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	03/19/2026

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 0600 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake 2795434Based on observation, interviews and record review, the facility failed to protect the residents' right to be free from abuse verbal and physical from a staff member (CNA D) for one resident (resident #33) of two reviewed.Findings include: Resident #33 Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] revealed R33 was admitted to the facility on [DATE] with diagnoses that includes dementia. R33 scored 03 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) and was not interview able. R33 was observed sitting in her wheelchair on 03/17/26 at 8:40am upon approach R33 was pleasantly confused and not able to participate in a reliable interview. Review of the facility reported incident file included, Licensed Practical Nurse (LPN) C's unsigned statement written on a word document. The bottom of the word document had the dated 2/01/2026, it was unclear if that was the date of the incident or the interview with LPN C or who interviewed LPN C. The word document reflected LPN C was going to assist Certified Nursing Assistant (CNA) D with transferring R33 to bed using a mechanical lift. The statement reflected LPN C was a new nurse and upon entering the room R33 was mumbling and CNA D tapped R33 on the head. R33 didn't like it that and said she would report him and CNA D responded go ahead. According to the word document CNA D left the room LPN C stayed with R33 to comfort her, R33 reported she was didn't like being hit on the head and was scared. LPN C notified another Nurse, and the Nursing Home Administrator (NHA) A was notified. On 03/18/2026 at 10:10 AM during a phone Interview with LPN C stated she was a new employee and on 2/01/26 upon entering R33's room, CNA D was already in the room, R33 was agitated and mumbling and witnessed [name redacted] hit her upside the head and he then yelled Stop! LPN C stated CNA D went and retrieved R33s white board (used for communication due to R33's hearing impairment.) and wrote that LPN C was there to help her. LPN C reported R33 was still mumbling and agitated and raised her hands, at which time CNA D got in R33's face and started taunting R33, then grabbed her hands and pushed them down. R33 stated she was going to report him to the state and CNA D laughed in R33's face and said, go ahead, nobody cares about you! LPN C stated she had never seen anything like that and was very uncomfortable with CNA Ds aggressive treatment of R33. LPN C elaborated after CNA D left the room she stayed because R33 was upset stating she was afraid and didn't like being hit on the head. After R33 was settled she stated she was so uncomfortable by the interaction she told another Nurse who informed her the NHA A had to be notified. LPN C reported she informed NHA A the exact same chain of events that she just informed writer. Review of CNA D statement located in the facility incident file, unlike LPN C's statement, CNA Ds statement was on a facility form and included the name and position of the person being interviewed, who was conducting the interview, the date of the interview, the date of the incident, and location. CNA D's statement acknowledge/agreed he hit tapped her on the side of the head as he was trying to get R33's attention because she was yelling at the new nurse. CNA Ds statement went on to say he didn't hit R33 hard enough to make a sound and he could of chosen to tap R33 on the shoulder or arm but opted not to. The statement also acknowledged R33 stated she would report CNA D's statement and revealed CNA D told R33 to stop (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	saying that. On 03/18/2026 at 11:51 AM, during a phone interview with CNA D reported he was hired at the facility on 12/02/25 and quit after the facility reported incident because he knew he'd be fired and thought it would look better to have quit then be terminated. CNA D elaborated and stated LPN C was a new employee and new Nurse and didn't understand how to work with R33. CNA D said the moment LPN C walked into R33's room R33 was upset because she has dementia and LPN C was a stranger, CNA D stated he did in fact hit R33 on the head but not hard enough to hear it or leave a mark. When queried about R33 stating she was going to report him, CNA D responded that R33 did say that but he denied giving any response to R33. CNA D then elaborated that he was made aware by NHA A that it was alleged CNA D verbally abused R33, when quired about when NHA A informed him of the allegation against him for verbal abuse, CNA D stated it was the day of the incident as he was so panicked about being suspended. Stating he had called NHA A from the facility parking lot and was informed of allegations of verbal and physical abuse relating to R33. On 3/18/26 at 10:25am during an interview