STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235506	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelby Health and Rehabilitation Center	46100 Schoenherr Rd Shelby Township, MI 48315

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on interview and record review, the facility failed to obtain a physician's order for an advance directive (form designed to communicate health care treatments in advance) upon admission for one resident (R106) out of two reviewed for advance directives. Findings include: A review of the medical record revealed R106 admitted into the facility on [DATE] with the following medical diagnoses, Cerebral Infarction and End Stage Renal Disease. A review of the most recent Minimum Data Assessment set revealed a Brief Interview for Mental Status score of 8/15 indicating an impaired cognition. R106 also required staff assistance with bed mobility and transfers. Further review of the physician orders revealed there was no advance directive order in place. On 3/5/2025 at 9:15 AM, an interview was conducted with Social Worker (SW) J. SW J stated the admitting nurse puts the code status order in on admission and that social work reviews it at the care conference. SW J stated that the nursing staff is responsible for putting the advance directive orders in and confirming them. On 3/5/2025 at 12:03 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the advance directive order should be entered upon admission. The DON stated they were unaware of why it was not completed with R106. A review of a facility policy titled, Advance Directives-Code Status revealed the following, .If the resident and/or their legal representative has chosen for the resident's code status to be a Full Code: o The physician's order for Full Code status will be entered into Point Click Care (PCC) using the template in the order's tab. From the physician order the resident's Full Code status will auto-populate and be prominently displayed on the resident's chart header in PCC and will also populate to the resident's face sheet.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44750 Based on observation, interview, and record review, the facility failed to provide sufficient feeding assistance for one resident (R142) out of one reviewed for Activities of Daily Living (ADL). Findings include: On 3/3/2025 at 12:07 PM, R142's lunch tray was observed sitting on the bedside table. R142 stated they were hungry but waiting for someone to help them eat. R142 stated they were visually impaired and needed feeding assistance. On 3/3/2025 at 12:14, 12:21 and 12:28 PM, R142's tray was still observed sitting on the bedside table, untouched. On 3/3/2025 at 12:31 PM, Physical Therapy was observed entering R142's room and mentioning R142 had not eaten lunch yet. R142 was heard stating they were still waiting for feeding assistance. On 3/3/2025 at 2:30 PM, R142 stated someone did come and help them eat, but the food was cold so they did not eat much. A review of the medial record revealed R142 admitted into the facility on [DATE] with the following diagnoses, Cerebral Infarction and Dysphagia. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 10/15 indicating an impaired cognition. R142 also required staff assistance with bed mobility and transfers. Further review of the physician orders revealed R142 was supposed to be a 1:1 feeding assist and were in a trial period. On 3/5/2025 at 8:45 AM, R142's breakfast tray was observed sitting beside their bed. R142 stated they were waiting for somebody to come back because they wanted more French toast. R142 stated they did not know how long they had been waiting for someone to come back, but it had been a while, and they were hungry. On 3/5/2025 at 9:00 AM, R142's breakfast tray was still observed in the room. R142 stated they were still waiting on assistance to finish their breakfast, and they were still hungry. On 3/5/2025 at 9:01 AM, Registered Nurse (RN) E was informed R142 was waiting for someone to help them finish breakfast. RN E stated someone was in there helping and they would go and see if R142 was still hungry. R142 was heard informing RN E that they were still hungry and needed further assistance. On 3/5/2025 at 9:20 AM, Registered Dietitian (RD) R. RD R stated R142 is a 1:1 feed because they are visually impaired. RD R stated R142 should continue to be a 1:1 feed because they just discontinued their tube feeding and should be encouraged to eat on a consistent basis. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/2025 at 12:06 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the staff should leave the tray on the cart until staff is ready to go in the room and provide feeding assistance. The DON stated they expect for staff to stay with the resident until they are done assisting the resident. A review of a facility policy titled, Assistance with meals noted the following, .It is the Center's Policy that all patient/residents shall receive assistance with meals in a manner that meets their individual needs and per Plan of Care.

