STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235359	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faith Haven Senior Care Centre	6531 W Michigan Avenue Jackson, MI 49201

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2575924Based on interview and record review, the facility failed to honor the residents right to refuse a hospital transfer in one (Resident one) out of three reviewed for resident rights. Findings include:Review of the medical record reflected that R1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including chronic pain syndrome, carpal tunnel syndrome, jaw pain, muscle spasms, restless legs syndrome, opioid dependence, intervertebral disc disorders (a condition that affects the disc between the vertebrae of the spine), adjustment disorder with mixed anxiety and depression, temporomandibular joint disorder (causing pain and dysfunction of the jaw), migraine, post-traumatic stress disorder, dental caries, anxiety disorder, depression, low back pain, and sciatica. The Minimum Data Set (MDS) reflected that R1 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS), a cognitive screening tool. R1 was no longer at the facility.Facility reported incident reflected on 6/30/25, RN C received a verbal order to increase R1's pain medication but did not enter it until 7/3/25. She admitted she failed to follow up with the physician in a timely manner. A physician statement dated 7/8/25 confirmed that the order for Norco was agreed upon with R1 on 6/30, but by the weekend, the changes were still not made. The Physician Assistant noted concern and intervened.Further review of the facility reported incident dated 7/22/25 reflected Resident (R1) reported allegations against a staff member. R1 requested a review of a previous concern she had made that she did not feel was resolved. Upon further investigation, the NHA [covering Nursing Home Administrator] determined the need to report the allegation. A thorough investigation is being conducted. The alleged staff member will not return to work until a conclusion is made. Review of the Facility Reported Incident Report dated 7/22/25 indicated that on that date, covering NHA E reviewed two Concern Forms R1 had written on 7/5/25 along with the statements collected during the initial investigation. NHA E decided to formally report the allegations and initiate a separate investigation, as R1 continued to express unresolved concerns. R1 alleged that Registered Nurse (RN) C had threatened her life and well-being by telling her that narcotic medications would be withheld if she refused to go to the Emergency Department. R1 also alleged that RN C failed to process a physician's order dated 6/30/25 to increase her pain medication.Review of a Resident Assistance Form completed by R1 and dated 7/5/25 stated: [RN ‘C'] threatened my life and my well-being. She refused to listen to my wishes. I have a detailed EMS (Emergency Medical Service) report which backs up my claims. [RN ‘C'] also refused to put in doctor's orders on Monday. A second Resident Assistance Form contained allegations of unequal treatment from RN C. R1 again accused RN C of nearly killing her, threatening her life and well-being, and added, people like RN ‘C' do not deserve to have anyone's life in their hands. If this doesn't stop, she will definitely kill more people. The form again referenced the EMS report from a 6/25/25 hospital transfer.Review of a Nurse's Note dated 6/25/25 at 11:58 AM stated: Resident [R1] c/o (complained of) dizziness and fatigue. Pulse 45 and O2 (oxygen saturation) 70%. 2L (liters) nasal cannula applied, O2 increased to 80%. Pulse increased to 49. This writer contacted PA (Physician's Assistant) and received an order to send to ER (Emergency Department). EMT contacted and resident transferred to ER.Review of the Prehospital Care Report Summary from EMS for the 6/25/25 transfer revealed that EMS arrived at 10:33 AM. The Narrative History Text stated that EMS arrived to find R1 lying in bed. Patient (R1) was surprised they were there to transport her to the ED. Staff stated they believed her pain medication had caused her heart rate and SpO2 to drop. R1 stated she felt better and refused to go to the ED. Contact was made with the ED Physician, who confirmed that if the patient was alert and oriented (A&Ox4) and refused, she could not be forced to go. R1 continued to refuse. Staff then stated, we will not give you any kind of pain medication if you stay here. R1 responded, you will put me into DT (delirium tremors) if you do that. Staff allegedly replied, that's fine, I will make you go to the hospital when you are unconscious.In an interview on 8/20/25 at 10:47 AM, Confidential Staff Member K described RN C as snippy and rude and reported hearing her say things like, well if you would follow what you're supposed to do, this wouldn't be happening. At 12:03 PM, LPN S stated that R1 was visibly upset over medication changes and felt she was treated differently by RN C. At 12:48 PM, LPN L stated she was present during the 6/25/25 hospital transfer. RN C reportedly said, Can you help me, [R1] is getting on my nerves and won't go to the hospital. LPN L entered the room and heard RN C tell R1, I'm not going to give you pain medication if you stay, to which R1 responded, If you withhold my medications, I'll fall over and die. RN C allegedly replied, I guess I'll send you to the hospital then and you won't be able to refuse. LPN L told