with NHA A he offered no explanation for CNA D's tapping R33 on the head and stated he was not aware of any allegation of verbal abuse and had planned to terminate his employment, but CNA D resigned before that happened. On 03/19/2026 at 11:55 AM, review of a past non-compliance (PNC) that was provided by NHA on 3/18/26 was reviewed. The PNC was related to resident-to-resident abuse and dementia care. When queried about the PNC provided, NHA A stated that was for an unrelated event. When quired if the facility had a PNC related to R33 and CNA D NHA stated there was no PNC for the incident at hand. Review of the facility's policy and procedure titled Abuse, Neglect And/or Misappropriation of Resident Funds or Property dated 5/13/14 with a revision date of 3/15/23. Page 2. defines physical abuse as includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment, which is physical including, but not limited to slapping of hands, flicking, or hitting with an object. The policy defines verbal abuse as any use of oral written or gestured language that willfully includes disparaging and derogatory terms to residents. Verbal abuse includes but is not limited to spoken, written or gestured language that includes insulting, offensive or disapproving terms to any resident (or within his/her hearing distance) regardless of age, disability, or ability to comprehend.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertain to Intake # 2795434 Based on observation, interview and record review, the facility failed to thoroughly investigate allegations of abuse for one resident (resident #33) of two residents reviewed for abuse.Finding include:Resident #33 Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] revealed R33 was admitted to the facility on [DATE] with diagnoses that includes dementia. R33 scored 03 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) and was not interview able. R33 was observed sitting in her wheelchair on 03/17/26 at 8:40am upon approach R33 was pleasantly confused. Review of the facility reported incident file included a word document with Licensed Practical Nurse (LPN) C's unsigned statement written on a word document. The bottom of the word document had the date of 2/01/2026, it was unclear if the 2/01/26 date was in reference to the date of the incident or the date LPN C was interviewed, the word document did not include who conducted the interview with LPN C or where LPN C was interviewed, (in person or via phone). The word document reflected LPN C was going to assist Certified Nursing Assistant (CNA) D with transferring R33 to bed using a mechanical lift. The statement reflected LPN C was a new nurse and upon entering the room R33 was mumbling and CNA D tapped R33 on the head. R33 didn't like it that and said she would report him and CNA D responded go ahead. According to the word document CNA D left the room LPN C stayed with R33 to comfort her, R33 reported she was didn't like being hit on the head and was scared. LPN C notified another Nurse, and the Nursing Home Administrator (NHA) A was notified. The statement/word document did not further query LPN C on what/how CNA D's tone of voice, inflection was used when he replied Go ahead to R33. statement included additional verbiage or the tone used. It also omitted CNA D yelling Stop at R33 while pushing R33's hands down. On 03/18/2026 at 10:10 AM during a phone Interview with LPN C stated she was a new employee and on 2/01/26 upon entering R33's room, CNA D was already in the room, R33 was agitated and mumbling and witnessed [name redacted] hit her upside the head and he then yelled Stop! LPN C stated CNA D went and retrieved R33s white board (used for communication due to R33's hearing impairment.) and wrote that LPN C was there to help her. LPN C reported R33 was still mumbling and agitated and raised her hands, at which time CNA D got in R33's face and started taunting R33, then grabbed her hands and pushed them down. R33 stated she was going to report him to the state and CNA D laughed in R33's face and said, go ahead, nobody care about you! LPN C stated she had never seen anything like that and she was very uncomfortable with CNA Ds aggressive treatment of R33. LPN C elaborated after CNA D left the room she stayed because R33 was upset stating she was afraid and didn't like being hit on the head. After R33 was settled she stated she was so uncomfortable by the interaction she told another Nurse who informed her the NHA A had to be notified. LPN C reported she informed NHA A the exact same chain of events that she just informed writer of. Review of CNA D statement located in the facility incident file, unlike LPN C's statement, CNA Ds statement was on a facility form and included the name and position of the person being interviewed, who was conducting the interview, the date of the interview, the date of the incident, and location. CNAD's statement acknowledge/agreed he hit tapped