiotics or if they had been ill recently, Resident #65 indicated they did not know. Record review revealed Resident #65 was most recently admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), left hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stroke), aphasia (difficulty speaking), gastrostomy, and dementia. Review of the MDS assessment dated [DATE] revealed the Resident was rarely/never understood and was dependent upon staff for completion of Activities of Daily Living (ADLs). Review of Resident #65's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #65) is on isolation precautions related to. cough, SOB (Shortness of Breath), COVID (Initiated: 12/31/25). The care plan did not specify what type of isolation precautions were in place due to Covid. An interview was completed with MDS Registered Nurse (RN) K on 3/23/26 at 10:30 AM. When queried regarding Resident #65's active care plan related to isolation precautions and Covid, MDS RN K stated, That is not me, that is IC (Infection Control). With further inquiry, MDS RN K verbalized IC implements and discontinues all care plans pertaining to infections and isolation precautions. An interview was conducted with IC Nurse H on 3/23/26 at 10:31 AM. When queried regarding Resident #65's active care plan related to isolation precautions and Covid, IC Nurse H stated, I thought I had them all closed out and indicated they would need to review the Resident's EMR. IC Nurse H reviewed the Resident's EMR and stated, I see it (care plan). I didn't close it because it is in a custom care plan. When asked if the care plan should have been discontinued, IC Nurse H verbalized it should have been. Review of facility provided policy/procedure entitled, Care Planning (Approved: 3/3/25) revealed, Each resident. will have a person-centered Plan of Care developed an implemented that. meet a residents medical, nursing, and mental and psychosocial needs. Procedure. 9. The care plan. will be updated. with significant changes. This includes adding new focuses, goals, and interventions and resolving ones that are no [NAME] applicable as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide activities of daily living (ADL) care for six dependent residents (R11, R15, R31, R50, R65, R122) of eight reviewed resulting in unkempt hair, facial hair on female residents, Resident #122 was soaked in urine for hours, unshaven male residents. Findings include:Resident #11: On 3/18/26 at 11:17 AM, a Certified Nursing Assistant (CNA) was observed exiting Resident #11's room. On 3/18/26 at 11:18 AM, Resident #11 was observed in bed, positioned on their back. The Resident was unshaven and had a disheveled appearance. The room lights were off and minimal personal items were observed in the Resident's area of the room. A urinal with dark yellow urine was hanging on a garbage can on the right side of the bed. An interview was completed at this time. When asked how long they had been at the facility, Resident #11 replied, Too long. When queried if they required assistance to get out of bed and to get cleaned up, Resident #11 responded that they are blind and indicated they required assistance. When asked if they had been assisted to complete oral care and get cleaned up, Resident #11 stated, They changed me, that it. Resident #11 was asked what they meant, and revealed staff had changed their brief due to incontinence. When asked if they liked their face shaven or if they preferred to have facial hair, Resident #11 verbalized they prefer to be shaved but cannot do it themselves because they are blind. Record review revealed Resident #11 was most recently admitted to the facility on [DATE] with diagnoses which included heart disease, schizophrenia, dementia, and vision loss in both eyes. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required moderate to maximum staff assistance to complete Activities of Daily Living (ADLs). Review of Resident #11's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #11) has a functional ability deficit and requires assistance with self-care/mobility. (Initiated and Revised: 1/8/24). An interview was completed with CNA O on 3/19/26 at 3:04 PM. When queried if Resident #11 gets out of bed, CNA O responded, (Resident #11) is blind. When queried if the Resident gets out of bed frequently, CNA O verbalized they took them to the bathroom once and stated, It depends on who it is. CNA O then stated, (Resident #11) don't like to sit up. When asked if they had assisted Resident #11 to get cleaned up, CNA O revealed they had not and then stated that Resident #11 change their top every other day. Review of Resident #11's Documentation Survey Report for 3/1/26 to 3/18/26 revealed the following: -A task entitled, ADL Care Statement with the description, Have you provided routine standard care which includes. shaving and nail care as needed, turning and repositioning, oral care, washing face and hands, hair care, clean clothes and linens. dignity and respect. keeping call light within reach. encouraging and assisting to activities? Y - Yes N – No. The documentation was to be completed each shift, three times a day. There were 14 blank areas where no documentation had been completed. There was also no documentation of Resident refusal of task completion. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A task titled GG- Personal Hygiene each shift (three times a day) and detailed, The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). There were 14 blank areas where no documentation had been completed. There was also no documentation of Resident refusal of task completion. Resident #50: On 3/18/26 at 11:59 AM, Resident #50 was observed lying in bed in their room. A foul body odor was present in the room and became stronger and more prevalent closer to the Resident. The Resident was positioned on their back and noted to have bilateral Above the Knee Amputations (AKAs). When spoken to, Resident #50 responded verbally but their speech was very difficult to understand and words were unable to be discerned. A triangle shaped foam cushion was in place on the left side of the Resident's bed, under the fitted sheet. The Resident's call light was on the floor and not within the Resident's reach. Resident #50's fingernails were long and jagged with a dark colored, unknown substance present under the nails. An interview was completed with Certified Nursing Assistant (CNA) O on 3/18/26 at 12:04 PM. When queried regarding Resident #50's speech, CNA Q verbalized the Resident is normally difficult to understand when talking. CNA O was then asked about the triangle shaped foam cushion on the left side of the Resident under the sheet and replied, We rotate it because (the Resident) lean. When queried if they had provided morning ADL care to Resident #50, CNA O revealed they had not. Record review revealed Resident #50 was originally admitted to the facility on [DATE] with diagnoses which included right hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stroke), aphasia (difficulty speaking), dysphagia (difficulty swallowing), and gastrostomy (feeding tube inserted through the abdomen into the stomach to deliver food and medications). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and dependent upon staff for completion of Activities of Daily Living (ADLs). Review of Resident #50's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #50). has an ADL Self Care Performance Deficit. has been observed to decline assistance with grooming. will say yes to one staff member who asks, then say no to another. (Initiated: 10/30/23; Revised: 1/15/25). The care plan included the interventions: - Report refusals of ADL care, personal hygiene, nail care, bathing, and showers. (Initiated: 3/12/24) - Personal Hygiene/Oral Care: (combing hair, shaving, nail care, and washing and drying face and hands) Dependent 1PA (Person Assist) (Initiated: 10/30/23; Revised: 3/3/25) Another care plan in Resident #50's EMR was titled, (Resident #50) is at risk for falls r/t (related to) poor safety awareness decreased cognition. (Initiated and Revised: 4/2/24). The care plan included the intervention, Keep environment as safe as possible with. call light within reach. (Initiated and Revised: 2/4/25) Review of Resident #50's Documentation Survey Report for 3/1/26 to 3/17/26 revealed a documentation section titled GG- Personal Hygiene each shift (three times a day). The category detailed, The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). Detailed review revealed (continued on next page)

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

no documentation of Resident #50 refusing care. Additionally, there was no documentation (blank) of task completion 10 times. The report also included the task, Shower/Bathing: Wednesday Saturday Day Shift and PRN (as needed). The was no documentation (blank) of Resident #50 receiving and/or refusing scheduled shower/bathing on Saturday 3/14/26.

On 3/23/26 at 11:00 AM, Resident #50 was observed in their room. The Resident was in bed, positioned on their back. The Resident's fingernails remained unkempt and long with jagged edges and an unknown black substance under the nails.