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2575924Based on interview and record review, the facility failed to protect the resident's right to be free from mental abuse and verbal abuse by a staff member. Findings Include:Review of the medical record reflected that R1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including chronic pain syndrome, carpal tunnel syndrome, jaw pain, muscle spasms, restless legs syndrome, opioid dependence, intervertebral disc disorders (a condition that affects the disc between the vertebrae of the spine), adjustment disorder with mixed anxiety and depression, temporomandibular joint disorder (causing pain and dysfunction of the jaw), migraine, post-traumatic stress disorder, dental caries, anxiety disorder, depression, low back pain, and sciatica. The Minimum Data Set (MDS) reflected that R1 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS), a cognitive screening tool. R1 was no longer at the facility.Facility reported incident reflected on 6/30/25, RN C received a verbal order to increase R1's pain medication but did not enter it until 7/3/25. She admitted she failed to follow up with the physician in a timely manner. A physician statement dated 7/8/25 confirmed that the order for Norco was agreed upon with R1 on 6/30, but by the weekend, the changes were still not made. The Physician Assistant noted concern and intervened.Review of the facility reported incident dated 7/22/25 reflected Resident (R1) reported allegations against a staff member. R1 requested a review of a previous concern she had made that she did not feel was resolved. Upon further investigation, the NHA [covering Nursing Home Administrator] determined the need to report the allegation. A thorough investigation is being conducted. The alleged staff member will not return to work until a conclusion is made.Review of the Facility Reported Incident Report dated 7/22/25 indicated that on that date, covering NHA E reviewed two Concern Forms R1 had written on 7/5/25 along with the statements collected during the initial investigation. NHA E decided to formally report the allegations and initiate a separate investigation, as R1 continued to express unresolved concerns. R1 alleged that Registered Nurse (RN) C had threatened her life and well-being by telling her that narcotic medications would be withheld if she refused to go to the Emergency Department. R1 also alleged that RN C failed to process a physician's order dated 6/30/25 to increase her pain medication.Review of a Resident Assistance Form completed by R1 and dated 7/5/25 stated: [RN ‘C'] threatened my life and my well-being. She refused to listen to my wishes. I have a detailed EMS (Emergency Medical Service) report which backs up my claims. [RN ‘C'] also refused to put in doctor's orders on Monday. A second Resident Assistance Form contained allegations of unequal treatment from RN C. R1 again accused RN C of nearly killing her, threatening her life and well-being, and added, people like RN ‘C' do not deserve to have anyone's life in their hands. If this doesn't stop, she will definitely kill more people. The form again referenced the EMS report from a 6/25/25 hospital transfer.Review of a Nurse's Note dated 6/25/25 at 11:58 AM stated: Resident [R1] c/o (complained of) dizziness and fatigue. Pulse 45 and O2 (oxygen saturation) 70%. 2L (liters) nasal cannula applied, O2 increased to 80%. Pulse increased to 49. This writer contacted PA (Physician's Assistant) and received an order to send to ER (Emergency Department). EMT contacted and resident transferred to ER.Review of the Prehospital Care Report Summary from EMS for the 6/25/25 transfer revealed that EMS arrived at 10:33 AM. The Narrative History Text stated that EMS arrived to find R1 lying in bed. Patient (R1) was surprised they were there to transport her to the ED. Staff stated they believed her pain medication had caused her heart rate and SpO2 to drop. R1 stated she felt better and refused to go to the ED. Contact was made with the ED Physician, who confirmed that if the patient was alert and oriented (A&Ox4) and refused, she could not be forced to go. R1 continued to refuse. Staff then stated, we will not give you any kind of pain medication if you stay here. R1 responded, you will put me into DT (delirium tremors) if you do that. Staff allegedly replied, that's fine, I will make you go to the hospital when you are unconscious. Per the EMS prehospital summary, R1's vital signs were as follows