STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235492	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheffield Manor Nursing & Rehabilitation Center	15311 Schaefer Rd Detroit, MI 48227

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to effectively clean and maintain the physical plant effecting 97 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage. Findings include:On 2/24/2026 at 9:00 A.M. during a tour of the kitchen the air vent covers and adjacent ceiling tiles over the tray line were heavily soiled with visible dust, fuzz strings and lint. The ceiling tile strips had areas of rust and corrosion over the steam table and dish room area. The Bakers pride convection (stove) was soiled with burnt ash and food residue. Both glass doors of the convection stove were soiled with yellowish colored stains and food residue that blocked visibility into the stove. The window panels and legs of the stove were soiled with splattered grease and collected food particles. The deep fat fryer needed cleaning and the grease needed changing. The grease was dark in color and had floating debris. The water drains under the three-compartment sink was soiled and discolored. The floors throughout the kitchen and dish room area needed deep cleaning. The crevasses and edges of the cracked tile in the cooking area were embedded with a visible collection of crumbs, grease and food preparation liquids. On 2/26/26 at 12:40 P.M. during an interview with Dietary Manager (DM) I concerning the cleaning of the kitchen equipment and environment, DM I stated, The department had a cleaning schedule and staff should be cleaning as they worked. The floor should be cleaned at least twice a day, but we are making adjustment in the staff responsibilities, and it may not be done as it has in the past. DM I acknowledged recently the dietary and housekeeping department had agreed to share their cleaning machine, but the dietary department could only use the cleaning machine when housekeeping allowed them to. The cleaning person previously assigned to do the cleaning is no longer here and we are trying to reassign those duties and address the cleaning. The 2002 FDA Model Food Code section 6-501.12 states: Physical facilities shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of food is exposed such as after closing. On 2/26/2026 at 8:43 AM, a tour of the laundry facility was conducted with Maintenance Director (MD) L. The following was noted. -Peeling floor paint on concrete flooring in front of washing machines estimated four feet by eight feet, an approximate 10-inch by 1/4 inch crack in the concrete floor directly in front of the washing (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	machines. -Soiled flooring on the sides and behind the washing machines. -Five cracked floor tiles in the clean linen room. -Four broken/cracked floor tiles in dirty laundry room. MD L said the flooring should be repaired and repainted and the cracked/broken floor tiles should be replaced. MD L agreed the floor could not be effectively cleaned due to the damaged flooring. On 2/26/2026 at 10:15 AM, the Nursing Home Administrator (NHA) was interviewed and agreed that the laundry room floor needed to be repaired and repainted. On 2/26/2026 at 10:45 AM, clean and sanitary environment and floor care policies were requested and not provided by the end of the survey.

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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 - Some	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 utilize safe food practices, provide a safe and sanitary kitchen for food storage, preparation service affecting 90 residents, resulting in the potential for food borne illnesses.Findings include:On 2/24/26 at 8:50 A.M. during observation of the tray line the ambience room temperature exceeded 100 degrees Fahrenheit. Three of the four employees on the tray line were observed with soaked perspired uniforms and facial masks. One employee was observed perspiring profusely as sweat trickled down her face, commenting, I need some air in here. During this observation a large clear container of raw chicken was stored on the counter approximately 20 minutes. The air conditioning units for the kitchen were observed off or not working.On 2/25/26 at 8:30 A.M., during observation of the tray line a colander of diced turkey cubes were thawing in the first sink of the three-compartment sink.At 12:20 P.M. a local vendor delivered 21 (assorted boxes of food) both frozen and staple supplies were stored on the floor without a pellet. Approximately 30 minutes later DM (Dietary Manager) I was observed labeling the boxes and placing them where the items belong. DM I was interviewed concerning who was responsible for putting up the items. DM I responded, this is one of the things we are trying to figure out. I don't have a stock person. I have one position that's not filled so I will put the stock away.At 1:30 P.M. during observation of the three-compartment sink, Dietary Aide O could not correctly identify the immersion time frame for sanitizing pot/pans in the sink.On 2/26/26 at 10:00 A.M. while