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	09/04/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews, and policy review the facility failed to clean the kitchen convection oven and handwashing sink. In addition, the facility failed to ensure staff wore hairnets and didn't touch food with their contaminated gloved hands. The facility reported a census of 34 residents. Findings include: During an initial kitchen walk through on 9/2/25 at 9:18 AM observed the white hand washing sink had a dark brown discoloration around the drain measuring approximately 6 inches by 6 inches. In addition, the convection oven had a brown-like sticky discoloration on the inside and the outside of the doors, throughout the inside of the oven and on the metal racks. An observation of the Dietary Manager wearing a baseball cap without a hair net, and the hair appeared over one inch in length protruding out below the baseball cap. During a follow-up walk through observation on 9/3/25 at 11:56 AM the hand washing sink continued to have a dark brown discoloration around the drain measuring approximately 6 inches by 6 inches. The convection oven also continued to have a brown sticky-like discoloration on the inside and outside of the doors and throughout the inside of the oven and on the metal racks. During an observation on 9/3/25 at 11:59 AM the Dietary Manager held a cool whip container with a gloved hand and a spatula with another gloved hand. As she scooped out the cool whip onto the dessert to serve, she took the gloved hand holding the cool whip container and used her index finger to scrape off the spatula to get the whip cream to cover dessert. During the observation, she continued to wear a baseball cap without a hairnet. During an observation of the noon meal service on 9/3/25 from 11:55 AM to 12:55 AM while wearing gloves, Staff D, Cook, touched the diet name cards, serving utensils, plates, and transportation carts. Staff D proceeded to grab the garlic bread and place one on each residents' plate with the same gloved hands. Staff D served approximately 32 servings of garlic bread with contaminated gloves During an interview on 9/3/25 at 12:55 PM Staff D revealed he didn't use tongs during meal service and instead grabbed each piece of garlic bread and set them on the plates with his gloved hands. He explained as long as he had gloves on, he didn't need to use a tongs to touch the bread. During an interview on 9/3/25 at 2:45 PM the Infection Preventionist said she hadn't completed audits on the kitchen practices.During an interview on 9/4/25 at 10:47 AM the Director of Nursing (DON) reported she didn't know why Staff D wore gloves during 9/3/25 noon meal service, as that isn't their normal routine. She expected them to use tongs to place the bread on the plates. During an interview on 9/4/25 at 10:37 AM the Administrator revealed she would expect the Dietary Manager to wear a hairnet and not just a baseball cap. She also informed Staff D during the 9/3/25 noon meal service does not normally wear gloves as that is not their normal routine and practice and believe it was due to being nervous, and food should not be touched with contaminated gloves. The facility's undated General Food Preparation and Handling policy directed the following: a. Clean and sanitize the kitchen surfaces and equipment as appropriate. b. Disposable gloves are single use item and should be discarded after each use. Employees should wash hands prior to putting gloves on and after removing gloves. c. Food should be prepared and served with clean tongs, scoops, forks, spoons, spatulas or other suitable implements to avoid manual contact with prepared foods. d. Use tongs or other servings utensils to serve breads or other items to avoid bare hand contact with food

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation and staff interviews the facility failed to post daily staffing in a visible place for all visitors and residents to see. The facility reported a census of 34 residents.Findings include: During an observation on 9/2/25 at 10:42 AM the facility posted the Daily Staffing on a bulletin board behind the nurses' station out of view of residents, families, and visitors.During an observation on 9/3/25 at 1:55 PM the Daily Staffing remained at the same place out of site from residents, families, and visitors behind the nurses' station. During an interview on 9/4/25 at 10:37 AM the Administrator reported they kept the Daily Staffing behind the nurses' station. During an interview on 9/4/25 at 10:47 AM the Director of Nursing (DON) explained they used to keep the staff in the hallway in front of the nurses' station until the tack board broke. Now it's positioned behind the nurses' station.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on record review, observation, staff interview, and policy review the facility failed to provide the correct portion size of 8 ounce (oz.) of chicken and pasta alfredo for 32 of 34 residents during a meal observation on 9/3/25 at the noon meal service. The facility reported a census of 34 residents. Findings include:The facility's menu for the noon meal on 9/3/25 titled, Week 2 Wednesday, dated 5/14/25 instructed to provide 8 oz. of chicken and pasta alfredo. During an observation of the noon meal service on 9/3/25 from 11:55 AM to 12:55 AM, Staff D, Cook, used a 6 oz. scoop instead of an 8 oz. scoop as the menu directed for serving 32 servings of chicken and pasta alfredo. During an interview on 9/3/25 at 12:53 PM the Dietary Manager reported they provided a heaping 6 oz. scoop of the chicken and pasta alfredo to all residents instead of using an 8 oz. scoop as they didn't have 8 oz scoops