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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** 49699 Related to MI00150481 Based on interview and record review, the facility failed to ensure one resident (R131) of one reviewed for outside of facility consultations recieved the recommendations from an consultant appointment. Findings Include: Review of the medical record for R131 revealed an admission into the facility on [DATE] with pertinent diagnoses of: Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety. R131 was evaluated by a consulting hearing service. The consulting physician was unable to remove impacted ear wax for R131 and recommended a medication to soften the wax with a return visit in 1-3 months. That order was not noted or carried out. An interview with the responsible Social Worker C revealed the process for communication occurs when the Social Work receives the completed consult/report, reviews the documentation and requests appropriate orders from physician and/or sets up follow up appointment. SW C revealed the consult and the recommendation was missed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled for two residents (R51 and R78) of ten residents reviewed, three of thirteen medication carts. Findings include: R78 On 3/3/25 at 1:30 PM, an observation was made of a medicine cup filled with a red liquid on R78's dresser. R78 was interviewed and asked about the medicine cup on their dresser and stated, I think it's cough medicine. R78 was asked if they self-administered their medication and said nursing administered their medications to them. On 3/3/25 at 1:35 PM, Unit Nurse Manager, Licensed Practical Nurse (LPN) I was requested to come to R78's room and was shown the medicine cup on R78's dresser and asked about it. LPN I indicated the medicine cup contained a protein supplement and removed the medicine cup from R78's dresser and discarded it. A review of R78's electronic medical record (EMR) indicated the following physician's order, Start date: 1/22/25; End date: 3/5/25. Order: House Liquid Protein Source One time a day for Protein assistance. Further review of R78's EMR revealed R78 was most recently admitted to the facility on [DATE] with diagnoses that included, Sepsis (Infection) and Paroxysmal atrial fibrillation (Irregular Heartbeat). R78's most recent minimum data set assessment dated [DATE] revealed R78 had a moderately impaired cognition and was fully dependent and/or required maximum assistance for all activities of daily living (ADLs) other than toileting and eating. 49102 R51 On 03/03/25 at 9:25 AM, R51 was observed sitting up in bed finishing their breakfast tray. A bottle of Vitamin C and a bottle of Vitamin B-12 were observed sitting on the night stand. When asked about the bottles, R51 stated, Those are my bottles, I take one of each pill every day. On 03/04/25 at 1:15 PM, R51 was observed sitting up in the bed watching television. The same bottles of Vitamin C and Vitamin B-12 was observed on the nightstand. A review of R51's medical record revealed they were admitted to the facility on [DATE] with diagnoses including mild dementia, generalized anxiety disorder, adjustment disorder and hypertensive heart disease. A review of R51's Minimum Data Set, dated dated dated [DATE] revealed the Brief Interview for Mental Status score of 15 indicating intact cognition. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/25 at 1:18 PM, the Director of Nursing (DON) was asked to accompany surveyor to R51's room. Upon entering R51's room, the DON noted the two bottles of vitamins on the bedside table. The DON stated R51 has not been assessed for self administration of medications and should not have medications at the bedside. 49699 On 03/04/25 at 02:10 PM, during a review of the low numbered medication cart with Licensed Practical Nurse (LPN) A, on Unit 100, a narcotic (Norco) tablet was found in a medicine cup, partially dissolved. LPN A revealed they had given a resident the narcotic with they're other medication and the resident spit it out. LPN A explained they were waiting for a second nurse to dispose of the medication appropriately. On 03/04/25 at 02:35 PM, during review of the high numbered medication cart for unit 300 with LPN F, A KwikPen Humalog insulin pen was noted without a label or date. LPN F indicated the KwikPen should have a label and date. On 3/4/2025 at 03:00 PM, review of medication storage and labeling for Unit 400 medication , low number cart with LPN B, two KwikPen Humalog insulin were found without identifying label or open date. On 03/04/2025 at 2:30 PM, an interview with the Director of Nursing (DON) revealed that wasted narcotics are to be wasted in the container that renders the medication harmless, at the time the medication is not going to be used after removing from the medication cart. The DON revealed this process requires two licensed nurses. On 3/5/25 at 11:04 AM, the Administrator (NHA) was interviewed regarding their expectations for medication storage and labeling. The NHA indicated that all medications should be stored safely. A review of a facility policy titled, Medication and Treatment Storage Issued Date: 8/7/2023 revealed the following, Policy Overview: It is the policy of this facility to ensure accurate labeling and dating of medications for safe administration and safe secure storage .of all medications and treatments. Labeling of medications and biologicals dispensed by the pharmacy will be consistent with applicable federal and State requirements and currently accepted pharmaceutical principles and practices including expiration dates . Medications designed for multiple administration, the label will identify the specific resident for who it was prescribed. Multi-use vials will be dated when the vial is first accessed. All medications requiring refrigeration are stored in refrigerators in the medication room .logs are kept on each refrigerator and temperature levels are recorded daily .