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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>235506 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                            | (X3) DATE SURVEY COMPLETED<br><br>07/10/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Shelby Health and Rehabilitation Center |                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>46100 Schoenherr Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>This citation pertains to intake MI00153799.</p> <p>Based on observation, interview, and record review, the facility failed to maintain a sanitary environment in one of one kitchenettes located off the main dining room. Findings include:</p> <p>Review of a complaint intake received 6/19/25, noted that on 6/18/25, the cupboard located underneath the sink in the main dining room kitchenette, was observed to be wet and stained with mold.</p> <p>On 7/9/25 at 10:20 AM, the kitchenette located off the main dining room was observed with the Administrator. The cabinet located under the sink was observed with water damaged doors. The particle board was swollen and warped from past water damage. The bottom shelf of the cabinet was wet, and there was a black, mold-like substance on the surface. The Administrator stated he was unaware of the problem with the cabinet, and would have it cleaned right away.</p> <p>On 7/9/25 at 10:30 AM, the Administrator stated they had spoken over the phone with the Maintenance Supervisor and said that Maintenance wasn't aware it looked as bad as it did. The Maintenance Supervisor stated the issue with the cabinet was seasonal due to the warmer weather and humidity.</p> |

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