observing the room temperature in the kitchen, 6-7 Rolls of ground beef was observed thawing in standing water in the cook's sink. DM I observed the observation and commented, .we normally defrost the frozen meat in the refrigerator, but the P.M. cook forgot to take it out of the freezer.The 2005 Food Code section 3-501.13 (Thawing) potentially hazardous foods shall be thawed (A) under refrigeration that maintains the food temperature at 5 degrees centigrade (41 degrees Fahrenheit) or less at 7 degrees centigrade (45 degrees Fahrenheit) or less. completely submerged under running water. (B) Completely submerged under running water. (C). Microwave- thawed food in a microwave oven if it is cooked just after thawing.When frozen food is thawed and exposed to the temperature danger zone, any pathogens in the food will begin to grow. To reduce this growth, never thaw food at room temperature.On 2/26 at 9:00 A.M. and on 2/26/26 at 1:00 P.M. employee personal clothing (hat/coat) was hanging in the kitchen from a storage rack among food supplies. During the observation D.M. I was queried concerning employee lockers for staff. D.M. I stated: the employees have lockers. Their personal coats, hats . should not be left in the kitchenOn 2/26/26 at 1:20 P.M. during an interview with the Administrator, Director of Nursing and Registered Dietitian, the Administrator explained the Dietary department was in the process of changing and addressing the concerns presented. A policy was requested and provided. The facility's policy dated 11/12/2021 titled Dietary Cleaning and Sanitation did not specifically address the aforementioned deficiencies. ,

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat one (R72) of three residents reviewed for resident rights, with dignity and respect during incontinence and routine activities of daily living care resulting in mistrust and discomfort, with the potential for mistreatment.Findings include:On 2/26/2026 at 11:30 a.m. R72 was observed in the hall, going to an activity, and wanted the interview to be held at the nurse's station. R72 was alert, oriented to person, place, and situation, and able to recall the incident that was alleged on 12/17/25. R72 said CNA D became upset because she needed to be changed. R72 stated, (CNA D) said why did you wait so long to be changed. You're always doing this. While we were in the bathroom, and I was on the toilet, she tossed the brief at me. I got mad because the aide (CNA D) had been good to me before this. What she did to me hurt my feelings, so I started to curse at her (CNA D). Although the aid apologized and I accepted it, I still didn't have a good feeling about what happened. The trust was gone. The aid (CNA D) would still come into the room, walk pass me without speaking and give care to my roommate. I would just leave the room every time she came in. R72 said they were uncertain why CNA D was still allowed to come into the room after what occurred and bothered them. R72 said the concern was expressed to the Social Worker. On 2/25/25 at 2:00 p.m. an attempt to contact CNA D was made via telephone. Review of clinical record revealed R72 was admitted into the facility on 8/13/16 with diagnoses that included Parkinson's disease with dyskinesia, adjustment disorder with mixed anxiety and depressed mood, generalized anxiety disorder, vascular dementia, major depressive disorder, hemiplegia, and cerebral infarction. According to the quarterly Minimum Data Set assessment dated [DATE], R72 was cognitively intact (BIMS-15), and required extensive one-person assistance with most activity of daily living. Review of the Social Service progress note dated 12/22/2025, documented in part the following: I was able to talk to (R72) about the incident with one of the CNAs throwing pamper at her. She mentioned that she is not sure what's going to happen to her. She just feels like she doesn't want to be around her anymore. On 02/26/2026 at 1:24 p.m. review of Daily Assignment forms, CNA D was assigned to R72's room on 1/17/26, 1/18/26 and 1/28/26. On 2/26/26 at 1:38 p.m. the Nursing Home Administrator (NHA) was interviewed about R72 allegation against CNA D and being assigned to R72's room. The NHA said the Abuse Coordinator (NHA) was responsible for ensuring the nurse aide's assignment was away from R72. The NHA said they were unaware CNA D continued to have contact with R72 and have the right to feel comfortable in the bedroom. The aide should have been removed from the unit and R72 should have never been made to feel uncomfortable by CNA D. The NHA informed SA, CNA D was terminated on 2/24/26 for an unrelated incident. There was no return communication from CNA D by the end of the survey. Review of the facility's policy titled Resident Rights, revision date of 5/14/24 documented the following in part: The facility protects and promotes the rights of each resident. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility. Residents have freedom of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules and regulations affecting resident conduct and those regulations governing protection of resident health and safety.

