

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Shell Rock Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 920 North Cherry Street Shell Rock, IA 50670	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858</p> <p>Based on observation, clinical record review, interviews, facility policy, and investigation review, the facility failed to ensure staff provided a safe transfer with a mechanical lift for 1 of 4 residents reviewed that required transfer assistance (Resident #1). Resident #1 sustained a fall on 2/19/24 from a mechanical lift transfer when the mechanical lift sling strap came undone resulting in Resident #1 falling to the floor feet first, striking their head, and receiving a left subtrochanteric femoral fracture (hip fracture). The facility reported a census of 34 residents.</p> <p>Finding include:</p> <p>Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired decision-making abilities. Resident #1 required substantial to maximal assistance with transfers and bed mobility. The MDS included diagnoses of cerebrovascular accident (stroke), non-Alzheimer's dementia, hemiplegia/hemiparesis (weakness/paralysis to one side of the body), and generalized weakness. Resident #1 had no falls since entry.</p> <p>The Care Plan Focus dated 6/8/21, identified Resident #1 as a high fall risk due to their history a stroke. The Goal listed Resident #1 wouldn't have a major injury related to a fall. The Interventions indicated Resident #1 required the assistance of two staff for transfers with a full mechanical lift with the large divided leg sling.</p> <p>The Care Plan Focus dated 2/19/24, identified Resident #1 had a left femur fracture related to a fall. The Goal reflected Resident #1 wouldn't have signs or symptoms of pain, would return to their previous routine, and have diminished pain. The Interventions directed the following:</p> <ol style="list-style-type: none"> a. Resident #1 required a full-body mechanical lift to transfer and reposition with two staff members. b. Up in wheelchair for all meals. c. Stabilize left leg during bed mobility - no twisting or turning leg inward or outwards, limit hip bending as much as possible. <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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An undated Self-Report reflected on 2/19/24, at approximately 11:00 AM, the Director of Nursing (DON) notified the Executive Director, Resident #1 fell from the full-body mechanical lift and sustained a laceration to his scalp. The facility sent him to the hospital by ambulance. The Hospital faxed documentation to confirm pelvic fracture on 2/21/24, around 9:00 AM. On 2/19/24, at approximately 10:20 AM, Staff A, Certified Nursing Assistant (CNA), and Staff B, CNA, provided perineal (peri-) care to Resident #1 in his room. Staff B heard the call light of another room go off over the walkie and left Resident #1's room to check on the other resident. Staff A continued working alone with Resident #1. Staff A connected Resident #1's sling to the full-body mechanical lift and began to transfer him from the bed to the wheelchair. Resident #1 began to vigorously cough, causing the sling to come undone from the hook on the lift. Resident #1 slid out of the sling, fell to the floor, and started to bleed from the top of his scalp. The DON's head to toe assessment on 2/19/24 revealed a bleeding head wound and decreased responsiveness. At 11:00 AM, on 2/19/24, emergency medical services (EMS) arrived and left with Resident #1 at approximately 11:20 AM. The inspection of the full-body mechanical lift sling used to transfer Resident #1 revealed the sling intact with no rips or tears. The Maintenance staff inspected the mechanical lift following the incident. The lift had a missing spring in the black loop clip on the full-body mechanical lift. Maintenance replaced the spring on 2/19/24, and tested the full-body mechanical lift to ensure proper functioning. Staff A and Staff B stated the full-body mechanical lift and clips worked properly prior to initiating the transfer. Resident #1's Care Plan at the time of the incident directed he required two staff for the full-body mechanical lift transfer. Two staff were not present as stated in the Care Plan at the time of the incident. The community will continue to follow the current Care Plan and add therapy's recommendations for transfers and repositioning. The maintenance staff inspected all of the mechanical lifts and slings in the facility on 2/19/24, to ensure they worked properly. On 2/19/24, the DON educated Staff A and Staff B on the facility's safe resident handling policy and observed them complete a full-body mechanical lift transfer in accordance with the facility full-body mechanical lift competency. The DON would educate all nursing staff regarding the facility safe resident handling policy and transfer competency.