her on the side of the head as he was trying to get R33's attention because she was yelling at the new nurse. CNA Ds statement went on to say he didn't hit R33 hard enough to make a sound and he could of chosen to tap R33 on the shoulder or arm but opted not to. The statement also acknowledged R33 stated she would report CNA D's behavior and statement revealed CNA D told R33 to stop saying that. On 03/18/2026 at 11:51 AM, during a phone interview with CNA D reported he was hired at the facility on 12/02/25 and quit after the facility reported incident because he knew he'd be fired and thought it would look better to have quit then be terminated. CNA D elaborated and stated LPN C was a new employee and new Nurse and didn't understand how to work with R33. CNA D said the moment LPN C walked into R33's room R33 was upset due her dementia and LPN C was a stranger. CNA D stated he did in fact (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hit R33 on the head but not hard enough to hear it or leave a mark. When queried about R33 stating she was going to report him, CNA D agreed that R33 did say that, but he denied giving any response to R33. CNA D further stated that he was made aware of allegations made that he both physically and verbally abused R33. When queried how he was made aware of the allegations, CNA D stated after he was walked out /suspended on 2/01 he was panicked and called NHA A from the facility parking lot and NHA A informed him of allegations of verbal and physical abuse related to R33. On 3/18/26 at 10:25am during an interview with NHA A he offered no explanation for CNA D's tapping R33 on the head and stated he was not aware of any allegation of verbal abuse and had planned to terminate his employment, but CNA D resigned before that happened. When queried about CNA D's written statement about R33 reporting him and his written response was Go ahead did he probe further? i.e. the tone used or query LPN C about the statement. NHA A stated he knew nothing about it and was confused as to why LPN C stated she had reported it to him and was also confused as to why CNA D stated he was made aware of the allegations in detail by NHA A on 02/01/26. When queried why LPN C's interview was on a word document and not the facility form like CNA D's statement, NHA A stated he conducted the interview with LPN C from home on [DATE]. Which was why it did not have any signatures. When queried how/why CNA Ds statement was on facility form and signed by NHA A on the also on 02/01 NHA A offered no explanation. On 3/19/26 at 10:39am, during an interview with Senior Executive Director O she played voice mails from CNA D and showed text messages from CNA D to NHA A the correspondence revealed all was after 02/01/26 in which CNA D acknowledged hitting R33 on the head. Senior Executive Director O pointed out CNA D did not mention verbal abuse, and felt the statement CNA D acknowledge of go ahead possibly meant CNA D encouraged R33 to exercise her right to report him. There was no investigated pieces/documentation that the facility provided that reflected CNA D was encouraging R33's rights or investigation into LPN C' allegation that CNA D taunted, yelled and verbally abused R33. On 03/19/2026 at 11:55 AM, review of a past non-compliance (PNC) that was provided by NHA on 3/18/26 was reviewed. The PNC was related to resident-to-resident abuse and dementia care. When queried about the PNC provided, NHA A stated that was for an unrelated event. When quired if the facility had a PNC related to R33 and CNA D NHA stated there was no PNC for the incident at hand. Review of the facility's policy and procedure titled Abuse, Neglect And/or Misappropriation of Resident Funds or Property dated 5/13/14 with a revision date of 3/15/23. Page 2. defines physical abuse as includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment, which is physical including, but not limited to slapping of hands, flicking, or hitting with an object. The policy defines verbal abuse as any use of oral written or gestured language that willfully includes disparaging and derogatory terms to residents. Verbal abuse includes but is not limited to spoken, written or gestured language that includes insulting, offensive or disapproving terms to any resident (or within his/her hearing distance) regardless of age, disability, or ability to comprehend Page 4. Under investigative protocol read in part Interview the resident, the accused (if employee, suspend until investigation complete), and all witnesses shall include anyone who (1) witnessed or heard of the incident; (2) came in close conduct with either the resident the day of the incident (including other residents, family members, etc.); (3) employees who worked closely with the accused employee(s) and or alleged victim the day of the incident. To the extent possible, all interviews should be summarized into a written statement, which is signed and dated.