At 11:08 AM on 3/23/26, an interview and observation of Resident #50's fingernails was completed with Licensed Practical Nurse (LPN) P. When queried regarding the Resident's fingernails, LPN P confirmed the presence of the unknown black substance under the nails and that the nails needed to be trimmed. LPN P verbalized they would have someone take care of the Resident's nails.

Resident #65:

On 3/18/26 at 11:55 AM, Resident #65 was observed in their room in bed. The Resident's arms were sharply bent with their hands by their face. Resident #65's fingers appeared misshapen and contracted. Their call light was not within their reach. The Residents appearance was disheveled and unkempt. An interview was completed at this time. When queried how they are treated by facility staff, Resident #65 stated, Not good. Resident #65 was asked what they meant but did not provide further information. While speaking, the Resident's teeth were observed to have a significant amount of build up and debris on them. When queried if they required assistance to complete oral care, Resident #65 indicated they did. Resident #65 was then asked if a staff member had assisted them with oral care today and shook their head indicated they had not. When asked the last time they had received oral care, Resident #65 indicated they did not know.

Record review revealed Resident #65 was most recently admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), left hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stroke), aphasia (difficulty speaking), gastrostomy, and dementia. Review of the MDS assessment dated [DATE] revealed the Resident was rarely/never understood and was dependent upon staff for completion of Activities of Daily Living (ADLs).

Review of Resident #65's EMR revealed a care plan entitled, (Resident #65) has a functional ability deficit and requires assistance with self care/mobility. (Initiated and Revised: 10/8/23). The care plan included the interventions:

- Personal Hygiene: dependent combing hair, shaving, nail care, and washing and drying face and hands (Initiated: 12/21/23; Revised: 3/12/24)

- Oral Care: Dependent (Initiated and Revised: 12/21/23)

- Bath/Shower: Dependent (Initiated and Revised: 12/21/23)

Review of Resident #65's Documentation Survey Report for 3/1/26 to 3/18/26 revealed the following:

-A task entitled, ADL Care Statement with the description, Have you provided routine standard care
(continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	which includes. shaving and nail care as needed, turning and repositioning, oral care, washing face and hands, hair care, clean clothes and linens. dignity and respect. keeping call light within reach. encouraging and assisting to activities? Y - Yes N – No. The documentation was to be completed each shift, three times a day. There were 14 blank areas where no documentation had been completed and no documentation of Resident refusal of task completion. - A task entitled, GG- Oral Hygiene was also reviewed. The task included documentation sections three times a day, during each shift. Review revealed 14 blank areas where no documentation had been completed. NA was documented 10 times on the night shift from 11:00 PM to 7:00 AM. On 3/23/26 at 11:03 AM, Resident #50 was observed in their room. The Resident was in bed, positioned on their back. The significant, visible substance build-up remained on Resident's teeth. At 11:08 AM on 3/23/26, an interview and observation of Resident #65's was completed with LPN P. When queried regarding the Resident's teeth, LPN P confirmed and stated, Need to do oral care. An interview was completed with the Director of Nursing (DON) on 3/19/26 at 2:11 PM. When queried if there a blank area on daily care documentation means the care task was not provided, the DON replied, Yes. The DON was then informed of observations of Resident #'s 11, 50, and 65 as well as interviews completed. The DON did not provide further explanation. Resident #122 A record review of the Face sheet and Minimum Data Set/MDS assessment indicated resident #122 was admitted to the facility on [DATE] with diagnoses: Debility, heart disease, arthritis and osteoporosis. The MDS assessment dated [DATE] indicated the resident had full cognitive ability with a Brief Interview for Mental Status/BIMS score of 13/15, was dependent with care for toileting and was always incontinent of bladder and bowel. On 3/18/2026 at 11:15 AM, prior to entering Resident #122's room a strong odor of urine was noted in the hallway near the door. Upon entering the room, the foul smell of old urine was evident. While approaching Resident #122's side of the room near the window, the smell became much stronger. The resident was lying on her right side facing away from the left side of the bed; a blanket was covering her, but the left side of the bed was visible. On the bottom sheet was a large brownish urine stain, partially dry and partially wet and the smell was worse. On 3/18/2026 at 11:20 AM, the room was exited and Certified Nursing Assistant/CNA F was asked if she could come to the Resident #122's room, and she stated Sure. While entering the room and approaching the side near the window with Resident #122, CNA F was asked if she could smell the urine, she said Yes she could. The CNA stood at the end of the bed and she was asked if she could see the resident's bed on the left side, she stated, I see it. The CNA was asked if she could see that the brown colored urine was up near the resident's neck and the length of her body and she stated, Night shift probably didn't change her. I have all of these residents, and I am making my way through my assignment. I haven't got to her yet. On 3/18/2026 at 1:45 PM, Resident #122 was observed sitting in her bed. She appeared clean, with clean clothes. The bed linens appeared clean and there was still a slight smell of urine in the room. The resident was smiling and talking to a visitor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/2026 at 11:34 AM, Resident #122 was observed lying in her bed awake and watching TV; there was no smell of urine. The resident was asked if she received timely assistance with incontinence care and she said she was not changed the previous night (3/19/2026), but was now clean and dry with dry bedding, When asked about yesterday (3/18/2026), she said she had not been changed that night either and stated, Sometimes they don't get to it because they don't have enough people. I just wait for them. Sometimes it takes a long time. A record review of the Care Plans for Resident #122 identified the following: (Resident #122) is incontinent of (bladder &/or bowel) r/t (related to). This was left blank with no explanation, dated 9/26/2025 and revised 10/20/2025 with Interventions including: Brief Usage: Resident uses disposable briefs. Change q (every) 2 hours and prn (as needed), date initiated 9/26/2025 and revised 10/20/2025; Check q 2 hours and prn for incontinence. Wash, rinse and dry perineum. Change clothing after incontinence care as needed, date initiated 9/26/2025. (Resident #122) has a functional ability deficit and requires assistance with self care/mobility r/t: decreased mobility, disease process, date initiated 9/26/2025 and revised 9/30/2025 with Intervention including: Toilet Hygiene: (Resident #122) is dependent for toilet hygiene, date initiated 9/30/2025. A review of the Kardex for Resident #122 provided, Bladder/Bowel/Toileting: Brief Usage: Resident uses disposable briefs, Change q 2 hours and prn; Check q 2 hours and prn for incontinence. Wash, rinse and dry perineum. Change clothing after incontinence. On 3/23/2025 at 3:15 PM, during an interview with the Director of Nursing/DON, she said there had been staffing issues with call ins and a lack of scheduled staff. Reviewed with the DON both the residents and staff were verbalizing there were not enough staff and Resident #122 was not changed after being incontinent during the night shift on 2 occasions and on the day shift until after 11:30 AM after being wet all night. The DON said the facility was trying to hire more staff. A review of the facility policy titled, Resident Dignity & Personal Privacy, date effective 3/12/2025 provided Policy: The facility provides care for residents in a manner that respects and enhances each resident's dignity, individuality. groom appropriately and to resident's desire. A review of the facility policy titled, Routine Resident Care date effective 3/12/2025 revealed, Residents receive the necessary assistance to maintain good grooming and personal/oral hygiene. Incontinence care is provided timely according to each resident's needs. Resident's call lights are answered timely and resident's requests are addressed. Resident #15: R15 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include dementia, anxiety, schizophrenia and hyperlipidemia. On 03/17/2026 at 12:16PM, R15 was sitting on the edge of the bed, observed with long chin hairs and other long hair on her face. On 03/19/2026 at 3:00PM, R15 was resting in bed, R15 was again observed with chin hairs and long (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facial hair on her cheeks. R15 was asked if the staff offers to help her with facial hair removal. R15 stated, no, I have to ask staff for help, and they take their time getting it done. R15 was asked when the last time was the staff helped you with hair removal on your face. R15 stated, that is has been about two weeks. R15 stated that she does not like having facial hair and that she would ask her son to do it if the staff won't do it. On 03/19/2026 at 3:04PM, an interview was conducted with certified nursing assistant (CNA) A. CNA A was asked if the staff offers to help R15 with facial hair removal. CNA A stated, yes, but sometimes she will refuse. I gave her a shower on 3/13/26 and she refused to let me shave her chin at that time. CNA A stated that she would go down and see if R15 needed any assistance. On 03/19/2026 at 3:15PM, record review of care plans for R15 revealed that she is a one person assist for personal hygiene. On 03/23/2026 at 10:32AM, observation this morning revealed some chin hair and facial hair were still present. Resident #31: R31 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include muscle wasting, chronic obstructive pulmonary disease, anxiety and depression. On 03/17/2026 at 1:05PM, R31 was resting in bed, observation revealed her hair was greasy and not combed. On 03/19/2026 at 2:54PM, R31 stated she gets two showers a week, most weeks. R31 stated there is a staff member that doesn't like to help her with showers, but she cannot recall the name of the employee. R31 was asked when the last time she had a shower. R31 wasn't sure when she had a shower last. R31's hair was observed to be greasy and not combed again. Record review of the task list for bathing revealed that R31 did not receive a shower on 3/19/26, as scheduled in the electronic medical record (EMR) to be completed on the first shift. On 03/19/2026 at 2:56PM, an interview was conducted with CNA B. CNA B was asked if R31 refuses showers. CNA B stated, I honestly don't know, her showers are on second shift and I work first shift. CNA B stated, I have tried to give her a shower before and she would tell me no, that it is too cold. CNA B was asked what R31's shower days are. CNA B stated that R31 is scheduled for Wednesday and Saturday, second shift showers. CNA B was made aware that the EMR shower task indicates that R31 is scheduled for showers on Monday and Thursday, first shift. CNA B was made aware that the EMR does not match the shower book at the nurse's station. On 03/19/2026 at 3:00PM, record review of the most recent minimum data set (MDS) assessment dated [DATE], revealed that R31 is a max assist for bathing and moderate assist for personal hygiene care. Review of the policy titled, Routine Resident Care, revealed, Residents receive the necessary assistance to maintain good grooming and person/oral hygiene. Guidelines: (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Daily personal hygiene minimally includes assisting or encouraging residents with washing their face and hands, shaving, nail care, combing their hair each morning, and brushing their teeth and/or providing denture care. Any concerns will be reported to the nurse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide enteral tube care per professional standards of practice for four residents (R50, R65, R81, R115) of four residents reviewed. Findings include:Resident #50: On 3/19/26 at 11:13 AM, Resident #50 was observed in their room. The Resident was in bed, positioned on their back. The Head of the Bed (HOB) was elevated to 15 degrees, and they were receiving tube feeding via infusion pump at a rate of 59 milliliters (mL) per hour. On 3/19/26 at 3:40 PM, Resident #50 was observed in their room in bed. The Resident's tube feeding was infusing via pump at 59 mL per hour and the HOB was elevated 24 degrees. An interview was completed with Licensed Practical Nurse (LPN) M on 3/19/26 at 3:48 PM. LPN M was asked how high the HOB should be when a Resident is receiving tube feeding and replied, 30 to 40 degrees. LPN M was asked check how high the head of Resident #50's bed was elevated. After exiting Resident #50's room, LPN M was queried regarding the HOB and confirmed the HOB was not elevated 30 degrees. Record review revealed Resident #50 was originally admitted to the facility on [DATE] with diagnoses which included right hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stroke), aphasia (difficulty speaking), dysphagia (difficulty swallowing), and gastrostomy (feeding tube inserted through the abdomen into the stomach to deliver food and medications). