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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165309	A. Building B. Wing	09/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shell Rock Senior Living	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)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review and staff interview the facility failed to code the Minimum Data Set (MDS) to reflect 1 of 2 residents (Resident #1) reviewed for hospice was receiving hospice services. The facility reported a census of 34 residents. Findings include: Resident #1's Census documented she started hospice services on 9/28/23. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] lacked documentation that she received hospice services. On 9/15/24 at 11:53 AM the Director of Nursing expected the facility to code the MDS correctly if a resident received hospice services. The facility used the Resident Assessment Instrument (RAI) for guidance on accurate coding.

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on observation, policy review, staff, and resident interview, the facility failed to find or replace 1 of 1 resident (Resident #25) hearing aides when they identified them missing. The facility reported a census of 34 residents. Findings include: Resident #25's Minimum Data Set (MDS) assessment dated [DATE] reflected he wore a hearing aid. The MDS identified a Brief Interview of Mental Status (BIMS) of 9, indicating moderately impaired cognition. The MDS included diagnoses of dementia, depression, and need for assistance with personal care. The Progress Note dated 6/13/24 at 9:36 AM reflected he saw his Doctor at the facility. The facilities Social Worker (SW) must review with him regarding lost hearing aids. On 9/13/24 at 11:21 AM Resident #25 reported he lost his hearing aids a few months ago and is hard of hearing. He explained it bothered him and he didn't want to talk because he couldn't hear. On 9/15/24 at 11:52 AM the Director of Nursing (DON) reported she believed the SW had the responsibility of looking into the situation but went on leave and it possibly got overlooked. She explained she expected the staff find or replace Resident #25 hearing aids as soon as possible so he could effectively communicate. During an interview on 9/15/24 at 12:21 PM the Administrator explained he learned the SW last worked on 6/13/24 at the facility and currently taking leave. The Grievance Process policy, reviewed January 2023 instructed residents have the right to file grievances, and the facility will make prompt efforts to resolve grievances.

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NAME OF PROVIDER OR SUPPLIER Shell Rock Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 920 North Cherry Street Shell Rock, IA 50670	

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41537 Based on observation, record review, resident and staff interviews the facility failed to provide routine repositioning for 1 of 3 residents (Resident #19). The facility reported a census of 34 residents. Findings include: Resident #19's Minimum Data Set (MDS) assessment date 8/14/24 identified a Brief Interview of Mental Status (BIMS) score of 8, indicating severely impaired cognition. Resident #19 required total assistance from staff for transfers and bed mobility. The MDS reflected he didn't walk. The MDS included diagnoses of hemiplegia/hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), hip fracture, and a need for assistance with personal care. On 9/14/24 at 1:15 PM Staff A, Certified Nurse Aide (CNA), reported Resident #19 will get up in the morning and staff didn't assist him to lay down or reposition him until after lunch on most days of the week. She added the staff never reposition him when in bed. The Care Plan Focus dated 6/18/21 reflected Resident #19 had limited physical mobility with a high fall risk related to a stroke. The Intervention instructed Resident #19 required assistance of 2 staff to reposition and turn in bed. On 9/14/24 at 2:12 PM Resident # 19 revealed he laid in bed and didn't get get repositioned while in his bed. During an interview on 9/15/24 at 11:56 AM the Director of Nursing (DON) reported they expected all dependent residents to receive routine repositioning.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41537 Based on record review and staff interviews the facility failed to have a full time (40 hours a week) Director of Nursing (DON) at the facility. In addition, the facility failed to have eight (8) hours of consecutive Registered Nurse (RN) coverage a day for 4 of 30 days reviewed. The facility reported a census of 34 residents. Findings include: Record review of nursing schedules from 8/12/24 to 9/12/24 lacked RN coverage for 4 days: 8/16/24, 8/19/24, 8/28/24, and 9/2/24. During an interview on 9/13/24 at 11:16 AM the Administrator confirmed the facility didn't have 8 consecutive hours of RN coverage from 8/12/24 to 9/12/24. The days that the facility didn't have RN coverage: 8/16/24, 8/19/24, 8/28/24, and 9/2/24. During an interview on 9/15/24 at 11:46 AM the DON reported being the current DON as of 9/12/24. She informed she came to the facility for a routine rounding visit, as she is Regional Clinical Quality Specialist for the facilities corporation. She let she let the DON at the time know the state entered the building for the annual recertification survey and the DON said she no longer wanted to be the DON and gave notice effective immediately. She also reported she expected to have a full-time DON employed at the facility and have 8 hours of RN coverage a day. The Administrator informed on 9/15/24 at 12:29 PM the prior DON last worked in the facility on 8/12/24. They said the prior DON hadn't been to the facility since. They wanted her license removed and she would no longer be the DON of the building effective 9/12/24.