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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** Based on interview and record review, the facility failed to implement policies and procedures for ensuring the timely reporting to the state agency suspicion of a sexually transmitted disease for one vulnerable resident (R64) of three residents reviewed for abuse.Findings include:A review of R64's electronic medical record (EMR) revealed an admission to the facility on [DATE] with the diagnosis of Vascular Dementia with Agitation, Depressive disorder, and Chronic Obstructive Pulmonary Disease. A review of R64's Brief Interview for Mental Status (BIMS) disclosed a score of 00 (score of 00 indicates severe cognitive impairment).A review of R64's diagnosis list did not note a Herpes virus diagnosis nor a review of R64's previous medical record from another facility.Registered Nurse (RN H) documented the following on 8/15/25 at 3:00 PM: Resident (R64) with white bumps on her vaginal labia (skin folds (inner and outer lips) surrounding the vaginal opening), multiple whitish raised bumps. Labia appeared swollen. No complaints of pain or itching.RN H documented on 8/15/25 at 5:53 PM: Called (Doctor K) ordered to start acyclovir (prescription antiviral medication used to treat and manage herpes virus infections).for 7 days.A review of R64's laboratory order created by Nurse Manager M on 8/19/2025, noted testing for Sexually Transmitted Disease (STD):Results revealed R64's positive Herpes Simplex Virus (HSV) Type 1 and Type 2 on 9/2/2026.On 02/25/2026 at 2:49 PM, the Director of Nursing (DON) and Nurse Manager M were interviewed and reported they did not report the STD incident regarding R64 to the Abuse Coordinator. Nurse Manager M stated, No. I did not think nothing of it.On 02/26/2026 at 09:45am, the Nursing Home Administrator (NHA)/Abuse Coordinator was interviewed regarding not investigating and not reporting an unexplained STD. The NHA stated, This is not a case of abuse. there was no reason to report to the State Agency. The Abuse Coordinator stated that the labs proved that R64 had antibodies to the Herpes so there was no need to report or investigate. It was shared with the Abuse Coordinator that the physician started R64 on an antiviral medication on 8/15/25 used to treat herpes viruses, and R64 tested positive for Herpes on 9/2/25. However, the Abuse Coordinator was unable to explain why the suspicious incident was not reported to the State Agency at the time it occurred, followed by an investigation.

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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** Based on observation, interview, and record review, the facility failed to investigate the suspicion of a sexually transmitted disease for one vulnerable resident (R64) of three residents reviewed for abuse.Findings include:On 02/24/2026 at 11:30 AM, R64 was observed in bed, wearing a gown, with their eyes closed. R64 did not respond to name being called.A review of R64's electronic medical record (EMR) revealed an admission to the facility on [DATE] with the diagnosis of Vascular Dementia with Agitation, Depressive disorder, and Chronic Obstructive Pulmonary Disease. A review of R64's Brief Interview for Mental Status (BIMS) disclosed a score of 00 (score of 00 indicates severe cognitive impairment). There was no diagnosis of Herpes Simplex Virus Type 1 or 2.A review of R64's Care plan revealed the following: Focus Goal Interventions: (R64) is at risk for impaired skin integrity/pressure injury R/T (related to): Incontinence and debility Date Initiated: 10/30/2024 Created on: 10/30/2024. There was no update to the Skin integrity care plan.Conduct weekly head to toe skin assessments, document and report abnormal findings to the physician. Date Initiated: 10/30/2024 Created on: 10/30/2024.Observe skin with showers/care. Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care. Date Initiated: 10/31/2024 Created on: 10/31/2024.