STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504014	A. BUILDING _____ B. WING _____	9/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBY HEALTH AND REHABILITATION CENTER	46100 SCHOENHERR RD SHELBY TOWNSHIP, MI 48315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS The Shelby Health and Rehabilitation Center Nursing Home was surveyed for an Abbreviated survey on 09/27/23. Intakes: MI00133219, MI00133738, MI00134323, MI00134500, MI00135035, and MI00135407. Census: 175	F0000		
F0689 SS= G	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00135407. Based on interview and record review, the facility failed to ensure the assessed number of staff were used during shower care for one resident (R901) of three whose falls were reviewed resulting in a resident fall from a shower bed and sustained bruising, lacerations and bleeding to the face and head. Findings include: A review of a complaint for R901 revealed: "On 9/14/23, (R901) had one person assisting (them) in a shower and (R901) was dropped during the shower. (R901) sustained multiple fractures to the nose, jaw and skull." Additional injuries included five fractures to the right eye socket, 18-20 stitches on the forehead and a brain bleed. (R901)	F0689	F689 Free of Accident Hazards/Supervision/Devices Per 2567 Facility Failed to: •Ensure the assessed number of staff were used during shower care POC Responses Element 1 Resident R#901 no longer resides in the facility. Element 2 All residents who currently reside in the facility who require 2 person bathing assistance have the potential to be impacted by the identified event. Any resident who requires 2 person bathing assistance will be added to the Like Resident list. Any new admission to the facility that are assessed at requiring 2 person assist for bathing will be added to the Like Resident List. Element 3 All licensed CNAs will receive education (which includes return demonstration) of how to look up the bathing status of each resident in order to ensure the correct number of staff	10/10/2023

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

Electronically Signed | 10/06/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504014	A. BUILDING _____ B. WING _____	9/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBY HEALTH AND REHABILITATION CENTER	46100 SCHOENHERR RD SHELBY TOWNSHIP, MI 48315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	is currently at the hospital. The complaint further noted: the aides are overworked with 25 or more residents to care for at times, only one person was used for transfer to the shower bed with the lift, there are not enough lifts to provide timely care and the rails on the shower bed were held up by pins and did not function properly. Further concerns reported included not being fed regularly, not awakened to be fed, not given water consistently and incontinence not cleaned up timely. A review of the facility Risk Management Report dated 09/14/23 at 1:18 PM, documented, "Resident observed laying on their right side in shower room after rolling out of the shower chair during a staff assisted shower. Laceration observed to right side of forehead with bleeding...Bruising to right flank and right shoulder, Bruising observed to ridge of nose with nasal bleeding present, 911 was called and resident was taken to (hospital name). Daughter at bedside...Occasional labored breathing, Load moaning or groaning, crying, facial grimacing, rigid, fists clenched, knees pulled up, pulling or pushing away, striking out, unable to console, distract or reassure..." On 09/27/23 at 12:03 PM, Unit Manager "G" was asked about R901's fall and reported: The Certified Nurse Assistant (CNA "K") was giving R901 a shower and during the shower R901 fell from the shower bed. The railing went down when the CNA turned R901. A number of nurses responded to the fall. R901 was seen on their right side next to the shower bed. The CNA said they were turning R901 and R901 slipped out of the shower bed. R901 was assessed and treated and then picked up with a carrying blanket and sat into a wheelchair. The daughter was present after the fall. The Unit Manger reported there was nasal bleeding and bruising to the bridge of the nose. The Unit Manager was asked about the care		are utilized for residents who require a 2 person assist with bathing. Element 4 As part of the Quality Assurance process, the IDT team will identify residents who require 2 person bathing assistance. Any new admission to the facility that are assessed at requiring 2 person assist for bathing will be added to the Like Resident List. DON or designee will conduct audits 3x per week for 5 weeks to ensure CNAs can demonstrate how to access the Kardex ADL task list. DON or designee will also conduct audits 4x per week for 5 weeks to ensure that the number of staff present and actively engaged in showering task is correct per plan of care. Element 5 The facility opts for a date of compliance of October 10, 2023. Any negative findings noted on audits will be address and run through QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504014	A. BUILDING _____ B. WING _____	**9/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBY HEALTH AND REHABILITATION CENTER	**46100 SCHOENHERR RD SHELBY TOWNSHIP, MI 48315**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plan status and noted R901 was a two person for the lift but was not sure of the shower bed mobility. Unit Manager "G" reported the CNA was in the shower room by themselves and was let go (terminated) after the incident. Unit manager "G was asked about staffing at the time of the fall and reported there were six regular aides and the one shower aide. There was not a second shower aide. On 09/27/23 at 2:03 PM, the Administrator, Director of Nursing (DON) and an Administer-In -Training were present and R901's fall was reviewed. The Administrator reported the root cause was