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	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelby Health and Rehabilitation Center	46100 Schoenherr Road 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This citation pertains to intake 2568581.Based on observation, interview and record review, the facility failed to ensure resident care needs were met timely for six residents (R707, R700, R708, R709, R706, and R704) of twelve reviewed for resident care. Findings include: R707On 09/04/25 at 9:23 AM, R707 was interviewed and reported their number one concern was that staff do not answer the call bell all the time. R707 reported the call system had been down on their unit for at least a month and a half and they had been given a small hand bell to ring when help was needed. R707 further reported they did not feel safe with the call system down, especially when put in the bathroom. R707 noted the hand bell was not brought into the bathroom. R707 noted they required staff assistance to get up (using a stand lift) and could not ring the bell more than two or three times before they dropped it due to numbness in the hands. R707 was observed to have bilateral wrist and hand splints. R707 reported they just wanted a little respect as yesterday it was an hour and a half before they were assisted to the restroom and that was too long to hold pee. R700On 09/04/25 at 9:25 AM, R700 was interviewed in their room. They were sitting up in their wheelchair and dressed. The call lights were observed to be hanging on the wall over the junction box. The resident was asked about the call lights and indicated they were not working. When asked how they request assistance from staff the resident reported they have a bell to ring, and they looked around but were not able to locate their bell. R700 noted the need for assistance with dressing, transfer and bathing. R708 and R709On 09/04/25 at 9:34 AM, R708 and R709 reported the call light system had been down for a long time. R708 reported when their roommate R709 had first come to their room, R708 observed R709 leaning over the side of the bed having a breathing problem and neither of them had a working call light to alert staff. Both further noted one can only ring the hand bell a short amount of time. R709 further noted they felt like they were not being heard. R708 reported they were more independent and R709 noted they needed assistance to transfer and use the restroom. R706On 09/04/25 at 10:56 AM, R706 was observed to be in bed dressed in a hospital gown. The wheelchair and walker were away from the bed. The walker at the foot of the bed and the wheelchair. R706 reported they had told staff just after breakfast they wanted to be changed, dressed and up in their wheelchair and did not recall the exact time. R706 tugged at their gown and reported they had other clothes they could wear. A urine odor was noted and R706 noted they needed to be changed. R706 was asked about what they needed help with and reported to shower and get dressed. R706 was then observed to ring their hand bell and no one came. An observation of the hall revealed no staff in the hall of the unit and one at the nurse station who did not no response to the hand bell ring. At 11:08 AM R706 rang again with no staff response. At 11:24 AM, Certified Nursing Assistant (CNA) C reported they could hear a bell and would just have to walk down the hall and ask the resident who it was. R704On 09/04/25 at 12:27 PM, R704 reported it was hard to hear their call bell as they were down at the end of the hall. R704 reported they need help with things like a brief change, and it could vary from five minutes to a couple hours for the wait time. R704 reported staff really can't tell who it is that is ringing the bell and what happens if the need is more urgent. On 09/04/24 at 12:38 PM, Licensed Practical Nurse (LPN) D reported the call light system was an electrical issue and most every unit was affected. LPN D reported each new admission is given a hand bell. LPN D further commented it was hard to distinguish where ring was coming from, and they may not hear it if not in the immediate area. At 12:45 PM, CNA E reported call light system problems going back four months and reported it was difficult when more than one resident was ringing their handbell at the same time. CNA E noted one would have to go to the rooms of the residents and ask if they had rung their bell. At 1:19 PM, CNA H reported they had worked on the 300 unit and was told the unit call system was not working and the residents had been given hand bells, but had not had any specific training or program change related to resident assistance or monitoring, At 1:45 PM, the Assistant Maintenance Director (AMD) reported the call system had been down for three and a half weeks after a repair blew out two other boards. It was completely down on five units at the facility. The AMD did not have a date for the completion of the repair. On 09/04/25 at 2:16 PM, the Director of Nursing (DON) was asked about the call system outage and reported new admits are given hand bell and staff are expected to round on the residents. The DON confirmed unit one, three, five, seven and nine had the call light outage. The DON was asked about discussion of an action plan in the Quality Assurance (QA) meetings and reported they were not sure if there was a formal education plan written, but it was discussed.A request for an action plan for call lights from QA was requested to be provided if available on 09/04/25 at 3:23 PM via email and not received prior to survey exit.A review of the QA committee agenda