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and dependent upon staff for completion of Activities of Daily Living (ADLs). Review of Resident #50's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #50) an alteration in nutrition and/ or hydration status. (Initiated 6/22/16; Revised: 1/7/26). The care plan included the intervention, (Resident #50) needs the HOB elevated 45 degrees during and 1 hour after tube feed (Initiated: 6/22/16; Revised: 6/4/24). On 3/23/26 at 10:57 AM, on observation of Resident #50 was completed. The Resident was in bed, on their back with tube feeding solution infusing via pump at 59 mL per hour. The head of the Resident's bed was elevated less than 20 degrees. Upon exiting Resident #50's room, LPN N was observed in the hallway. When queried if they were Resident#50's assigned nurse, LPN N verbalized they were. LPN N was asked what the HOB should be elevated to when a resident is receiving tube feeding and replied, 20 to 25 degrees. LPN N was asked to enter Resident #50's room and what their HOB elevation was. LPN N entered the Resident's room and proceeded to raise the head of Resident #50's bed. When queried, LPN N verbalized the head of Resident #50's bed was elevated less than 20 degrees. No further explanation was provided. Resident #65: Record review revealed Resident #65 was most recently admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), left hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stroke), aphasia (difficulty speaking), gastrostomy, and dementia. Review of the MDS assessment dated [DATE] revealed the Resident (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was rarely/never understood and was dependent upon staff for completion of Activities of Daily Living (ADLs). On 3/23/26 at 10:41 AM, Resident #65 was observed in their room in bed. The Resident was positioned on their back with the HOB elevated at 20 degrees. Tube feeding administration set was hanging via pump and connected to the Resident. The tube feeding container was empty and Feed Error was displayed on the tube feed pump message screen. The tube feeding container was noted to contain approximately 1000 mL of feeding solution and was dated 3/22 at 2000 (8:00 PM) with a rate of 80 mL/hour written on the container. No staff were present in the hallway. At 3/23/26 at 10:51 AM, Certified Nursing Assistant (CNA) O was walking past the Resident's room. CNA O was stopped. When queried regarding the error message on Resident #65's tube feeding pump, CNA O indicated they did not know and would have to find the nurse. CNA O verbalized Hospice staff had just left. When queried how high the HOB should be elevated when a Resident is receiving tube feeding, CNA O did not provide a response. Review of Resident #65's EMR revealed a care plan entitled, (Resident #65) has alteration in nutritional and/or hydration status. (Initiated: 9/19/23; Revised: 9/4/25). The care plan included the intervention, Elevate HOB 30-45 degrees during tube feeding administration (Initiated: 9/19/23; Revised: 2/16/24) Resident #81 A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #81 was admitted to the facility on [DATE] with diagnoses: history of a stroke, left-sided weakness, history of cranial surgery after a stroke/craniotomy with skull flap, heart disease, neuropathy, Frontotemporal neurocognitive disorder, and hypertension. The MDS assessment dated [DATE] indicated the Resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 14/15 and needed assistance with care. On 3/18/2026 at 10:39 AM, Resident #81 was observed lying in bed, awake and readily answered questions. She was observed to have a soft helmet on, and she said she had previously had a stroke and had surgery on her head and wore the helmet for protection. She said she was supposed to have surgery again at some point. Resident #81 said she had a feeding tube but she also received a meal tray with a diet. The resident said tube feeding might be restarted, but she wasn't sure. The resident showed there was a gauze dressing on her abdomen over the feeding tube insertion site. She said the staff usually changed the dressing in the morning. A review of the physician orders for Resident #81 identified the following: Flush PEG (feeding tube) with 60cc H2O (water) every 6 hours, start date 12/13/2025. Cleanse Peg tube site with wound cleanser and apply dry dressing every night shift as needed, start date 12/15/2025. No added salt diet, regular texture, Thin consistency (fluids) for diet, start date 12/12/2025. Further review of Resident #81's MDS Comprehensive assessment dated [DATE] section K: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Swallowing/Nutritional Status did not indicate the resident had a feeding tube or that she was receiving water flushes/fluid intake via the feeding tube. A review of the progress notes revealed the following: 3/16/2026 at 4:31 PM, a Skin check, provided . Resident does not have an external device. There was no mention of the feeding tube inserted into the resident's stomach. 3/09/2026 at 11:11 PM a psychiatric note provided, . Anoxic brain injury secondary to CVA (stroke). s/p (status post) PEG tube placement. 2/17/2026 at 1:00 AM, a provider Encounter note revealed, . PEG tube placement. 2/2/2026 at 1:00 AM, a provider Encounter note revealed, . Keep PEG tube patent with routine flushes. Keep area clean and dry. 1/10/2026 at 3:36 PM, a Nurses Note provided, Tube feeding patent with flushes done each shift per order. Will continue to monitor. The resident was noted to have multiple Skin checks that mentioned no external device. It did not identify the feeding tube. The feeding tube was not being routinely monitored. A review of the Medication Administration Records/Treatment Administration Records (MAR/TARs) for Resident #81 identified the following: Flush PEG tube with 60cc H2O every 6 hours for patency, start date 12/13/2025. Enhance barrier precautions every shift for peg, start date 12/13/2025. There was no entry on the MAR/TAR for changing the gauze dressing on the PEG tube insertion site or to monitor the site. A review of a Nutritional Re-evaluation assessment dated [DATE] did not identify Resident #81 had a feeding tube or that she was receiving water flushes every 6 hours. A review of the Care Plans for Resident #81 identified the following: (Resident #81) has a peg tube r/t (related to) inadequate nutrition, date initiated and revised 12/13/2025 with 1 Intervention: Use enhanced barrier precautions, date initiated 12/13/2026. (Resident #81) has potential alteration in nutritional and/or hydration status. date initiated 12/15/2026 and revised 3/21/2026. There was no mention that the resident had a feeding tube or that she was receiving water flushes. On 3/23/2026 at 11:21 AM, Dietary Manager D was interviewed related to Resident #81's feeding tube, she said it was the Registered Dietitian who ordered the water flushes, but she had resigned the prior week. The Dietary Manager said it was her understanding it was not being used. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/23/2026 at 1:42 PM, Nurse Practitioner/NP G was interviewed related to Resident #81's feeding tube. She was asked why the resident still had a feeding tube, since admission [DATE], without being used, as it could be an infection risk or develop complications. The NP was asked what the plan for the feeding tube was as there was no documentation found in the chart clarifying this. She was also asked about monitoring of the abdominal insertion site, as there was no identified routine monitoring. NP G said she would check on it. On 3/23/2026 at 2:21 PM, NP G was interviewed and she said she spoke with Resident #81's son as he was visiting the resident. She said the son said his mom would need another craniotomy when the swelling in her brain subsided and he would like the feeding tube to stay in until after that surgery. NP was asked about documentation for the feeding tube as there was nothing that explained that and NP G said she would make a note about it. She said there should have already been a note. Resident #115: R115 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include dysphagia, anxiety, depression and traumatic subdural hemorrhage. On 03/19/2026 at 9:08AM, the medication administration task was conducted with Licensed Practical Nurse (LPN) C. R115 has a Percutaneous Endoscopic Gastrostomy (PEG) tube, medication orders revealed they are to be administered via PEG tube and some via mouth. LPN C did not verify placement of the PEG tube prior to the administration of medication and did not properly flush the PEG tube after medication administration. On 03/19/2026 at 9:35AM, an interview was conducted with LPN C. LPN C was asked what the process is for verifying placement of a PEG tube. LPN C stated, we usually take the residual