(R64) is at risk for decline in cognition and has impaired cognitive function or impaired thought processes R/T: Dementia, Inability to recall current season, location of room, staff names and faces, placement in nursing home. Date Initiated: 08/18/2025.Ambulation/Walking: Resident is unable to ambulate and requires a Geri chair for locomotion. Resident need to be pushed to desired locations. Date Initiated: 10/31/2024Revision on: 11/19/2025.A review of R64's progress notes noted the following:Registered Nurse (RN H) documented on 8/15/25 at 3:00 PM: Resident (R64) with white bumps on her vaginal labia (skin folds (inner and outer lips) surrounding the vaginal opening), multiple whitish raised bumps. Labia appeared swollen. No complaints of pain or itching.RN H documented on 8/15/25 at 5:53 PM: Called (Doctor K) ordered to start acyclovir (prescription antiviral medication used to treat and manage herpes virus infections).for 7 days.A review of R64's laboratory order created by Nurse Manager M on 8/19/2025, noted testing for Sexually Transmitted Disease (STD): Testing included the following:Herpes simplex virus (HSV)-1 (typically causes oral herpes)HSV-2 (genital herpes through sexual contact)Human immunodeficiency virus (HIV) AntibodySyphilis Antibody, Chlamydia and Gonorrhea (detected using a urine sample).Results revealed R64 positive for Herpes Simplex Virus (HSV) Type 1 and Type 2 on 9/2/2026.The order for the STD was signed in the EMR by Doctor K on 9/6/2025 at 6:54PM.*A Sexually Transmitted Disease panel test is a comprehensive, single-session screening that checks for multiple sexually transmitted infections.A review of R64's EMR revealed the following:- RN H observed R64 with white bumps on (their) vaginal labia, multiple whitish raised bumps, labia appeared swollen on 8/15/2025.-Doctor K was notified and ordered to start acyclovir on 8/15/2025.-Labs for STD were entered on 8/19/2025.-Labs for STD were collected by an outside agency on 8/29/2025.According to the Genital Herpes CDC -Fact Sheet, Herpes simplex virus (HSV) can infect many different parts of your body, most commonly your mouth area (oral herpes) and genitals (genital herpes). HSV causes fluid-filled blisters that break open and crust over wherever the infection is. This is known as a herpes outbreak. *A positive HSV IgG test indicates exposure to the Herpes Simplex Virus and has developed antibodies.On 02/25/2026 at 2:49 PM, the Director of Nursing (DON) and Nurse Manager M were interviewed about RN H documentation of R64's with white raised bumps on the vaginal labia, the appearance of swollen labia, and Doctor K labs and treatment ordered for Herpes Simplex Virus. The DON said she did not remember that occurrence. Nurse Manager M also said that she did not remember that incident. At this time, Nurse Manager M was reminded that she entered the laboratory order in R64's EMR on 8/19/25 and explained that she did not think anything of the STD labs and did not question the reason for the labs. Nurse Manager M was queried if there was a (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspicion of possible sexual abuse being that R64 was over [AGE] years old, with impaired cognitive function, and the fluid-filled blisters on R64's vaginal area. Nurse Manager M said she did not consider the thought of sexual abuse. Nurse Manager M said she did discuss R64's condition with the DON or the Abuse Coordinator (Nursing Home Administration-NHA).On 02/26/2026 at 09:45 AM, the NHA was asked if he was aware of R64's vaginal blisters, acyclovir medication, lab orders for STDs, and not investigating an unexplained STD. The NHA stated, This is not a case of abuse.we did not investigate it because there was no reason to investigate. The NHA stated that the labs (from 9/2/2025) proved that R64 had antibodies to Herpes so there was no need to investigate. The NHA was informed that the EMR revealed R64 was treated for the herpes virus and positive Herpes lab results were noted on 9/2/25. The NHA stated, The antibodies are proof that (R64) had it (herpes) before. The NHA did not respond to why the facility did not investigate at the time of R64's herpes diagnosis. The NHA was informed that the facility's EMR and R64's previous facility's notes did not reveal a previous Herpes diagnosis or outbreak.According to CDC Screening for genital herpes.*A positive HSV-2 IgG test indicates antibodies to the herpes simplex virus type 2, suggesting a past or current infection.