</p> <p>A Facility Fall Report and corresponding progress note documented by the DON, on 2/19/24 at 10:45 AM, revealed a CNA called from Resident #1's room requesting help and stated a resident fell . Upon entering the room, witnessed Resident #1 lying on his left side on floor, with a large amount of bloody drainage surrounding his head. The CNA reported she transferred Resident #1 with full-body mechanical lift, when he started vigorously coughing and the strap to lift came undone. At that time Resident #1 fell to the floor, hitting his head. Staff applied pressure to his observed laceration on his right occipital (back part of the brain). The nurse initiated a neurological (neuro) that revealed Resident #1 had a decreased response and labored breathing. The staff continued talking with Resident #1 and he became more alert, responding to questions with appropriate answers. The facility called the ambulance to transport him to the emergency room (ER).</p> <p>The Adverse Event Note dated 2/19/24 at 11:16 AM, reflected a CNA requested help in a</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>resident's room because a resident fell . Resident #1 laid on his left side on the floor with a large amount of bloody drainage surrounding his head. The CNA reported as she transferred Resident #1 with the full-body mechanical lift, he began vigorously coughing and the strap came off the lift dropping Resident #1 to the floor, hitting his head. The staff applied pressure to the laceration on his right occipital. The completed neuro checks and head to toe assessment revealed decreased responsiveness and labored breathing. The nurse talked with Resident #1, as he became more alert, responding to questions with appropriate answers. The nurse contacted an ambulance for transport to the ER. The facility notified his wife who planned to meet him at the ER. At 11:00 AM, emergency medical services (EMS) arrived and left with Resident #1 at approximately 11:20 AM.</p> <p>Interview on 5/9/24 at 11:15 AM, Staff A confirmed on 2/19/24 at approximately 10:20 AM, Staff B and her placed the full-body mechanical lift sling underneath Resident #1 while he laid in bed, and then attached the sling to the full-body mechanical lift. Staff B heard on the walkie another resident had a call light sounding, so Staff B left his room. Staff A continued to transfer Resident #1 without Staff B assistance. While Staff A swung Resident #1 around to position him in the wheelchair with his back to the wheelchair, Resident #1 started to cough and on the third cough the front right side on the sling popped off the lift. Resident #1 started to fall out of the sling. Staff A stated that she attempted to stop him from falling but couldn't get around the full-body mechanical lift before Resident #1 landed on the floor. She hollered for a nurse to come to the room to assist Resident #1. Staff A recalled the sling and full-body mechanical lift in good working condition. Staff A, confirmed the facility policy instructed to always transfer a resident with two staff at all times. Staff A confirmed the facility educated her on using two staff with mechanical lift transfers at all times, double check sling placement, and the sling is connected correctly.</p> <p>Interview on 5/8/24 at 3:45 PM, Staff B confirmed on 2/19/24 at approximately 10:20 AM, Staff A and her placed the full-body mechanical lift sling underneath Resident #1 while he laid in bed, and then attached the sling to the full-body mechanical lift. Staff B heard a call light going off in another resident's room on the walking and then left Resident #1's room. When Staff B returned, she saw Resident #1 on the floor with blood coming from their head. Staff B stayed with Resident #1 and Staff A went into the hallway to summon a nurse. Staff B couldn't recall the position of the full-body mechanical lift or if the lift had the sling attached. Staff B verified it is the expectation to always use two staff with a full-body mechanical lift transfer. Staff B reported they received education on using 2 staff at all times with the mechanical lift transfers, double check sling placement, and check the sling connection.</p> <p>Interview on 5/9/24 at 11:45 AM, the DON, stated that on 2/19/24 approximately 10:20 AM, Staff A, came out of Resident #1 room screaming that she needed a nurse immediately. The DON went right away and found Resident #1 on the floor perpendicular (similar to a T) to Resident #1's bed. His wheelchair sat at the end of the bed and the full-body mechanical lift in the northwest corner with the bar about 60 inches (5 foot) off the floor, with the sling still attached to the full-body mechanical lift, and the right front strap of the sling was off the bar of the full-body mechanical lift. The DON confirmed they expected the staff to always use 2 assists with all full-body mechanical lift transfers. They verified educating Staff A and Staff B on the required use of 2 staff with mechanical lift transfers, double check the sling placement, and check correction connection of the sling to the lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 5/8/24 at 2:15 PM, the Executive Director explained their investigation of the incident on 2/19/24, determined incompatibility of the brand of full-body mechanical lift and the slings used by the facility. The facility threw all the incompatible slings away and ordered new slings for the specific full-body mechanical lift. The facility inspected the full-body mechanical lift after the incident and found a sprung black clip on the right upper side of the bar, that wouldn't spring back. They put that lift out of commission until fixed. The Executive Director confirmed they expected the staff use 2 staff for full-body mechanical lift transfers.