that only one person was used when two should have been. The Administrator admitted the facility was at fault and had educated staff post the fall. The Administrator also reported it was determined the aide did not intentionally injure R901. On 09/27/23 at 2:48 PM, the DON was asked about the events around R901's fall and reported they had been in a meeting at the time of the fall but did go down to see R901. They could tell the face was "split" and that R901 had nasal bleeding and the head was wrapped. When asked about the cause the DON reported R901 was a "two person assist" and only one was in the shower with R901. The DON was asked about staffing and reported it was a "work in progress" and staff have been hired but not all remained with the facility. On 09/27/23 at 2:52 PM, the Maintenance Supervisor was asked about the shower bed used by R901 during the the fall and reported it was functioning properly at the time. It was also reported that they were unaware if any concerns about the shower bed had been reported as there were none entered in the (maintenance) system.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504014	A. BUILDING _____ B. WING _____	**9/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBY HEALTH AND REHABILITATION CENTER	**46100 SCHOENHERR RD SHELBY TOWNSHIP, MI 48315**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 09/27/23 at 2:58 PM, CNA "I" was asked about the normal daily routine for R901 and reported they check on R901 at the start of their shift to see if they are wet and R901 was normally dry, R901 would be left in bed until just before lunch, then they would get R901 up and clean up R901 and combed R901's hair and then put R901 out in the lounge for lunch, then after lunch R901 was taken back to bed and checked on until their shift ends. CNA "I" reported to be on the unit but did not see the transfer of R901 to the shower bed and was not asked to assist in the shower for R901. CNA "I" reported they would normally give R901 a bed bath. CNA "I" reported two persons were used by them during a bed bath and transfers. CNA "I" reported that the unit R901 resided on was a "heavy" unit with a lot of lifts and two person residents. CNA "I" reported days when it is "crazy" and it not able to get a break unless "you force it" and may not sit down for their whole shift. On 09/27/23 at 4:23 PM, CNA "K" was asked about the fall incident with R901 and reported, "It was a hectic day. I had to do 12-13 showers by myself." CNA "K" reported they had been scheduled to do a double shift that day. CNA "K" reported that the shower bed had been broken for years according to the other aides and nurses. CNA "K" reported that the hoyer lifts were supposed to be two people but aides operated them with one (staff member) "all the time" in order to transfer residents and get care done. CNA "K" reported that the daughter had helped transfer R901 to the shower bed. CNA "K" commented that the daughter was happy that R901 was getting a shower and had never had a shower. CNA "K" confirmed they were the seventh aide and was assigned to the showers. CNA "K" reported that the expectation of the DON was to give showers and not bed baths and do whatever it took to get them done. CNA "K" reported the other staff , nurse and unit managers watched			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504014	A. BUILDING _____ B. WING _____	9/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBY HEALTH AND REHABILITATION CENTER	46100 SCHOENHERR RD SHELBY TOWNSHIP, MI 48315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	them push resident in and out of the shower room all day by them selves and did not comment or ask if help was needed. CNA "K" was asked how the fall occurred and reported that they were turning R901 away from them to further clean R901 and when R901 was turned the rail went down and R901 went onto the floor. CNA "K" then commented, "In that building you have to do everything yourself" and reported they did what they thought they were expected and had to do. A review of the record for R901 revealed R901 was admitted into the facility on 03/09/20. Diagnoses included Alzheimer's, Dementia, Joint Contractures and Diabetes. A review of the Minimum Data Set (MDS) assessment dated 06/15/23 indicated severely impaired cognition and the need for extensive assistance of two persons for bed mobility and total assist of two persons for transfers. The need for total care assistance of one person was indicated for locomotion, dressing, and personal hygiene. A review of the nursing care plan "ADL (activities of daily living) and mobility deficits related to ongoing health events" dated 03/09/20 documented, "Bathing Hygiene requires two (person) assist...Bed mobility two person assist..." A review of the facilty policy titled, "Fall Risk / Injury Prevention" approved 06/20/22, documented, "It is the policy of this facility to assess every resident for fall risk and provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents... A care plan will be completed for each resident to address items identified on the fall risk assessment and/or by the IDT team. The care plan will be updated accordingly. The care plan will include			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504014	A. BUILDING _____ B. WING _____	**9/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBY HEALTH AND REHABILITATION CENTER	**46100 SCHOENHERR RD SHELBY TOWNSHIP, MI 48315**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interventions, including recommended assistance, consistent with a resident ' s needs, goals, and current standards of practice in order to reduce the risk of an accident..." A review of the facility policy titled, "Care Plan - Comprehensive and Revision" revised 08/25/23 documented, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident... The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment."			