in the facility and needed to order more. She explained she told Staff D he should use 2, four (4) oz. scoops, but he didn't. During an interview on 9/3/25 at 12:55 PM Staff D said he used a 6 oz. scoop of chicken and pasta alfredo instead of the 8 oz. scoop as the facility didn't have any 8 oz. scoops. During an interview on 9/4/25 at 10:47 AM the Director of Nursing (DON) stated she expected all residents get the intended scoop size of the chicken and pasta alfredo. She added if the facility didn't have an 8 oz. scoop, they should have placed an order to get new ones. During an interview on 9/4/25 at 10:37 AM the Administrator reported she expected the staff to follow the menu and use the scoop size as directed. The facility's undated Select Menu policy lacked direction to use the proper scoop sizes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on clinical record review, observation, policy review, and staff interviews, the facility failed to have a separate entrance and exit for clean and dirty laundry into the laundry room. In addition, the facility failed to use proper infection control practices when staff touched resident medication with their bare hand prior to medication administration. The facility reported a census of 34 residents. Findings include:1. On 9/3/25 at 1:48 PM observed the laundry room, the staff used the same entrance and exit for clean and dirty laundry items. The room entrance/exit measured approximately 5 feet in width and couldn't keep workflow from cross-contamination. During an interview on 9/3/25 at 1:52 PM the Laundry Manager reported they used the same exit and entrance for clean and dirty laundry items. During an interview on 9/3/25 at 2:45 PM the Infection Preventionist explained she hadn't completed audits on laundry. During an interview on 9/4/25 at 10:47 AM the Director of Nursing (DON) said having clean and dirty laundry going in and out the same door wouldn't prevent cross-contamination. 2. During an observation on 9/3/25 at 3:19 PM Staff A, Certified Medication Aide (CMA), failed to perform hand hygiene after leaving the medication cart to go to the medication room. She returned carrying a cold tub of pudding and supplement drinks. Staff A pulled the medication cart keys from her pocket, unlocked the medication cart, touched the laptop mouse, and laptop keypad. Staff A reviewed Resident #31 Electronic Medication Administration Record (EMAR) for acetaminophen (Tylenol) 650 milligrams (MG) scheduled at 4:00 PM. Staff A pulled a stock bottle of acetaminophen from the medication cart, shook out two 325 MG tablets from the bottle into the lid with one of the pills falling to the left outside of the medication cup. Staff A picked up the acetaminophen tablet with her bare left hand and placed the pill back in the cup. Staff A then administered the medication to Resident #31. Resident #31's September 2025 EMAR showed Staff A signed to indicate administration of the acetaminophen 650 MG at 4:00 PM. Interview on 9/4/25 at 8:34 AM Staff B, CMA, reported staff shouldn't touch medications with their bare hands. She used a spoon or a glove to handle medications. Interview on 9/4/25 at 8:35 AM Staff C, Licensed Practical Nurse (LPN), voiced staff should never touch pills with bare hands. She would put on a glove to handle a pill. In addition, she explained someone should complete hand hygiene before starting and ending a medication pass. During an interview on 9/4/25 at 9:17 AM the Director of Nursing (DON) explained staff should complete hand hygiene before and after a medication pass. She expected the nurses and/or CMAs to do hand hygiene after logging onto the computer and before setting up the medications. The nurses/CMAs should sanitize their hands or put on a glove if they need to touch a resident's medication. The Medication Management-Medication Administration Policy updated 4/16/24 directed to clean hands before handling medication and before having contact with the resident. The Policy failed to address how staff responsible for medication pass should touch medications during medication set up.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on clinical record review, Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User Manual, and staff interview the facility failed to complete a significant change in condition assessment for 1 of 1 residents admitted to hospice care services (Resident #23). The facility identified a census of 34 residents.Findings include:/Resident #23's Minimum Data Set (MDS) assessment dated 6??/18/25 identified a Brief Interview for Mental Status (BIMS) score of 9, indicating a moderate cognitive loss. The MDS included diagnoses of stroke, atrial fibrillation (irregular heart rate), high blood pressure, diabetes mellitus, and pain unspecified.Resident #23's Clinical Census reviewed 9/3/25 identified Resident #23 admitted to hospice care on 6/19/25. The Hospice Visit Noted dated 6/19/25 at 6:41 PM reflected Resident #23's legal representative signed paperwork for her to start hospice care services with a primary diagnosis of stroke and a secondary diagnosis of failure to thrive with congestive heart failure. The Progress Note reflected hospice left copies of her hospice admission paperwork for the Director of Nursing (DON) and the Business Office/Executive Director. A Hospice Election Form signed by Resident #23's legal representative documented a date of 6/19/25. A Hospice Comprehensive Assessment and Plan of Care Update Report documented a Start of Care (SOC) date of 6/19/25 and documented the last hospice visit date as 6/25/25. The reason listed for the meeting as Resident #23's a new admission to hospice care. The Care