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	04/30/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2982336.Based on interview and record review, the facility failed to ensure a copy of the care plan and updates were provided to the resident or the resident representative for one resident (R120) of two reviewed for participation in care planning. Findings include: On 04/28/2026 at 1:53 PM, two resident representatives (Representatives one and two) were seated bedside with R120. The two representatives were listed on the resident's face sheet as contacts for R120. The representatives reported R120 had been at the facility since 03/27/26 and expressed concerns and frustrations about the timing of care and lack of information provided. It was reported the representatives had been told R120 was no longer receiving physical (PT) or occupational therapy (OT) and themselves, or the Power of Attorney (POA) had been informed or received an explanation. The representatives also reported two messages were left with the with Director of Nursing (DON) on Friday (4/24/26) and they had not heard back. A review of the medical record documented R120's therapy end date as 04/27/26. On 04/28/2026 at 2:44 PM, the Director of Rehab Services (DORS) reported they were trying to clarify R120's status in order to continue with Rehabilitations Services which included PT and OT. The end date of 04/27/26 was reported as correct but there seemed to be some miscommunication as they had to determine if R120 met the need for skilled care. The DORS reported no notification for the end of services had been given the POA.On 04/28/2026 at 4:08 PM, a third listed representative of R120, reported an email had been sent to the social worker and others about care concerns and what was happening with the resident and no reply had yet been received. The representative also indicated frustration with timely response or any response to queries about R120.On 04/28/29 at 4:29 PM, Physician C had entered during an observation of wound care for R120. The Administrator also arrived at the door with Social Worker (SW) B to R120's room around this time and reported on some communications with the representatives of R120. On 04/29/2026 at 11:41 AM, a phone call was made to the POA. The POA reported they had sent a professional email Saturday (04/25/26) morning to the SW B, the Administrator and the Medical Director about concerns with the care for R120 did not hear from anyone over the weekend (did not expect to hear over the weekend) and waited until the end of business the following Monday. The POA had not heard back from them and attempted to call the Medical Director and a message was left. The POA commented it was tough to tell who you were leaving a message for due to the voicemail recording indicating you reached extension xyz (recording on voicemail). The POA reported they did finally get a call from (Physician C) on Tuesday (04/28/26) who filled in all the details that should have been given prior to that point. The POA further reported they felt updates should have been given all along and commented requests had fallen on deaf ears and staff always, regardless of who it was, pass the buck and you get the run around. Information has not been consistent. The POA was asked if they had a copy of the care plan and reported they had not received one. The POA recalled the orientation meeting but did not receive a care plan at that time. On 04/29/2026 at 4:25 PM, SW B reported R120 representatives and the POA did attend the initial care conference, and the standard of practice would be to offer and provide a copy of the plan of care and orders to the POA at the time of the care conference. SW B reported their (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact with the POA was to update them on insurance reviews and discharge plans. SW B reported any representative under the contacts in the electronic medical record (EMR) could receive information about R120 from staff. SW B confirmed an email had been received from the POA related to care concerns and it had been sent to the administrator and other staff. SW B reported no prior contact with R120's representatives other than the POA. A review of the care conference notes in the EMR dated 03/30/26 and 03/31/26 revealed the checks under section seven titled Plan of Care were left blank.On 04/30/2026 at 8:27 AM, the administrator reported they had communicated with the POA who was reported to be at their wits end. On 04/30/2026 at 10:02 AM, Unit Manager (UM) E reviewed the progress noted for R120 and noted some representative complaints about wound care and R120 not eating and if staff were even trying to assist R120. UM E reported they had addressed these concerns with them and acknowledged the staff may be able to do better. On 04/30/2026 at 10:31 AM, Licensed Practical Nurse (LPN) F reported R120's family had asked them about the wound dressings and R120 not eating enough.On 04/30/26 at 2:53 PM, the DON acknowledged the identified concerns and reported there was a new team in place, and they were actively working on improvements in patient care.A review of the record for R120 revealed R120 was admitted into the facility on [DATE]. Diagnoses included Dementia, Heart Disease, and Pressure Ulcer of the Sacral (lower back and tailbone area).The April 2026 Treatment Administration Record (TAR) documented order changes for the heel wounds on 04/05 and 04/16 and the addition of a right lower extremity wound on 04/18. A treatment initiated 04/22 for a skin tear on the top of the left foot. The Minimum Data Set (MDS) dated , 04/02/26 documented, severe cognitive impairment, the dependence on staff for lower body dressing, toileting, rolling left and right in bed, sitting at the side of the bed and transfer. Substantial/Maximal assistance was required for upper body dressing.The active care plan initiated 03/27/26 documented, Difficulty Hearing .Impaired Vision .risk for fall . chronic pain . self-care deficit . indwelling urinary catheter . pressure ulcer .encourage and assist to reposition . at nutritional risk .A review of the care plan additions since the original care conferences included: Cognitive risk of Fluctuation initiated, 04/06/26 . resident wishes to return to community home, initiated 04/06/26 . At risk for changes in behavior and mood, initiated 04/06/26 . Risk for dehydration, initiated 04/07/26 . has anemia, initiated 04/07/26 . has hypothyroidism, initiated 04/07/26 . monitor nutritionally pertinent labs initiated 04/07/26, RD to evaluate and make diet change recommendations, initiated 04/07/26 . risked constipation, initiated 04/07/26 .Actual infection of urinary tract, initiated 04/15/26 . A wound consult note date 04/24/26 noted the three existing wounds to the buttocks had merged into one. A review of the progress notes did not indicate contact to the POA related to changes in the care plan and wounds.A review of the facility policy titled, Change in Condition Notification with reviewed date of 02/02/26, revealed, It is the policy of the facility to notify the resident, his or her attending physician/practitioner, and the resident's designated representative of changes in the resident's medical/mental condition and/or status . The nurse will notify the resident, the resident's physician/practitioner, and the resident's designated representative when there is: An accident or incident involving the resident which results in an injury and has the potential for requiring physician/practitioner intervention. A significant change in the resident's physical, mental, or psychosocial status, such as deterioration which includes life-threatening conditions or clinical complications. A need to alter the resident's medical treatment significantly such as: A new treatment. Discontinuation of current treatment due to adverse consequences, an acute condition, or exacerbation of a chronic condition .