STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	254220	A. BUILDING _____ B. WING _____	**6/4/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KITH HAVEN	**G 1069 BALLENGER HWY FLINT, MI 48504**

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F0000 SS=	INITIAL COMMENTS Kith Haven was surveyed for an Abbreviated Survey exiting on 06/04/2025. Event ID: OBGO11 Intake Numbers: MI00152441, MI00152575, MI00152740, MI00153135, MI00153289, MI00153294 Census: 129	F0000		
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation pertains to intakes MI00153289 and MI00153294. Based on interview and record review, the facility failed to provide supervision for three residents (R5, R6, R7) of three residents reviewed for supervision, resulting in multiple resident to resident altercations. Findings include: Resident #5: R5 is 46 years old and admitted to the facility on 04/26/24 with diagnoses that include Huntington's disease, adjustment disorder with anxiety, cognitive communication deficit and schizoaffective disorder, bipolar type. R5 has a	F0689	F 689 Free of Accidents/Hazards Element 1 Resident #702 continues to resident within the facility. Resident continues to have a 1:1 for supervision. Resident care plan were reviewed and revised as appropriate. Resident #6 continues to reside in the facility. Resident care plans were reviewed and revised as appropriate. Resident #7 continues to reside in the facility. Resident care plans were reviewed and revised as appropriate Element 2 Like residents are identified as residents that reside within the facility involved in a resident to resident incident. The IDT made rounds on the like resident to ensure care planned interventions were in place in accordance with the plan of care, any concerns were addressed. Element 3 The procedure to implement the plan of correction included: 1. IDT reviewed F 689 2. IDT reviewed the “Abuse Policy” policy and deemed appropriate. 3. IDT were reeducated on the “Abuse ” policy with emphasis on ensuring interventions of	7/8/2025

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

Electronically Signed | 06/27/2025

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

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	brief interview for mental status (BIMS) score of 8, indicating mild cognitive impairment. Resident #6: R6 is 52 years old and admitted to the facility on 05/15/24 with diagnoses that include alcoholic cirrhosis of liver with ascites, adjustment disorder with depressed mood, chronic diastolic heart failure and pulmonary hypertension. R6 has a BIMS of 0, indicating severe cognitive impairment. Resident #7: R7 is 55 years old and admitted to the facility on 12/14/24 with diagnoses that include unspecified disorder of adult personality and behavior, adjustment disorder with depressed mood, bilateral above the knee amputations and anxiety disorder. R7 has a BIMS of 15, indicating they are cognitively intact. Record review of an Incident and Accident Investigation Form and progress note revealed that on 05/16/2025 at around 4:47pm, R5 and R7 were involved in a resident to resident altercation. The facility conducted a review of their camera system to aid the investigation. R7 was sitting at the front reception desk and signing back in to the building. R5 was observed to be walking towards the front door, at this time the receptionist approached R5 and redirected him away from the front door. R7 appeared to say something to R5 and that upset him, and he pushed the wheelchair and right shoulder of R7. R7 hit R5 on the arm and R5 walked away until they were escorted by the Director of Nursing (DON). R6 was present during There were no injuries noted during this interaction. R5 was directed out on to the back patio placed on every 15-minute checks.		supervision are in place and the care plans have meaningful interventions in place and have been implemented timely. All staff were reeducated to ensure they accompany the resident away from the environment in which the behavior has occurred. Element 4 The process to ensure that the specific citation remains corrected includes: 1. The Director of Nursing or designee will review with the IDT interventions to ensure adequate supervision is in place for resident incidents. The Admin will conduct rounds to ensure there is adequate supervision for residents involved in an incident. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. The Admin will be responsible for sustained compliance	

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	Record review of an Incident and Accident Investigation Form and progress note revealed that on 05/16/2025 at around 5:30pm, R5 and R6 were involved in a resident-to-resident altercation. The facility conducted a review of their camera system to aid the investigation. R5 re-entered the building from the back patio and walked up and down the hall and then eventually to the dayroom. R6 was observed sitting in the hallway and then got up and went to the dayroom. R5 exited the dayroom appearing upset and knocked over a mop bucket. The facility conducted an interview with a resident who observed the incident, and he stated that R5 swung at R6 multiple times and hit him once in the face. R6 stated that he approached R5 to scold him for the incident prior to this one where he hit R7 by the front door. R6 stated he stood up eye to eye with R5 and that R5 clocked him in the face four times, R6 stated he sat back down and went back outside. R5 was placed on 1:1 monitoring, R6 had a skin assessment completed and it revealed a small abrasion near his left eye. On 06/04/25 an interview was conducted with the DON. The DON was asked about R5. The DON stated that R5 has Huntington's disease and schizoaffective disorder, he is truly good if he is left alone. On the day in question, he was trying to go out the front door and the receptionist was handling it, R7 started shaking her finger at him and scolding him, this upset him and he open hand shoved her in the right shoulder. R7 then hit him on the arm. The DON was asked what intervention was put in place at the time of the incident to prevent further incidents. We put R5 on 15-minute checks for 72hours. The DON was asked about the second resident altercation that occurred after that. The DON stated that after the second incident that occurred, R5 was placed on 1:1 monitoring for 72 hours after that he had an escalation of behavior and was placed on 1:1 monitoring full time. The DON was asked about			