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to honor food preferences for one resident (R142) out of one reviewed for food. Findings include: On 3/3/2025 at 12:28 PM, R142's lunch tray was noted to be sitting on their bedside table. A review of their dietary ticket had dislikes-no cucumbers with it highlighted in a pink color. An observation of the side salad revealed cucumbers on the salad. R142 stated they do not like cucumbers, and the kitchen staff often put them on even though they've said they do not want them. A review of the medical record revealed R142 admitted into the facility on [DATE] with the following diagnoses, Cerebral Infarction and Dysphagia. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 10/15 indicating an impaired cognition. R142 also required staff assistance with bed mobility and transfers. On 3/5/2025 at 9:43 AM, an interview was conducted with Dietary Manager (DM) Q. DM Q stated the dietary staff should read the tray ticket, and they highlight it to make sure it is seen. DM Q stated that floor staff should also be checking before they give the resident the tray. A review of a facility policy titled Food Preferences and Select Menus noted the following, The facility will provide meals that accommodate resident allergies, intolerances, and food preferences.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to stock, demonstrate sufficient Infection Control practices, and don/doff (put on/take off) Personal Protective Equipment (PPE- gown, gloves, and masks) for three residents (R141, R17 and R106) in isolation and precautions out of three reviewed for Infection Control (IC). Findings include: R141 On 3/3/2025 at 11:57 AM, R141's call light was activated, and their intravenous (IV) machine was heard beeping. R141 had a PPE caddy on their door, with a sign stating they were on contact isolation (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident ' s environment) and should don gloves, mask, and gloves when entering room. On 3/3/2025 at 12:01 PM, a nurse was observed entering R141's room without putting on any PPE. The nurse was then observed to silence the IV machine, come back out and grab supplies to disconnect the IV machine from R141. The nurse was then observed to reenter R141's room without putting on PPE and disconnected R141's IV machine from the resident only donning gloves. A review of the medical record revealed R141 admitted into the facility on [DATE] with the following medical diagnoses, Osteomyelitis, Left Ankle and Foot. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 3/15 indicating an impaired cognition. R141 also required staff assistance with bed mobility and transfers. On 3/5/2025 at 11:30 AM, an interview was completed with Infection Control Preventionist (ICP) D. ICP D stated their expectation of staff entering a contact isolation room is that they don all appropriate PPE and stated the signs on the door clearly list what they should be putting on prior to entering the room and performing care. ICP D confirmed the nurse that entered R141 should have put on all appropriate PPE needed for contact precaution, including a gown, prior to disconnecting their IV. 38207 R17 On 3/3/25 at 10:53 AM, an observation of R17's room revealed signage which indicated R17 was on EBP (Enhanced Barrier Percautions -set of infection control practices). A PPE caddy (storage unit for PPE) on R17's door was observed to contain no gloves or face masks. On 3/4/25 at 11:00 AM and 3:52 PM, R17's caddy was observed to contain no face masks. On 3/4/25 at 3:56 PM, R17 and confidential family member S were interviewed and asked if staff consistently wore PPE when providing care for R17. R17 and family member S stated, I don't think so. On 3/5/25 at 9:38 AM, R17's caddy was observed to contain no gowns or face masks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/5/25 at 11:47 AM, ICP D was interviewed about their expectations for PPE which should be available in the door caddy of residents on EBP. ICP D indicated that the caddy should be fully stocked with gloves, gowns, and face masks. ICP D indicated the nurses on the units should be replacing the PPE in the caddy as needed. A review of R17's EMR revealed that R17 was most recently admitted to the facility on [DATE] with diagnoses that included Kidney failure and Post traumatic stress disorder (PTSD) (Mental health condition). R17's Nursing Admission Evaluation completed on 2/26/25 revealed that R17 had an intact cognition and required assistance for all activities of daily living (ADL's) including catheter care. 49699 R106 On 03/20/2025 at 07:35 AM, Licensed Practical Nurse (LPN) B retrieved the glucometer tray from medication carts bottom drawer and entered R106's room that had a PPE [NAME] on the door with a sign specifying what PPE to don (gown, gloves, and mask) for the room. LPN B was observed to place glucometer tray and blood pressure cuff on R106's bed without a barrier, hand hygiene was not performed, PPE was not used. LPN B was not satisfied with the reading obtained for R106's blood pressure and left the room to obtain a wrist blood pressure machine. No hand hygiene performed. Upon completion of these tasks LPN B took the equipment and left R106's room. Hand hygiene was not performed. Blood pressure equipment was returned to nursing station, the glucometer tray replaced in medication cart without cleaning. No hand hygiene was performed upon leaving R106's room. On 3/4/2025 at 2:00 PM, LPN B was asked what the cleaning protocol was for the glucometer and blood pressure cuffs. LPN B stated the glucometer tray, the glucometer, and the blood pressure cuffs were supposed to be cleaned with bleach wipes. The Equipment cleaning policy was requested but not received by end of survey.