*A positive IgG result cannot distinguish between a recent or distant infection.*The test detects IgG antibodies, meaning infected at some point in the past (weeks, months, or years ago).On 02/26/2026 at 10:43 AM, the DON was queried if an investigation was initiated related to R64 testing positive for Herpes Simplex Virus (HSV) Type 1 and Type 2. The DON stated, It should have been investigated. I don't know how this got passed me. The DON said she did not remember the incident and was not sure if she knew about the positive Herpes test.On 2/26/26 at 10:17AM, an attempt to contact RN H was unsuccessful. A voice message was left. On 2/26/26 at 10:21am, an attempt to contact Doctor K was unsuccessful. A voice message was left. A review of the facility's Abuse Prohibition Policy dated 9/9/2022 revealed the following: Allegations of resident abuse, exploitation, neglect.adverse event or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies.References: References:Centers for Disease Control and Prevention. Screening for genital herpes.Centers for Disease Control and Prevention (CDC). Genital herpes - CDC fact sheet.[NAME], L., Fan, M., [NAME], X. et al. Herpesvirus-associated diseases: biomarkers and advancements in clinical research. Virol J 22, 177 (2025). https://doi.org/10.1186/s12985-025-02795-7Mody, P. H., [NAME], S., [NAME], L. K., & [NAME], J. V. (2020). Herpes Simplex Virus: A Versatile Tool for Insights Into Evolution, [NAME] Delivery, and Tumor Immunotherapy. Virology : research and treatment, 1178122X20913274. https://doi.org/10.1177/1178122X20913274

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a bottle of hydrogen peroxide was not stored at bedside for one resident (R29) out of three residents reviewed for accidents.Findings include: On 2/24/2026 at 10:10 AM, a bottle of hydrogen peroxide was observed from R29's doorway stored on a bedside table in front of a container with R29's name written on it. When R29 was asked about the bottle, R29 said the bottle was hers but could not state the reason for the hydrogen peroxide. R29 was observed in a wheelchair and was able to self-propel and able to reach for items on her bedside table. R29 was alert and oriented times two and was difficult to understand.On 2/25/2026 at 9:00 AM, a bottle of hydrogen peroxide was observed on R29's bedside table.On 2/25/2026 at 9:15 AM, Registered Nurse E was observed entering R29's room and made R29's bed.On 2/25/2026 at 9:37 AM, a bottle of hydrogen peroxide was observed on R29's bedside table with Licensed Practical Nurse (LPN) F. LPN F was interviewed and said R29 should not have the hydrogen peroxide at bedside. LPN F stated, It's a potential accident due to her behaviors. LPN F said R29 has a history of spitting, hitting other residents and staff.On 2/26/2026 at10:30 AM, The Director of Nursing (DON) was interviewed and stated, The hydrogen peroxide should not be at bedside. It is a hazardous material. The DON further said R29 had a history of behaviors and resided on the lockdown unit because she needed increased supervision. Record review of R29's Electronic Health Record (EHR) revealed R29 admitted to the facility on [DATE] with pertinent diagnoses of Schizophrenia, Adjustment disorder with mixed anxiety and depressed mood, Dysphagia, and Violent behavior. There were no orders allowing self-administration of medications or an order for hydrogen peroxide. There was no evidence in the electronic medical record of an interdisciplinary team assessment for self-administration of medications. Review of the care plan did not reveal any interventions for self-administration of medications. Review of the facility policy titled Medication Administration revised 10/17/2023 revealed in part.Resident medications are administered in an accurate, safe, timely, and sanitary manner. Self-Administration-residents are allowed to self-administer medications when specifically authorized by the attending physician in accordance with the guidelines for self-administration of medication. A self-administration evaluation will be completed prior to the resident starting the self-administering process. Self-administering of medication will be reflected in the resident care plan along with any special considerations.