gastric content and make sure it doesn't go over a certain amount (200ml) then we push it back in. LPN C was asked if they should have verified placement of the PEG tube before giving medication. LPN C stated, yes, I should have verified placement, but I didn't. The water was flowing freely, so I knew it was in place. LPN C was asked how much you should flush the tube with after medication administration. LPN C stated, usually we put in 150-200cc of water, I put about 150cc in the end to flush the tube. On 03/19/2026 at 9:46AM, an interview was conducted with the Director of Nursing (DON). The DON was asked if R115 is supposed to have anything by mouth. The DON stated, no, I don't believe that he is able to have anything by mouth. His oral meds were to be put on hold until he had a video swallow. The DON was made aware that R115 has physician's orders both by mouth and by PEG tube. The DON was asked what the process is for verifying PEG tube placement. The DON stated, I believe it is verified once a shift and we verify residual. If it is under the threshold then we re-feed it and we know it is in place. The DON was made aware that placement was not verified prior to medication administration. Review of the policy titled, Medication Administration-Enteral,' revealed: Procedure: 11. Verify placement of tube by using a piston syringe to aspirate stomach contents. Fasting gastric secretions are clear, grassy green or brown. Replace gastric contents after aspirating. If unable to (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obtain gastric secretions, hold medication and tube feeding and notify physician for further orders. Re-clamp tube if present. Verify Dobhoff and Jejunal placement per policy. Once placement in verified release clamp from tube, if present, and instill at least 15ml of water into the tube through the syringe to check for patency via Gravity Flow. If water flows in easily, tube is patent. If it flows in slowly, raise the syringe to increase pressure. If water does not flow properly, stop the procedure and notify the physician. 16. After giving all the medication, instill at least 15ml of water to irrigate the tube.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure residents were 1) consistently assessed for Influenza and Pneumococcal vaccinations on admission, per Standards of Practice; 2) provided an educational vaccination information sheet for each vaccination, 3) and document vaccination information in the residents' medical record, including consent or declination of the vaccinations, which could potentially effect all residents, including Residents (#5, #15, #61, and #74) reviewed for vaccinations, resulting in the potential for exposure to Influenza and Pneumococcal disease, and severe illness. Findings Include: CDC/Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report (MMWR), Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices- United States, 2025-26 Influenza Season, Weekly/ [DATE]. Routine annual influenza vaccination is recommended for all persons aged >= 6 months who do not have a contraindication to vaccination. For most persons who require only 1 dose of influenza vaccine fo the season, vaccination should ideally be offered during September or October. However, vaccination should continue after October and throughout the influenza season as long as influenza viruses are circulating and unexpired vaccine is available. CDC/Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report (MMWR), Expanded Recommendations for Use of Pneumococcal conjugate Vaccines Among Adults >=50 Years: Recommendations of the Advisory Committee on Immunization Practices- United States, 2024, Weekly/[DATE]. Streptococcus pneumoniae (pneumococcus) is a common bacterial cause of respiratory tract infections, bacteremia, and meningitis. Pneumococcal pneumonia, accounting for 12%-13/5 of all hospitalized pneumonia cases, has been estimated to result in approximately 225, 000 U.S. adult hospitalizations annually. CDC Pneumococcal Vaccination, [DATE]: CDC recommends pneumococcal vaccination for people based on their age or if they have certain risk conditions. Pneumococcal vaccines help protect against pneumococcal infections, including invasive disease. Invasive disease means the bacteria invade parts of the body, such as blood, that are normally free from germs. Invasive disease is usually very serious and can sometimes result in death. Pneumococcal disease is common in young children, but older adults are at greatest risk of serious illness and death. CDC: Long-term Care facilities (LTCF's), [DATE], Viral Respiratory Pathogens Toolkit for Nursing Homes: Preventing the spread of respiratory viruses in nursing homes requires a comprehensive approach that includes not only vaccination, but also testing, treatment, and the prompt implementation of proven infection prevention and control measures. Taken together, these actions can protect residents and staff from respiratory viruses. Vaccinate: Provide recommended vaccines to residents and HCP (Healthcare Providers); Recommended vaccines help prevent severe illness, hospitalization, and death from respiratory viruses. On [DATE] at 2:10 PM, the facility Infection Control Program was reviewed with Infection Control Practitioner/ ICP H. Vaccinations including Influenza/Flu, Pneumonia and Covid-19 were reviewed. The ICP H said the facility had a vaccination clinic in the fall 2025 for residents and planned to have another vaccination clinic in [DATE]. She said she would be catching up on new residents. The ICP H said usually residents were assessed for vaccinations on admission. Their history of vaccinations was reviewed with the residents and responsible parties. She said at the initial care conference, vaccine information was provided to the new residents but consent or declination for the vaccinations was not provided at that time.During the interview with ICP H on [DATE] at 2:10 PM, she said since [DATE] to the current date, she said she had not offered the Flu, Pneumonia or Covid vaccinations to the residents. The ICP said there was a large Covid-19 outbreak in the facility with 36 residents and staff testing positive between [DATE] to the beginning of [DATE]. When asked why the residents were not being offered vaccinations and offered the opportunity to consent or decline the vaccinations, the ICP said she had been very busy with the outbreak. The ICP had been observed working as a staff nurse on the floor (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during the survey and when asked how often she worked as a nurse on the floor instead of working in her role as the ICP she said she often worked several days a week as a nurse on the floor. The census during the survey was 132 residents and when she worked on the floor, her duties as an ICP were not completed.A record review of resident vaccinations identified the following:Resident #5A record review of the Minimum Data Set/MDS assessment and medical record indicated Resident #5 was admitted to the facility initially on [DATE] and the most recent admission was [DATE] with diagnoses: Heart disease, diabetes and arthritis. The MDS assessment dated [DATE] identified a memory problem with a Brief Interview for Mental Status Score/BIMS of 7/15.A review of the resident's vaccination status revealed Flu [DATE], Pneumonia [DATE] and Covid-19 [DATE]vaccinations were documented as received. There was no additional consent or declination for vaccinations after then.Resident #61A record review of the MDS assessment and medical record indicated Resident #61 was admitted to the facility [DATE] with diagnoses: Cancer, heart disease, history of a stroke and Peripheral vascular disease. The MDS assessment dated [DATE] identified the resident had a memory problem.A review of the resident's vaccination status revealed the resident refused Flu, Pneumonia and Covid-19 vaccinations in the vaccination tab on the electronic medical record/emr, but no consent or declination form providing educational information about the vaccinations was identified.Resident #74A record review of the MDS assessment and medical record indicated Resident #74 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Heart disease, diabetes, and respiratory failure. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a BIMS score of 15/15.A review of the resident's vaccination status indicated: Flu refused [DATE], Pneumonia refused [DATE] and Covid-19 refused [DATE]. The only consent or declination was for the Covid-19 vaccination. There was no indication Flu or pneumonia vaccinations had been reoffered.Resident #15A record review of the MDS assessment and medical record indicated Resident #15 was admitted to the facility on [DATE] with diagnoses: Hypertension, Dementia and Schizophrenia. The MDS assessment dated [DATE] identified a BIMS score of 14/15 indicating full cognitive ability.A review of the resident's vaccination status indicated: Flu, Pneumonia and Covid-19 vaccinations were all refused on [DATE]. There were no consent or declination forms.Consent or declination forms for vaccinations that included information on the risks and benefits were not identified for the residents reviewed. The residents or representatives were not able to make an informed decision on whether they wanted to receive the vaccinations or not.A review of the facility policy titled, Infection Prevention Program Overview, dated effective [DATE] provided, Infection Prevention Program: Mission of Program- The infection prevention and control program (IPCP) must include, at a minimum, the following elements: The facility establishes a program under which it: Investigates, identifies, prevents, reports and controls infections and communicable diseases for all residents. Is based upon facility assessment; follows accepted national standards. Staff and resident education will focus on risk of infection and practices to decrease the risk. Policies, procedures and aseptic practices are followed. Immunizations are offered as appropriate to residents and staff to decrease the incidence of preventable infectious diseases.

