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	04/02/2025

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

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 This citation pertains to Intake MI00151476. Based on interview and record review, the facility failed to provide supervision during medication administration for one resident (R900) out of one reviewed for self administration of medications. Findings include: On [DATE] at 9:43 AM, a phone interview was conducted with R900's Family Member (FM) E. FM E reported they were told the day that the resident died they complained about being short of breath (SOB). FM E reported that they were informed the nurse put the nebulizer mask on R900 and left the room. FM E reported they were informed when the nurse came back R900 was found to be unresponsive. A review of the medical record revealed that R900 admitted into the facility on [DATE] with the following medical diagnoses, Chronic Obstructive Pulmonary Disease (COPD) and Acute Respiratory Failure with Hypoxia. A review of the Minimum Data Set assessment (MDS) revealed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] indicating an impaired cognition. R900 also required staff assistance with bed mobility and transfers. No self-administration of medication assessment and/or care plan was observed in the medial record. Further review of the progress notes revealed the following, Effective Date: [DATE] at 9:43. Type: Nursing-Progress Note .Resident had complaints of SOB, resident instructed to sit up as [R900] was laying flat. Writer was able to administer medications PO (by mouth) with no issues. Writer started breathing treatment to assist with SOB, on returning 10 minutes later, resident was slump over to the right, face mask off and non-responsive to verbal or physical stimuli . On [DATE] at 2:00 PM, an interview was conducted with the Director of Nursing (DON). The DON reported they expect for the nurse to stay with a resident while a nebulizer treatment is going and if they have to leave, then someone needs to be in the room with them. A review of a facility policy titled, Nebulized Medication Treatments noted the following, .Stay with resident during nebulizer treatment unless it has been determined that resident can use nebulizer on own. (a self-medication assessment must be completed.

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

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F 0684 Level of Harm - 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** 44750 This citation pertains to intake MI00151590 Based on interview and record review, the facility failed to promptly identify, assess, and contact physician for an acute change in condition for one resident (R902) out of two reviewed for change in condition, resulting in pain and hospitalization . Findings include: A review of intake MI00151590 noted the following, This facility failed to provide [R902] with a timely evaluation of a head injury that likely was the cause of [R902's] mental status change and instead appeared to choose to attempt to sedate them. A review of the medical record revealed that R902 admitted into the facility on [DATE] with the following medical diagnoses, Acute Posthemorrhagic Anemia and Gastrointestinal Hemorrhage. A review of the admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status(BIMS)assessment score of 15/15 indicating an intact cognition. It was also noted on the MDS that R902 did not have any behaviors on admission. R902 also required staff assistance with bed mobility and transfers. Further review of the progress notes revealed the following, Effective Date: 3/12/2025.Cena (Certified Nursing Assistant) emptied foley catheter at 0600 (6:00 AM) and the bag was 550 [milliliters] and full of blood. Effective Date:3/12/2025. Transition of Care: Apixaban (Blood Thinner) 5 MG twice daily. Monitor for spontaneous bleeding. Effective Date: 3/21/2025. Writer notified by cena that resident had fallen .When asked what happen resident stated, I was trying to get out of bed, to come and tell you that a small bunny came and kissed me. I grabbed the reacher to help me stand and I fell . Effective Date:3/22/205. Resident experiencing brief moment of confusion, c/o dizziness, SPO2(oxygen level) checked 88% RA (Room Air) . Effective Date: 3/24/2024. Pt. (Patient) receiving o2(Oxygen) at 2 lpm (liters per minute), noncompliant with o2 therapy, pt. constantly removes nasal cannula. Pt. constantly removes nasal cannula. Pt. not easily redirected, constantly removing top shirt . Effective Date: .3/26/2025Writer entered resident room and observed resident was sitting on floor opposite side of bed. Resident was trying to put her shoes on. Resident foley was pulled out and laying on the bed . Resident stated [they] were trying to get out of this place .Writer notified DON (Director of Nursing), supervisor and family .Writer is being very uncooperative and combative. Writer notified (Medical Doctor) of resident's combativeness and ordered a onetime order of Haldol 5mg (milligrams) . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/2/2025 at 11:24 AM, an interview was conducted with Licensed Practical Nurse (LPN) C. LPN C reported they were R902's nurse on 3/26/2025 and had to send them to the hospital. LPN C reported they had taken care of R902 once before and this was a complete change in behavior for them. LPN C reported R902 was very combative, picking their skin, and attempting to hurt themselves and others. LPN C reported they originally were directed to give R902 Haldol for the new behaviors and then eventually sent them to the hospital. On 4/2/2025 at 12:00, and interview was conducted with Certified Nursing Assistant (CNA) B. CNA B reported that they cared for R902 the day they went to the hospital. CNA B reported they were informed by the nurse that R902 had fallen and when they went in the room R902 was saying that they were trying to kill them and would not calm down. CNA B reported they put R902 at the nurse's station and took turns sitting with them. CNA B reported that R902 was digging in their skin, taking off their oxygen, and picking at their skin. CNA B indicated this was not normal behavior for R902, and they had taken care of them previously. CNA B reported the nurse was on the phone with the Director of Nursing (DON) and they were telling them what to do. CNA B reported R902 was sent out after hitting them and digging and peeling their skin off. On 4/2/2025 at 2:00 PM, an interview was conducted with the DON. The DON was queried if anyone had reported that R902 had a foley bag full of blood as indicated in the progress notes. The DON reported no one reported that to them and they were unsure if the physician team was ever notified. The DON was queried regarding the documented confusion following R902's falls. The DON reported that when someone has a unwitnessed fall, they complete the neurochecks and will send them out if there is a change. The DON reported they know R902 came into the facility with a 15/15 BIMS score but was unsure if there was always some underlying confusion. The DON was asked about giving R902 Haldol, instead of sending them out when there was a change in their behaviors. The DON stated they were unable to answer why the physician made that decision, but they sent R902 out when they began picking their skin and hitting people. A review of a facility policy titled, Change in Condition Notification noted the following, The nurse will notify the resident, the resident's physician/practitioner, and the resident's designated representative when there is: A significant change in the resident's physical, mental, or psychosocial status, such as deterioration which includes life-threatening conditions of clinical complications.