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview and record review, the facility failed to ensure adequate supportive personnel to consistently maintain the sanitation in the kitchen and ensure food safety practices were performed. This deficient practice had the potential to affect 90 of the 96 residents that consumed meals from the kitchen.Findings include:On 2/25/at 12:25 P.M. during observation of the sanitation in the kitchen Dietary Manager (DM) I stated, I am only budgeted for 9 employees a day Monday through Friday, that includes (Fine Dining for lunch), I cannot do any overtime. DM I was queried concerning the exact number of hours each employee worked a day. The manager explained about three weeks ago, an employee (stock person) had to be let go. DM I explained the stock person helped with the cleaning of the kitchen equipment, rotated stock and ensured the floors were cleaned and other things in the kitchen. Since that employee's vacancy all the staff, including the Dietary Manager, pitch in to complete the tasks normally performed by the stock person. DM I added that any further questions concerning replacement hours used for (call ins, vacation relief, and replacement of the stock person) should be referred to the Dietitian and or Administrator.On 2/26/26 at 1:00 P.M. during an interview with the Administrator, Director of Nursing and Registered Dietitian concerning the sanitation in the kitchen, the Administrator confirmed the number of budgeted employees (9) presently allocated but did not provide the exact budgeted hours or the basis for reference for the 9 employees. The Administrator indicated DM I was a Working supervisor and the allotted hours should be sufficient. The staffing schedule indicated the following schedule (A.M. shift) 1 cook, 3 aides, 1 porter 7 days a week), P.M. Shift (1 cook, 2 Aides, 1 porter 7 days a week). The Administrator reviewed proposed future changes in staffing by the end of the month; however, no actual numbers or other details were provided concerning the department's lack of personnel to perform and maintain sanitation in the department.On 2/26/26 at approximately 4:00 P.M the Administrator provided no additional information pertaining to the actual budgeted work hours per day for the department or the per patient day (PPD) amount used to calculate budgeted hours for the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235492	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheffield Manor Nursing & Rehabilitation Center	15311 Schaefer Rd Detroit, MI 48227

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive infection control program, encompassing outcome and process surveillance, accurate data collection/documentation/analysis, resulting in a lack of accurate and comprehensive infection control tracking, surveillance and data monitoring/analysis for one (R64) of six residents reviewed for infection control. Findings include:On 02/24/2026 at 11:30 AM, R64 was observed in bed, wearing a gown, with their eyes closed. R64 did not respond to name called.A review of R64's electronic medical record (EMR) revealed an admission to the facility on [DATE] with the diagnosis of Vascular Dementia with Agitation, Depressive disorder, and Chronic Obstructive Pulmonary Disease. A review of R64's Brief Interview for Mental Status (BIMS) disclosed a score of 00 (score of 00 indicates severe cognitive impairment).A review of R64's Care plan revealed the following:Observe skin with showers/care. Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care. Date Initiated: 10/31/2024 Created on: 10/31/2024.A review of R64's progress notes revealed the following:Registered Nurse (RN H) documented on 8/15/25 at 3:00 PM: Resident (R64) with white bumps on her vaginal labia (skin folds (inner and outer lips) surrounding the vaginal opening), multiple whitish raised bumps. Labia appeared swollen. No complaints of pain or itching.RN H documented on 8/15/25 at 5:53 PM: Called (Doctor K) ordered to start acyclovir (prescription antiviral medication used to treat and manage herpes virus infections).for 7 days.A review of R64's laboratory order created by Nurse Manager M on 8/19/2025, noted testing for Sexually Transmitted Disease (STD):Herpes simplex virus (HSV)-1 (typically causes oral herpes)HSV-2 (genital herpes through sexual contact)Human immunodeficiency virus (HIV) AntibodySyphilis Antibody, Chlamydia and Gonorrhea (detected using a urine sample).Results revealed R64's positive Herpes Simplex Virus (HSV) Type 1 and Type 2 on 9/2/2026.The order for the