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	235343	A. Building B. Wing	03/23/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to specify indication for usage and provide a clinical rationale for duplicate therapy of antipsychotic medication for one resident (Resident #88) of five residents reviewed for unnecessary medications.Findings include:Resident #88;On 3/23/2026 at 11:50 AM, a review was conducted of Resident #88's medical record and it revealed the resident initially admitted to the facility on [DATE] with diagnoses that included, Adjustment Disorder, Anxiety Disorder, Dementia, Psychotic Disorder with Delusions and Psychophysiologic Insomnia. Further review of her chart yielded the following:;Paliperidone (Invega) ER Oral Tablet Extended Release 24 Hour 1.5 MG (milligram)- give one tablet by mouth one time a day for antipsychotic. Ordered on 3/7/2025. Quetiapine (Seroquel) Fumarate Oral Tablet 25 MG- Give one tablet by mouth two times a day for psychotic disorder. Ordered on 4/9/2025. Both above medications are classified as antipsychotics. Mental Health Provider Progress Notes:Review was completed of progress notes from June 2025- March 2026 and there was no documentation located regarding clinical rational dual antipsychotic therapy for Resident #88. On 3/23/2026 at 2:10 PM, an interview was conducted with Social Worker E regarding Resident #88's antipsychotics (Seroquel and Invega). Review was completed of her chart, and she stated antipsychotic is not an appropriate indication for usage for Invega. Social Worker E stated her behaviors have been decreased as she has stabilized on her current medication regime. She was queried if the clinical rationale for duplicate antipsychotic therapy was clearly documented within Resident #88's chart and she stated she did not believe it was explicitly addressed within the practitioner's charting. Review was completed of the facility policy entitled, Psychoactive Medication Management, last approved 1/28/2026. The policy stated, The facility will provide appropriate treatment and services for residents who display or are diagnosed with a mental disorder or psychological adjustment difficulty.When pharmacological interventions are indicated, the licensed staff will verify that the physician order includes the appropriate clinically supported diagnosis.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely completion of a significant change Minimum Data Set (MDS) assessment for one resident (Resident #65) of one resident reviewed. Findings include:Resident #65:Record review revealed Resident #65 was most recently admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), left hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stroke), aphasia (difficulty speaking), and dementia. Review of the MDS assessment dated [DATE] revealed the Resident was rarely/never understood and was dependent upon staff for completion of Activities of Daily Living (ADLs). The MDS further detailed the Resident was receiving Hospice care. Review of Resident #65's Health Care Provider (HCP) orders revealed an order to admit to hospice services on 6/23/25. Further review of Resident #65's Electronic Medical Record (EMR) revealed the Resident's payor source was changed to Hospice on 6/23/25. Review of Resident #65's MDS assessments in the EMR revealed a Significant Change MDS assessment pertaining to decline and Hospice admission was completed on 8/11/25.Review of Resident #65's care plans revealed a care plan related to Hospice Services was initiated 6/23/25 and revised 8/13/25. An interview was completed with the Director of Nursing (DON) on 3/19/26 at 2:09 PM. When queried if a significant change MDS should be completed when a resident is admitted to hospice services while at the facility, the DON replied, Yes. Resident #65's HCP orders, payor change date, and Significant Change MDS dates were reviewed with the DON at this time. The DON was then asked if it was a concern that a Significant Change MDS had not been completed until August 2025 when the Resident was admitted to Hospice in June, and responded, Yes. An interview was completed with MDS Registered Nurse (RN) K on 3/23/26 at 10:25 AM. MDS RN K was asked if a Significant Change MDS should have been completed when Resident #65 was admitted to Hospice in June 2025 and stated, Let me find out. MDS RN K proceeded to contact Regional MDS Nurse L via phone. After speaking to Regional Nurse L, MDS RN K stated, Yeah, one should have been done and wasn't. When asked why the MDS assessment was not completed, no further explanation was provided.