</p> <p>Interview on 5/8/24 at 2:30 PM, the Maintenance Director, explained after the incident on 2/19/24, the facility inspected the full-body mechanical lift and found the left back spring, sprung not letting the black clip spring back into place. They took that full-body mechanical lift out of commission until they replaced the spring. The Maintenance Director they inspected the full-body mechanical lift every Monday morning. That full-body mechanical lift didn't get inspected until after the incident.</p> <p>Review of Resident Lifts: Inspect mobile lifts signed by the Maintenance Director on 2/19/24 indicated they replaced the clip spring on full-body mechanical lift after fall. They inspected all of the full-body mechanical lifts slings without concerns.</p> <p>The Full-Body Mechanical Lift competency checklist updated 5/11/21, signed on 2/19/24 by Staff A and Staff B, reflected they received education, in addition to verbal and hands-on demonstration of facility procedure for use of the full-body mechanical lift. Procedures include:</p> <ul style="list-style-type: none"> *Prior to conducting the transfer task, the two caregivers agree on who will take the lead and who will be the helper. *The sling and lift are visually inspected to assure both are in good condition prior to use. The sling is checked to make sure it is the correct size. *The two caregivers agree on the loops to be hooked up to the lift. *Both caregivers agree the clips and loops are secure to the lift and in proper position prior to moving the resident and positioned safely in the sling. *The lead pulls the lift from the bed. The helper may assist with moving the lift away from the bed if required but should primarily assist with turning the lift. *The helper should always maintain contact with the resident during the transfer. *Immediately stop transfer if resident moves, ensure resident safety and proper positioning then resume transfer. If unable to ensure safe positioning stop transfer and lower resident to safest positioning available, such as bed or chair <p>On 5/8/24 at 3:15 PM, observed Staff C, CNA, and Staff D, CNA, transfer Resident #1 with the full-body mechanical lift and a full body sling. Staff C and Staff D demonstrated proper transfer technique. They checked the engagement of the black safety clips and the sling didn't have frayed edges on the loops.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Safe Resident Handling Policy revised January 2016 directed to minimize or eliminate the manual lifting of a resident whenever possible. This is to ensure the safety of the resident and caregiver during transfer and repositioning task.</p> <p>Objective Criteria: Each resident will be assessed initially upon admission. Any changes in transfer status will be reassessed on an as needed basis or thorough quarterly reassessments. Nursing or therapy will determine the resident's transfer status based on the following criteria, but nursing has the final decision on the mode of transfer:</p> <p>Total Body Lift: (requires 2 caregivers)</p> <ol style="list-style-type: none"> 1. Resident is unable to bear weight. 2. Resident is unable to participate in transfer process. 3. Any other transfer type is excluded due to a medical condition or co morbidity. <p>Inspection:</p> <p>All lifts, slings, friction reducing devices, and lateral transfer devices will be visually inspected prior to use. If slings, friction reducing devices, or lateral transfer devices are noted to be ripped, torn, fraying, or have separating seams, they will not be used. Remove the damaged item from service and tag it as DO NOT USE. Any mechanical lift noted not in proper working condition or has potentially dangerous changes in assembly (i.e. nut/bolt loose on boom or wheel loose) should immediately be marked and tagged as DO NOT USE. Needs Repair. Tags are available at the nursing station or the DON's office. The staff will notify the charge nurse and maintenance as soon as possible. Staff must use a different mechanical lift for transfers. Complete the monthly maintenance on the lifts per manufacturer guidelines to ensure they are in good working order. If maintenance determines the lift is not safe to use, the maintenance department will mark and tag lift as DO NOT USE. Needs Repair and will either repair lift, or will contact vendor for them to repair lift. Tags are available at the nursing station or the DON's office.</p>		