Plan Focus initiated 7/3/25 documented Resident #23 had a terminal diagnosis that required hospice care and directed the staff to observe for signs and symptoms of discomfort and to report to the nurse. An Order Summary Report signed by the Provider on 8/5/25 lacked documentation of a hospice order. An CMS 802 Matrix form provided by the facility on 9/2/25 lacked documentation Resident #23 received hospice care services. A 9/2/25 review of Resident #23's MDS Summary Page lacked completion of a documented SCSA MDS when Resident #23 admitted to hospice care. During an interview on 9/3/25 at 12:38 PM the Assistant Director of Nursing (ADON) explained she completed a SCSA MDS when someone admitted or discharged from hospice care or if they have a change in condition from their baseline. The ADON reviewed Resident #23's MDS Summary Page and reported she did a quarterly MDS on 6/18/25, but missed the SCSA MDS for admission to hospice care.On 9/3/25 at 12:57 PM the Regional Nurse Consultant verbalized the facility didn't have an MDS Policy but, they followed the RAI Guidelines. The CMS LTC RAI 3.0 User's Manual, Version 1.19.1 October 2024, Chapter 2, page 2-24 and 2-25 under Significant Change in Status Assessment (SCSA) directed the SCSA is a comprehensive assessment that must be completed when the interdisciplinary team (IDT) determined that a resident met the significant change guidelines for either a major improvement or decline. A Significant Change is defined as a major decline in a resident's status that: will not normally resolve itself without interventions by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting. Impacts more than one area of the residents' health status; and requires interdisciplinary review and/or revision of the care plan. An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review the facility failed to identify a weight loss and notify the primary care provider (PCP), dietitian, and/or family for 1 or 2 residents (Resident #3) reviewed for weight loss. The facility identified a census of 34 residents. Findings include:Resident #3's Minimum Data Set (MDS) assessment dated [DATE] listed an admission date of 8/14/25. The MDS indicated Resident #3 weighed 191 pounds (#) at admission.The Order Summary Report (physician orders) included an order dated 8/18/25 to complete daily weights. In addition, call the PCP if Resident #3 had a difference in weight as 3# or more in a day, or 5# or more in a week. The Weights and Vitals Summary viewed 9/3/25 listed only the following weights. The dates not listed, lacked a weight:a. 8/14/25 191.4# b. 8/20/25 197.5# (difference of 6.1#). c. 8/23/25 191.4 (difference of 6.1#)d. 8/24/25 191.4#e. 8/25/25 188# (difference of 3.4#)f. 8/26/25 191.2# (difference of 3.2#)g. 8/28/25 186# (difference of 5.2#)h. 8/29/25 186#i. 8/30/25 186#j. 8/31/25 185#k. 9/1/25 180.5# (difference of 5.5#)l. 9/2/25 179#m. 9/3/25 180# The Progress Note written by Staff E, Licensed Practical Nurse (LPN), on 8/14/25 at 3:07 PM documetned the resident weighed 191.4# and was on a regular diabetic diet with unknown likes and dislikes. The clinical record lacked any further documentation of nutritional status or weights. The Nutritional Assessment Note written by Staff F, Dietitian, on 8/17/25 at 5:07 PM acknowledged the resident's weight as 191.4# on 8/14/25.The clinical record lacked any additional documentation by the Dietitian. The clinical record lacked documentation the facility notified the PCP or family. During an interview on 9/3/25 at 5:00 PM the Director of Nursing (DON) explained the Dietitian didn't know about Resident #3's weight loss and didn't address the loss. She added the facility didn't notify the PCP of any of the weight increases and decreases as ordered. During an interview on 9/4/25 at 11:47 AM, the administrator explained the facility didn't have a weight loss policy, that they followed the current standard of practice. She deferred to the Nurse Consultant when asked which standards of practice the facility followed. The Nurse Consultant explained the facility didn't have a weight loss policy, but she expected the facility to follow physician's orders. During an interview on 9/4/25 at 11:51 AM, the DON explained she didn't do any weekly notification to the Dietitian about weight loss.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, staff interviews, and policy review the facility failed to keep flies off the food prior to serving. The facility reported a census of 34 residents. Findings include: During an observation on 9/3/25 at 12:08 PM a fly landed on two (2) bowls of crushed pineapple, then flew over, and landed on pureed peas. The kitchen had (4) flies present during the observation in the kitchen and one (1) dead fly noted on a cupboard door from 11:55 AM to 12:55 AM. During an interview on 9/3/25 at 2:45 PM the Infection Preventionist reported she hadn't completed audits on practices in the kitchen.During an interview on 9/4/25 at 10:37 AM with the Administrator explained the facility had bug traps but didn't know when pest control last came to the facility. She reported flies shouldn't land on the food during food service. Review of the facility's undated General Food Preparation and Handling policy instructed to prepare food items to conserve maximum nutritive value, develop, enhance flavor, and keep free of harmful organisms and substances. Review of the facility's undated policy Pest Control Program directed the facility to use a variety of methods to control certain seasonal pests, i.e. (example) flies. The program would involve indoor and outdoor methods deemed appropriate by the outside pest service, state and Federal regulations.