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

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to ensure that communication was completed in an understandable language including availability of adaptive equipment and translation devices for one resident (Resident #88) of one resident reviewed, resulting in lack of implementation of planned interventions for communication with a resident who does not speak English. Findings include: Resident #88:On 3/18/26 at 12:51 PM, Resident #88 was observed walking unassisted in their room. The Resident had a Croc style shoe on their left foot and a gripper sock on their right. An interview was attempted to be completed at this time. When asked how they were doing, Resident #88 made eye contact but did not respond. Upon repeating the question, Resident #88 replied, No English. There were no communication and/or translation boards/devices present in the room. An Activity Calendar, with written words in English, was hanging on the wall. The question, How are you? was written and shown to the Resident. Resident #88 shook their head and stated, No English. An interview was conducted with Licensed Practical Nurse (LPN) Q on 3/18/25 at 12:52 PM. When queried regarding Resident #88, LPN Q stated, (Resident #88) only speaks Romanian. When asked how facility staff communicate with the Resident if they only speak Romanian, LPN Q responded the Resident had communication boards and a translator device they use. Record review revealed Resident #88 was most recently admitted to the facility on [DATE] with diagnoses which included heart disease, diabetes mellitus, psychotic disorder with delusions, and dementia. Review of Resident #88's Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required supervision to moderate assistance to complete Activities of Daily Living (ADLs) with the exception of set up assistance for eating. The MDS specified the Resident's preferred language was Romanian and Yes was selected as the response to the question, Do you need or want an interpreter to communicate with a doctor or health care staff? Review of Resident #88's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #88) has impaired communication r/t (related to) Language barrier as evidenced by not speaking English. does not speak English. primary language is Romanian. (Resident) uses a pocket talker to communicate and son is able to communicate for (Resident) when he is visiting. (Resident) will at times refuse to use the pocket talker to communicate. will sometimes just stare at you and say nothing. Due to dx (diagnosis) of dementia and word salad, the pocket talker has trouble picking up (the Resident's) words as speaks in broken Romanian, and the communication comes out broken (Created: 11/9/22; Initiated: 11/9/24; Revised: 3/3/26). The care plan included the interventions:- (Resident #88) is able to communicate via picture board and gestures. Pocket talker can be used to translate (Created and Initiated: 11/10/22)- Ensure availability, functioning and effectiveness of adaptive communication equipment pocket talker (Created, Initiated, and Revised: 11/09/22) A second care plan entitled, I, (Resident #88) am alert oriented an ambulate without assistance. I am Romanian and my primary language is Romanian. I use a talk box translator to assist me with making my wants and needs known to others that do not speak my language. (Created and Initiated: 11/9/22; Revised: 3/3/26) was present in the Resident's EMR. This care plan included the interventions:- Staff will encourage me to utilize my communication board to assist me with communicating my wants and needs (Created and Initiated: 12/2/24)- Staff will use my talk box translator to assist with communication as it relates to language barrier (Created and Initiated: 11/9/22) Review of Resident #88's Visual/Bedside Kardex used by Certified Nursing Assistant (CNA) staff to guide care revealed, Resident Care. (Resident #88) is able to communicate via picture board and gestures. Pocket talker can be used to translate. Communication. A sign in (Resident #88's) primary language (Romanian) was put on their assign room to help provide redirection. The Sign was made more noticeable/colorful for better appearance. Ensure availability, functioning and effectiveness of adaptive communication equipment (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pocket talker. Use communication techniques to enhance interaction: Allow adequate time to respond, Repeat as necessary, Do not rush, Request feedback, clarification from the resident, to ensure understanding, Face when speaking and make eye contact, Turn off TV/radio as needed to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs, and picture. On 3/19/26 at 11:52 AM, Resident #88 was observed in their room in bed. The lights were off in the room and the Resident's eyes were closed. A communication board and/or translation device were not observed in the room. A sign was observed outside of the Resident's room that was written in a language other than English. The words on the sign were entered into Google Translate. Per Google Translate, the language was Romanian and said, Welcome (Resident #88) this is the room. An interview was completed with Certified Nursing Assistant (CNA) R on 3/19/26 at 12:02 PM. When asked how they communicate with Resident #88, CNA R stated, I use a translator app on my phone. (Resident #88) speaks Russian. When asked to clarify if Resident #88 spoke Russian or Romanian, CNA R indicated they speak Romanian. CNA R verbalized they were not supposed to have and/or use their personal cell phones when working but they do not have any other way to communicate with Resident #88. When asked if the Resident had a translator box, CNA R responded that they did but it was missing and were not sure what had happened to it. CNA R was then queried if the Resident has a communication board in their room and replied, I haven't seen one. An interview was completed with Resident #88 on 3/19/26 at 12:13 PM in their room using google translate. When asked how they were doing using google translation, Resident #88 smiled and initially responded before the translation software was set to Romanian to English. Once the software began translating, Resident #88 stated, I miss him and I can't do it without him. After switching Google translate back to English to Romanian, Resident #88 was asked who they were talking about but did not provide a response. A conversation regarding their clothing and room was completed with the Resident using Google Translate. Resident #88 was noted to speak quickly, and not all words were captured due to delays with Google Translate in switching back and forth from English to Romanian and proximity of the laptop to the Resident. An interview was completed with LPN S on 3/19/26 at 12:14 PM. When queried regarding Resident #88, LPN S stated the Resident has a translator device. LPN S was then asked how long the translator device had been missing and replied, It's not missing. When asked where the translator device is, LPN S stated, It might be in the (medication) cart. LPN S was observed looking in the medication cart and then going into the medication room on the unit. LPN S returned and stated the translator device was not there. LPN S verbalized they were going to ask the social work. The Social Worker revealed they did not know where the translator device was and told LPN S to ask Activity staff. LPN S was asked how long the translator device had been missing and revealed they did not know. LPN S stated, Not sure what happened to the translator. LPN S indicated they were going to ask Unit Manager LPN T and would be right back. LPN S returned and stated that Unit Manager LPN T said Resident #88 is supposed to be using a (communication) board now. LPN S was asked how the Resident was supposed to use a communication board for language translation when there was no communication board in their room. LPN S indicated they would check the Resident's room for a board. LPN S confirmed a communication board was not present in Resident #88's room but did not provide further explanation. An interview was completed with Unit Manager LPN T on 3/19/26 at 12:20 PM. When queried regarding Resident #88's translator device and how staff are able to communicate with the Resident, LPN T stated, We was using a translator but as dementia progressed it was not accurate. When asked how they knew it was not accurate, LPN T did not provide a response. When queried regarding a communication board, LPN T stated, Supposed to be in there. LPN T was asked if the words on the communication board were written in Romanian. LPN T verbalized the communication board included pictures but did not provide a response to the question asked. When queried what happened to the translator device, LPN T stated, Not sure if the DON (Director of Nursing) has it. Review of prior MDS assessments revealed documentation of the (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident's primary language not being Russian in 2023 and requesting a translator at that time. At 12:22 PM on 3/19/26, LPN S approached and stated, The DON took (translator device) away. When asked how they are able to communicate with Resident #88 without the translator device or a communication board in a language the Resident can understand and indicated they point at things and gesture. LPN S was then asked how they communicate more complex thoughts with the Resident without the translator device and replied, I get what you are saying and confirmed they cannot. A follow-up interview was conducted with Unit Manager LPN T on 3/19/26 at 12:24 PM. When asked how staff are able to communicate complex thoughts/processes with Resident #88 when they do not speak Romanian and do not have access to the translator device to communicate to the Resident in Romanian. LPN T stated, (Resident #88) can understand English. When asked how they know the Resident can understand English, LPN T indicated the Resident was able to understand and speak some English when they were initially admitted to the facility. With further inquiry, LPN T verbalized that as Resident #88's dementia progressed, they were only able to communicate in Romanian. LPN T was asked again how they know the Resident was able to understand English if their dementia had progressed to a point where they were only able to communicate in their primary language of Romanian, LPN T did not provide an explanation. When queried what language Resident #88's family use to communicate with the Resident when visiting, LPN T responded that family members speak to the Resident in Romanian. An interview was attempted to be completed with Resident #88's Family Member Witness U on 3/19/26 at 1:28 PM. A voicemail message with return number was left but a return phone call was not received by the conclusion of the survey. An interview was conducted with the DON on 3/19/26 at 1:31 PM. When queried regarding Resident #88's translator device, the DON verbalized that the device was taken from the Resident. When asked the reason the translator device was removed, the DON replied that it was no longer working due to the Resident's advancing dementia. When asked why the translator device was still on the Resident's care plan, the DON stated, I don't know. The DON was then asked to explain how the translator device was not working and indicated that Resident #88's responses were non-sensical with the device. When queried why staff were not aware that the translator device had been removed, the DON was unable to provide an explanation. The DON was then asked if they were aware that facility staff were using translation apps on their personal devices in order to communicate with the Resident. The DON responded that staff are not allowed to have/use personal devices while working. When queried what their expectations are for communication with Resident #88 when the translator device is on the Resident's care plan and Kardex but not available and the staff do not speak Romanian. The DON responded that the device was not effective due to the Resident's dementia. The DON was then informed that I was able to have a conversation with Resident #88 using Google translate. When queried how the translation device was ineffective when I was able to converse with the Resident using Google Translate, even with the ineffectiveness of the application, the DON did not provide an explanation. The DON was then asked how staff are able to speak to the Resident and explain things in a language they can understand without a translation device and/or application available and did not provide any additional information. A review of Resident #88's documentation in the EMR did not reveal any documentation pertaining to discontinuation of the translator device. On 3/19/26 at 2:47 PM, Resident #88 was observed in the room, packing all of their clothing and toiletry items in a blanket on the bed and folding up