on 6/25/25 at 10:41 AM (seven minutes after arrival) Blood pressure 139/75 Pulse 54 SPO2 93%. At 11:06 AM (while still at the facility) blood pressure 127/67 Pulse 77 SPO2 92%. The vitals show that R1 was hemodynamically stable.In an interview on 8/20/25 at 10:47 AM, Confidential Staff Member K described RN C as snippy and rude and reported hearing her say things like, well if you would follow what you're supposed to do, this wouldn't be happening. At 12:03 PM, LPN S stated that R1 was visibly upset over medication changes and felt she was treated differently by RN C. At 12:48 PM, LPN L stated she was present during the 6/25/25 hospital transfer. RN C reportedly said, Can you help me, [R1] is getting on my nerves and won't go to the hospital. LPN L

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2575924Based on interviews and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act.Findings Include:Review of the medical record reflected that R1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including chronic pain syndrome, carpal tunnel syndrome, jaw pain, muscle spasms, restless legs syndrome, opioid dependence, intervertebral disc disorders (a condition that affects the disc between the vertebrae of the spine), adjustment disorder with mixed anxiety and depression, temporomandibular joint disorder (causing pain and dysfunction of the jaw), migraine, post-traumatic stress disorder, dental caries, anxiety disorder, depression, low back pain, and sciatica. The Minimum Data Set (MDS) reflected that R1 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS), a cognitive screening tool. R1 was no longer at the facility.Facility reported incident reflected on 6/30/25, RN C received a verbal order to increase R1's pain medication but did not enter it until 7/3/25. She admitted she failed to follow up with the physician in a timely manner. A physician statement dated 7/8/25 confirmed that the order for Norco was agreed upon with R1 on 6/30, but by the weekend, the changes were still not made. The Physician Assistant noted concern and intervened.Review of the facility reported incident dated 7/22/25 reflected Resident (R1) reported allegations against a staff member. R1 requested a review of a previous concern she had made that she did not feel was resolved. Upon further investigation, the NHA [covering Nursing Home Administrator] determined the need to report the allegation. A thorough investigation is being conducted. The alleged staff member will not return to work until a conclusion is made.Review of the Facility Reported Incident Report dated 7/22/25 indicated that on that date, covering NHA E reviewed two Concern Forms R1 had written on 7/5/25 along with the statements collected during the initial investigation. NHA E decided to formally report the allegations and initiate a separate investigation, as R1 continued to express unresolved concerns. R1 alleged that Registered Nurse (RN) C had threatened her life and well-being by telling her that narcotic medications would be withheld if she refused to go to the Emergency Department. R1 also alleged that RN C failed to process a physician's order dated 6/30/25 to increase her pain medication.Review of a Resident Assistance Form completed by R1 and dated 7/5/25 stated: [RN ‘C’] threatened my life and my well-being. She refused to listen to my wishes. I have a detailed EMS (Emergency Medical Service) report which backs up my claims. [RN ‘C’] also refused to put in doctor's orders on Monday. A second Resident Assistance Form contained allegations of unequal treatment from RN C. R1 again accused RN C of nearly killing her, threatening her life and well-being, and added, people like RN ‘C' do not deserve to have anyone's life in their hands. If this doesn't stop, she will definitely kill more people. The form again referenced the EMS report from a 6/25/25 hospital transfer. Review of an Employee Corrective Action form dated 7/8/25 showed RN C was disciplined for not following through with a doctor's order. It also noted a prior written warning on 6/2/25 with no substantial improvement since. An Employee Warning Record dated 7/25/25 cited disciplinary action for the 6/25/25 incident. The summary noted that RN C communicated a verbal physician's order in a way that made the resident feel threatened, though the investigation did not find intent to threaten. It recommended better tone, body language, and communication during stressful situations. It further stated that when an order needs clarification, the provider must be contacted immediately, and documentation must reflect all steps taken to process or delay a physician's order.In an interview on 8/21/25 at 10:11 AM, covering NHA E stated that after reviewing the grievances dated 7/5/25, it was clear that these concerns were allegations of abuse and should have been reported to the State Agency within the two-hour time frame. The Facility Reported Incident was not reported until 7/25/25, 20 days later.