STD was signed in the EMR by Doctor K on 9/6/2025 at 6:54PM.On 02/25/2026 at 2:49 PM, the Director of Nursing (DON) and Nurse Manager M were Interviewed about RN B observation of R64 with white raised bumps on R64's vaginal labia, and the appearance of a swollen labia. In addition, Doctor K ordered acyclovir on 8/15/2025, and labs ordered on 8/19/25 for STD. The DON said she did not remember that occurrence. Nurse Manager M also said that she did not remember that incident. Nurse Manager M was reminded that she entered the laboratory order in R64's EMR on 8/19/25. Nurse Manager M stated, I was helping someone with entering the orders. Nurse Manager M added that she did not think anything of the STD labs and did not question the reason for the labs. Nurse Manager M was queried if there was suspicion of possible sexual abuse being that R64 was over [AGE] years old, impaired cognitive function, and the fluid-filled blisters on R64's vaginal area. Nurse Manager M said she did not consider the thought of sexual abuse. Nurse Manager M was asked if the vaginal blisters, immediate order for acyclovir, and personally entering the order for STD labs were discussed with the DON. The DON and Nurse Manager M stated, No. Nurse Manager M was queried if the vaginal blisters, acyclovir, and STD labs were discussed with the Abuse Coordinator. Nurse Manager M answered, No. I did not think nothing of it.On 02/26/2026 at 09:05 AM the Infection Preventionist N was interviewed and queried about R64 white raised bumps labia, and Doctor K ordered acyclovir on 8/15/2025. Infection Preventionist N said she did receive R64 being started on Acyclovir on her dashboard. Infection Preventionist N was asked if she implemented a surveillance plan for tracking, monitoring communicable diseases including R64's Herpes diagnosis. Infection Preventionist N stated, the physician (Doctor K) ordered the antiviral and that was it. (R64) did not need to be monitor.On 02/26/2026 at 09:45am, the Nursing Home Administrator (NHA) was interviewed and asked if he was the facility's Abuse Coordinator. The NHA answered Yes. The NHA was asked if he was aware of R64 vaginal blisters, acyclovir medication, lab orders for STDs, and not reporting an unexplained STD. The NHA said that the lab results proved that R64 had antibodies to the Herpes so there was no need to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report or investigate. The NHA said that Doctor K told him and the DON on 02/26/2026 that R64 had antibodies. The NHA stated, The scientific proof is in the lab results.*A positive HSV-2 IgG test indicates antibodies to the herpes simplex virus type 2, suggesting a past or current infection.*A positive IgG result cannot distinguish between a recent or distant infection.*The test detects IgG antibodies, meaning infected at some point in the past (weeks, months, or years ago).References:Centers for Disease Control and Prevention. Screening for genital herpes.Centers for Disease Control and Prevention (CDC). Genital herpes - CDC fact sheet.On 02/26/2026 at 10:43 AM, The DON was queried if they reported R64's unexplained positive for Herpes Simplex Virus (HSV) Type 1 and Type 2. The [NAME] stated, It should have been reported and investigated. I don't know how this got passed me. The DON said she did not remember the incident and was not sure if she knew about the positive Herpes test. The DON was asked if it was their process to update the care plan and diagnosis list of the Herpes diagnosis. The DON said the care plan and diagnosis list should have been updated.On 2/26/26 at 10:17AM, an attempt to contact RN B was unsuccessful. A voice message was left. On 2/26/26 at 10:21am, an attempt to contact Doctor K was unsuccessful. A voice message was left. A review of the facility's Infection Prevention Program Policy dated 10/11/2023 revealed the following: Resident Infection cases are monitored by the Infection Preventionist. The Infection Preventionist completes the infection Surveillance Tracking Tool in Infection Watch and:Reports to the Infection Prevention CommitteeProvides feedback to staff as needed.Reports notifiable diseases to the local health department as directed.Infection Preventionist responsibilities may include:-Collection, analyzing, and providing infection data and trends to nursing staff and healthcare providers.-Consulting on infection risk assessment, prevention, and control strategies.-Compliance with Infection Prevention practice is monitored and documented by the Infection Preventionist through surveillance and observation.