the edges of the blanket to make a sack. Using Google Translate, Resident #88 was asked what they were doing and the Resident replied, Packing to go home. Resident #88 was then asked if it would be okay if I got a staff member to help them and replied, Okay. A policy/procedure related to communication was requested from the DON during interview on 3/19/26 at 1:31 PM but not received by the conclusion of the survey. Review of policy/procedure entitled, Resident Dignity & Personal Privacy (Approved 3/12/25) revealed, Policy. The facility provides care for residents in a manner that respects and enhances each resident's dignity, individuality. Information. Dignity means that when interacting with residents, staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility 1) failed to ensure that skin was assessed and monitored beneath a soft helmet for 1 resident (Resident #81) of 6 residents reviewed for skin care; and 2) Ensure that a resident received peak and through (max/min concentration of drug in bloodstream monitoring to maintain therapeutic medication levels by not obtaining timely laboratory testing for vancomycin antibiotic therapy for one resident (Resident #139) of one resident reviewed for IV therapy, resulting in the potential for sub therapeutic care and prolonged therapy. Findings Include:Resident #139 (R139): According to a review of R139's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to diagnoses including: chronic heart failure, Fracture of vertebrae (back), infection following surgical procedure; On 03/09/2026 R139 was re-admitted after hospital stay with a diagnoses of: Sepsis due to Methicillin Resistant Staphylococcus Aureus, Pneumonia (PNA), with peripherally inserted central catheter (PICC) place for IV therapy through 04/22/2026. The Minimum Data Set (MDS assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 13/15 indicated the resident had intact cognition. On 03/19/2026 at 11:10 AM, Resident observed laying in bed eyes closed under blanket and was unable to interview. A record review of R139's progress notes post hospital transfer on 02/19/2026 revealed resident was sent out for fever and decreased level of consciousness; resident had been being treated in facility for PNA and acute kidney injury (AKI) with peripheral IV fluids and Levofloxacin (antibiotic).A record review of R139's hospital discharge to facility record revealed medical diagnoses of Septicemia with MRSA, elevated tropins (cardiac markers), PNA with the last Peak and trough lab collection date of 03/09/2026 at 9:01 AM resulting in 17.7 UG/ML value (10-20 UG/ML) reference range. The next weekly lab draw would be due on 03/16/2026. A review of discharge prescription written by the hospital infectious disease (ID) doctor dated 03/09/2026 revealed orders: 'Vancomycin 1.25 grams 250ML in NaCl 0.9% (normal saline) intravenous solution, to be given 1.25g (gram) via IV piggyback Q24H (once every 24 hours) for 35 days through 04/12/2026. PICC care: Catheter care. Heparin flushes. Cathflo if needed. Labs: CBC with differential, BUN, Cr, WSR, C-reactive protein (QNT), Vancomycin though Q week.' On 03/19/2026 at 1:10 PM, R139 was asked and agreed to interview. During the interview he was asked about his IV and PICC site viewed and dated 03/17/2026. R139 said he had an infection but couldn't identify why or where it was located, he said he needed medication for a long time. He was asked if the staff drew blood for his medications levels and he said No, further said that hurts like hell and agreed that he did not like to have bloodwork done but would do it if he had to. A record review of R139's lab results at the facility revealed he had last had labs done at the facility on 02/18/2026, prior to his transfer to the hospital on [DATE]. A record review of R139's readmission order set revised on revealed: 'placed on 03/18/2026 for Laboratory; 03/18/2026 -03/20/2026 (directions one time only for 2 days)' for the following tests: CBC (complete blood count), CMP (complete metabolic panel), Vitamin D level, Lipid panel lab draw. There was no order for Vancomycin Peak and through placed. On 03/23/2026 at 9:39 AM, During an interview with ICP Nurse J was asked about R139 hospitalization, she said R 139 had PNA with worsening symptoms and was sent out to be evaluated, he was hospitalized from [DATE] and returned to the facility on [DATE] in the afternoon. ICP Nurse (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	J said that R139 returned with a PICC line in place and received IV antibiotic Vancomycin 1 dose a day for Septicemia. ICP Nurse J was queried on no labs ordered for R139 on re-admission and she said the admission nurse would have put in the orders, she said the admission nurse called her because she needed help to put in the orders, ICP Nurse J said that she put in the (contracted lab) lab order. When asked where that order in the chart was, she agreed it was not present. When asked to review the lab order she put into (contracted lab) she produced an order dated 03/18/2026 stat (now order- one time) for CBC with differential, CMP, Lipid panel and Vitamin D. there was no order for Vancomycin peak and trough (P&T) attached. ICP Nurse J said she placed a separate order for standing orders, but she could not find it in the (contracted lab) system so she would have to call and see why and said it must be a glitch in their system. ICP Nurse J was confirmed there was an order from the hospital ID doctor and acknowledged none from the facilities existed in the medical record. ICP Nurse J said R139 refused his blood draw on 03/18/2026 and that they attempted again on 03/20/206 in which he did get the labs drawn. ICP Nurse J was asked what the last day R139 had his P&T drawn she was unable to answer, ICP Nurse J was asked if she was going on the day R139 returned 03/09/2026 as the last draw then what was the date the next draw would be due, she said 03/16/2026. ICP Nurse J acknowledged that even though R139 had declined the stat lab on 03/18/2026, that it was ordered 2 days later that its scheduled time. ICP Nurse J said that the NP G went and talked to R139 and explained why he needed the lab and that was why he had it done on 03/20/2026. On 03/23/2026 at 11:18 AM, During an interview with Nurse I she confirmed that she was the nurse who was R139 nurse on readmission. She said she was very busy at the time the resident was being readmitted and that she reached out to ICP Nurse J and the DON for help putting in orders. Nurse I said that ICP nurse J handled the Vancomycin and labs and that DON placed the batch orders for that admission. Nurse I confirmed this with medical chart review that revealed order for Vancomycin placed by ICP Nurse J with no labs, and batch orders placed by DON. On 03/23/2026 at 11:29 AM, During an interview with ICP Nurse J she was asked about Nurse I 's call for help on date of admission for R139 and that she placed the Vancomycin order but no lab ordered, she said it was a miscommunication because she only put the lab order in (contracted company) system and not the medical chart for Nurse I. ICP Nurse J was asked to confirm the date of readmission on [DATE], yes. When asked to confirm the date the order was placed in [NAME], she said 03/18/2026 was the only one she could validate and that she was expected a call back from the (contract company) about standing order labs that she believed she placed. On 03/23/2026 at 11:45 AM, During an interview with NP G, she was queried about R139's admission orders that had not included an order for P&T with IV Vancomycin. NP G stated I asked the '(medical director)' who works at '(hospital)' and was advised that this was a standard dose for Vanco and they didn't need P&T from ID perspective. NP G was asked to review the ID doctor prescription with specific instructions to the facility on discharge. After NP G reviewed it out loud she stated Oh, I missed that, it should have been monitored.NPG said R139 had a P&T drawn, after queried about timing NPG admitted the order was placed 9 days after R139 returned on 03/18/2026 and only to the contracted company it was not in R139's chart until today after multiple conversations with staff, and that R139's initial refusal due to his needed explanation, prolonged obtaining levels another 2 days. A record review of R139's orders revealed on 03/23/2026 an order was placed in R139's chart for Weekly labs: CBC with diff, BUN, CR, WSR, C-reactive protein (QNT), Vanco trough. Hold Vanco from being administered until lab is drawn.A record review of R139's care plan revealed: dated 03/09/2026 Focus: R139 is on isolation precautions related to: Specify DX: bacteremia with interventions: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer medication as ordered. Observe for effectiveness and side effects, report abnormal findings to the physician; Obtain labs as ordered and report abnormal findings to physician. A record review of facility provided medication sheet on Vancomycin therapy revealed: Nursing considerations: . carefully monitor vancomycin level to adjust IV dosage requirements and patient teaching: Teach about the use of the drug and its administration.According to the Infectious Disease Society of America (IDSA) Vancomycin guidelines 2020 Update, The guidelines recommend an AUC/MIC (Area Under Curve/Minimum Inhibitory Concentration) ratio (parameter to assess effectiveness of an antibiotic) of 400–600 mg*hour/L to achieve clinical efficacy and ensure safety for patients being treated for serious methicillin-resistant Staphylococcus aureus infections and according to the IDSA clinical practice guideline recommendation achieving a trough (parameter to assess effectiveness of an antibiotic) concentration of 15-20 mg/L (milligram per liter) for complicated infections. Resident #81 A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #81 was admitted to the facility on [DATE] with diagnoses: history of a stroke, left-sided weakness, history of cranial surgery after a stroke/craniotomy with skull flap, heart disease, neuropathy, Frontotemporal neurocognitive disorder, and hypertension. The MDS assessment dated [DATE] indicated the Resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 14/15 and needed assistance with care. On 3/18/2026 at 10:39 AM, Resident #81 was observed lying in bed, awake and readily answered questions. She was observed to have a soft helmet on, and she said she had previously had a stroke and had surgery on her head and wore the helmet for protection. She said she had a skin flap where bone had been removed, and she was supposed to have surgery again at some point. The resident said the helmet caused her head to feel hot, itchy and sweaty at times and she removed it to show her hair underneath. She said her hair was starting to grow back in the area where she had surgery. Resident #81 said she also had a different soft helmet that had holes in it for aeration and she wore it in warm weather. A record review of the physician orders identified the following: Head helmet to be worn at all times. Nursing to inspect skin around Helmet each shift, every day and night shift, start date 12/13/2025. A review of Resident #81's Medication Administration Record/Treatment Administration Record (MAR/TAR) for March 2026: Head Helmet to be worn at all times. Nursing to inspect skin around Helmet each shift. Every day and night shift for protection, start date 12/13/2025. A review of the Kardex for Resident #81 revealed there was no mention of wearing a soft helmet or monitoring the skin beneath the helmet. The Skin section of the Kardex had 1 entry Cue to reposition self as needed. A review of the progress notes and Skin Checks revealed no mention of assessing or monitoring the skin underneath the resident's helmet. A review of the Care Plans for Resident #81 identified the following: (Resident #81) is at risk for fall related injury and falls r/t (related to): stroke; (Resident #81) is supposed to wear her helmet at all times. She frequently chooses to take it off, created 12/12/2025 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and revised 12/22/2025 with 1 Intervention mentioning the helmet: Encourage (Resident #81) to wear her helmet for her own safety. Encourage her to put it back on if observed that she has taken it off, date initiated 12/22/2025. There was no mention in the Fall Care Plan or other Care Plans for the resident that mentioned assessing and monitoring the skin under the helmet. On 3/23/2026 at 9:44 AM, Wound Nurse C was interviewed related to Resident #81's helmet. The physician's order dated 12/23/2025 for nursing assessment related to Resident #81's helmet, said to assess around the helmet each shift. There was no mention of assessing beneath the helmet. Reviewed there was no mention of assessing and monitoring beneath the helmet on the MAR/TAR or Care Plans for Resident #81. The Wound Nurse C said the nurses should assess under the helmet each shift.