

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235662	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Shelby Crossing Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 13794 21 Mile 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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>32220</p> <p>Based on observation, interview, and record review, the facility failed to ensure opened biologicals were dated or had an identifier on the medication in three of four medication carts reviewed. Findings include:</p> <p>On 03/25/25 at 8:56 AM, the 300 unit medication cart was observed with Licensed Practical Nurse (LPN) A. Four inhalers were not dated when opened or noted with an identifier on the inhaler these included Advair, albuterol and Symbicort. In the 300 medication room a tuberculin multi-use vial was not dated when opened.</p> <p>On 03/25/25 at 9:58 AM, during a medication pass observation the 200 B medication cart was observed with LPN B. An Incruse inhaler and a fluticasone inhaler were observed to be without a date opened on the inhaler and without a resident identifier on the inhaler. Two opened insulin pens were observed without an opened date on the pen.</p> <p>On 03/25/25 at 10:24 AM, the 200 A medication cart was observed with LPN C. A Lantus insulin pen and a Lispro insulin pen for the same resident were without a date opened on the pen. A Humalog insulin pen and a Lantus insulin for a second resident were without a resident identifier and an opened date on the pen. LPN C reported they had come with the resident from the hospital. Two albuterol Inhalers for a third resident were not dated when opened on the inhaler.</p> <p>On 03/26/25 at 10:33 AM, the Director of Health Services reported staff should date items on the actual vial for the tuberculin. It was also reported that at times the pharmacy does not provide a patient label for the medications such as inhalers and the insulin pens.</p> <p>A review of the facility policy titled, .when the original seal of a manufacturer's container or vial is initially broken the container or vial will be dated. A date opened sticker will be placed on the medication. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date .</p> <p>A review of the prescribing information from the Incruse.com web site revealed, How should I store Incruse Ellipta? Store Incruse Ellipta in the unopened tray and only open when ready for use. Safely throw away Incruse Ellipta in the trash 6 weeks after you open the tray or when the counter reads 0,</p> <p>(continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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NAME OF PROVIDER OR SUPPLIER Shelby Crossing Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 13794 21 Mile Road Shelby Township, MI 48315	

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>whichever comes first. Write the date you open the tray on the label on the inhaler .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>32220</p> <p>Based on observation, interview, and record review, the facility failed to perform appropriate hand hygiene and or sanitize a blood pressure cuff during two of six medication pass observations. Findings include:</p> <p>On 03/25/25 at 8:25 AM, Licensed Practical Nurse (LPN) A was observed to bring a machine to measure vital signs into the room of R 30. LPNA place a blood pressure cuff on the right arm of R30. R30 was on enhanced barrier precautions related to a foot wound. Upon completion of the medication pass, LPN A was observed to wheel the machine into the common area. The blood pressure cuff was not observed to be cleaned.</p> <p>On 03/25/25 at 9:58 AM, LPN B was observed to exit the room of a resident and move the medication cart and a vitals machine to the doorway of another resident. LPN B was observed to bring the vitals machine into the room and check the blood pressure of the resident on their bare left arm. Upon completion of the vitals checks the machine was placed outside the room. The cuff was not observed to be cleaned. LPN B was then observed to prepare 11 medications from the medication cart. The medications were placed on a barrier and transported into the room and placed on the overbed table. LPN B tore open the packages of pill to put them into a medication cup. During this process one of the pills popped out and onto the barrier. LPN B picked up the pill and placed it into the medication cup without first completing hand hygiene or putting on a glove. LPN B picked up a pill splitter and gloves from the medication cart. No hand hygiene was completed before application of the gloves and the return to the medication cart. The pill was cut and the gloves were doffed. No hand hygiene was observed and the pill splitter was not observed to be cleaned. LPN B returned to the medication cart and used a spoon to place some applesauce into the pill cup for the resident. No hand hygiene was observed prior to return to the medication cart. LPN B completed the medication pass after the resident was assisted with two inhalers. LPN B then washed their hands and exited the room.</p> <p>On 03/25/25 at 11:30 AM, the infection control nurse reported gloves should be used to pick up any pill designated for consumption by a resident.</p> <p>On 03/26/25 at 10:33 AM, the Director of Health Services confirmed: the need for gloves to pick up the pills if dropped on the barrier and returned to the cup; the need to complete hand hygiene before and after glove use; and the need to clean the blood pressure cuff after each resident use.</p> <p>A review of the facility policy titled, Medication Administration - General Guidelines revised 11/2018 revealed, .The person administering medication adheres to good hand hygiene: before beginning a medication pass, prior to handling any medications, after coming into direct contact with a resident, .examination gloves are worn when necessary, .hand sanitization is done with an approved sanitizer between handwashings, when returning to the medication cart or preparation area, .at regular intervals during the medication pass .</p>		