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	the mood of R5 during the 15-minute checks after the first incident. The DON stated that during the first three 15-minute checks R5 was out on the patio with the activities director and then R5 came back in the building and had an incident with R6. Was the activity director aware that R5 was on 15-minute checks and why R5 was on them. The DON stated, yes, the activity director was aware he was on 15-minute checks. We were aware he was coming back in the building on his own. The DON was asked why someone didn't accompany R5 back in the building after he had just had an incident with R7. The DON stated that the 15-minute checks were more to run interference to stop other residents from provoking R5. The DON was asked if someone should have been with R5 once he came back in the building. The DON stated we were in between 15-minute checks so someone wouldn't have necessarily been with R5 at the time. Documentation of the 15-minute checks were requested from the DON. The DON stated that there is no documentation of the 15-minute checks in the EMR. On 06/04/25 an interview was conducted with Activity Director "A". Activity Director "A" was asked if they knew why R5 was on every 15-minute checks. Activity Director "A" stated, I was not aware that R5 had an incident prior to him coming to the back patio, I told the DON that I didn't witness anything. But I came to the front reception area and took him out of the situation and out to the barbecue on the back patio. Activity Director "A" stated, when R5 was done at the barbecue I escorted him back into the building, I think R5 wanted something to drink, and I went and got that for him. When I returned with the drink, I was made aware that another incident had occurred with a resident. I have never seen him act out like that, I have seen him be frustrated in the past and knock stuff over.			

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	On 06/04/25 an interview was conducted with Receptionist "B". Receptionist "B" was asked about the incident that occurred by the front door. Receptionist "B" stated that R5 was trying to go out the front door, I redirected him to come back in, he was mad at me at this time. R6 and R7 were sitting at the front desk, and I think one of them said something to R5. R5 then hit R7and she hit R5 back. Receptionist "B" stated, I'm thinking that R5 might have been mad that he couldn't go outside. R6 and R7 could have been talking together but R5 might have thought they were saying something to him. R7 knows better to say anything to provoke him, she is always encouraging him and being nice. When I redirected R5 from the door we had to walk in between R6 and R7 to get out of the area. That could've been why R5 thought R6 and R7 were saying something to him. On 06/04/25 an interview was conducted with Social Worker (SW) "C". SW "C" was asked to tell me about R5 and his behavior in the facility. SW "C" stated that R5 is a very nice person, he has poor impulse control due to his Huntington's and psych diagnosis. When they did his Level 2, we were going to see if he could have specialized care, but they couldn't determine which diagnosis is more prevalent. SW "C" stated R5 can get upset, he does not like to be told "no". He loves pop and will ask you for pop constantly and he enjoys watching Nascar. Does R5 have a history of physical aggression without being provoked? There was an incident on 9/10/24, where R5 and R7 had an altercation when R7 attempted to redirect him from eating out of the garbage can, R5 hit her on the shoulder at that time. SW "C" was asked what kind of services does R5 receive here. SW "C" stated R5 sees Behavioral Care Solutions (BCS), which includes the nurse practitioner and the social worker. SW "C" stated that R5 also has a case manager that visits him from the Department of Health and Human			

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	Services (DHHS). SW "C" was asked, if based on R5's history of past incidents, do you think someone should have been with him when he came back in the building from the barbecue after his previous incident? SW "C" stated, yes, someone should have been with him. SW "C" was asked what their role is during investigations. SW "C" stated, I follow up with the residents, follow up with psych and update care plans to address the changes. On 06/03/25, R5 was observed resting in bed, being monitored 1:1 by staff in the room. Attempts were made to interview R5, but he would not respond. An interview was conducted with Dietary Aide "D", who was providing 1:1 care at the time. Dietary Aide "D" was asked if R5 leaves his room. Dietary Aide "D" stated, yes, when he does, I walk with him. He mostly just walks around. He doesn't really interact with any other residents and will sit in the lobby area. Dietary Aide "D" was asked if R5 seems confused when he talks. No, he seems pretty good to me. An interview was attempted with R6 to discuss the incidents and R6 refused to be interviewed. An interview was conducted with R7. R7 was asked about the altercation with R5. R7 stated that R5 thought I was talking to him, and he hauled off and hit me in the breast. R7 stated she was yelling at another resident (R6). R7 was asked if they thought R5 was purposeful in hitting her. R7 stated, yes, I believe it was, he knows better than that and he knows exactly what he is doing. He is much smarter than people give him credit for. When he sees me, he always calls me by name, he is more aware than they think. I have not had any issues with R5 since the incident. I told the DON that I would not interact with R5 for a while. R7 stated prior to this R5 elbowed me really hard in the right collar bone/shoulder area.			

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	R7 stated this happened a few months prior but could not recall when. I told the facility, and I don't think they did anything about. I believe they actually just threw the information out. Record review of the policy titled, "Abuse Prohibition," revealed: Procedure: D. Identification: 5. The facility supervisory staff will integrate into the supervisory process monitoring the behavior of staff members and guest/residents that are indicative of high stress levels that lead to abuse/neglect or may escalate a continuum of aggression. F. Protection of Guests/Residents during the Investigation. 4. f. Accompany the guest/resident to an area away from the environment in which the behavior has occurred. Use interventions identified by the interdisciplinary team to calm the guest/resident.			