STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165238	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denison Care Center	1202 Ridge Road Denison, IA 51442

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to accurately assess and provide appropriate interventions after a resident had an unwitnessed fall for 1 of 3 residents (Resident #1) reviewed. Staff attempted to move Resident #1 after they found her prone (face down), bleeding, and in pain. The facility reported a census of 28 residents.Findings include: Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated a severe cognitive impairment. The MDS list of diagnoses included non-Alzheimer's dementia, diabetes mellitus, and paroxysmal atrial fibrillation (irregular heart rhythm). The MDS indicated Resident #1 dependent for transfer chair/bed-to-chair transfer, and required substantial/maximal assistance to roll from right to left.Review of the Care Plan, dated 12/2/2024 revealed a Focus area to address [name redacted} has potential for falls r/t (related to) self-transfers. Review of a facility reported incident submitted on 10/10/25 at 4:16 PM revealed an Incident Summary: On 10/09 at approximately 7:00 PM, the resident attempted to stand from her wheelchair and sustained a fall. The resident was transported to the emergency room via ambulance, At approximately 11:43 PM the Director of Nursing ass notified that the resident had multiple fractures and was life-flighted to [name of hospital redacted} for further evaluation and treatment. The resident returned to the facility on 10/10 at approximately 10:30 am.Review of a document titled, Major Injury Determination Form, dated 10/10/25 signed by the [physician name redacted] at 10:45 AM documented, in part: Participant name: [name reacted, Resident #1]. Date and time of the injury: 10/9/25, 1854 (6:54 PM) Notified of Injuries at 2343 (11:43 PM). Description of Injury: odontoid fracture (a small bone in the neck that connects the skull to the second cervical vertebrae), head injury, nasal fracture, cervical fractures. Circumstances of the incident causing the injury: Fall. The physician checked the statement After reviewing the circumstances, injury and prognosis of the patient. I believe the injury sustained is a major injury pursuant to 481 Iowa Administrative Code 67.4(1)(a)(3). Review of October 2025 schedule revealed Staff A, RN (Registered Nurse); Staff B, CNA (Certified Nursing Assistant); Staff C, CNA and Staff D, [NAME] worked the evening of 10/9/25.During an interview on 10/22/25 at 11:14 AM, Staff A, Registered Nurse (RN) stated she worked the evening of 10/9025. Staff A stated during the night time medication pass she heard yelling from the dining room, and ran to the dining room. Staff A explained two of the Certified Nursing Assistants (CNA's) were taking residents back to their rooms after dinner. Staff A stated she found Resident #1 lying prone (face down) on the floor in the dining room. Staff A stated she completed an assessment and determined that Resident #1 was in pain. Staff A stated Resident #1 was not able to move her head. Staff A stated she could not tell if anything was broken. Staff A stated Resident #1 could move her extremities but not very much. Staff A stated Resident #1 could move her right arm but could not move it above her head. Staff A stated Resident #1 could move the left arm but even less than the right arm. Staff A stated she had no reason to suspect Resident #1 had a neck fracture. Staff A explained blood came from Resident #1's nose. Staff A stated after her assessment she and the CNA's attempted to roll Resident #1 over onto her back a couple of times but were unable to turn the resident on to her back. Staff A then stated 911 was called. Staff A explained after Emergency Medical Services (EMS) entered the facility they turned the resident onto her back without a C-collar. Staff A stated Resident #1 was sent to the ER (emergency room). Staff A explained Resident #1 was seated in a wheelchair prior to fall. On 10/22/25 at 12:03 PM Staff B, CNA stated she was familiar with Resident #1. Staff B acknowledged she was working the evening shift on 10/9/25 when Resident #1 fell. Staff B stated she was putting another resident to bed when the incident occurred. Staff B stated Resident #1 was in the dining room with other residents. Staff B stated the resident that she was putting to bed required a full body mechanical lift and there were only 2 CNA's. Staff B stated the other CNA working that night was Staff C. Staff B stated she and Staff C were in the resident who required the mechanical lift when Resident #1 fell. Staff B stated she heard yelling and ran down to the dining room and found Resident #1 lying face down on the floor and there was blood under her face. Staff B stated Resident #1 must have tried to stand up and fell. Staff B stated the nurse tried to turn Resident #1 over a couple of times but Resident #1 was hurting too bad to turn over. Staff B explained they tried to turn her over because Resident #1 could not do it on her own, and she was crying. Staff B stated 911 was called and once EMS arrived 2 EMT (Emergency Medical Technician) and 3 staff flipped Resident #1 onto her back. Staff B acknowledged Resident #1 was in a lot of pain at the time and did a lot of screaming. During an

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interviews, the facility failed to provide adequate nursing supervision for 1 of 3 residents (Resident #1) reviewed. A non-ambulatory resident with a history of attempting to self-transfer, fell when left unsupervised in the dining room, which resulted in a head injury, nasal fractures and cervical fractures. The facility reported a census of 28. Findings include:Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #1 with a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated a severe cognitive impairment. The MDS list of diagnoses included non-Alzheimer's dementia, diabetes mellitus and paroxysmal atrial fibrillation (irregular heart rhythm). The MDS indicated Resident #1 dependent for chair/bed-to-chair transfers, and required a manual wheelchair for mobility. Review of the Care Plan, dated 12/2/2024 revealed a Focus area to address [name redacted} has potential for falls r/t (related to) self-transfers. Review of a facility reported incident submitted on 10/10/25 at 4:16 PM revealed an Incident Summary: On 10/09 [2025] at approximately 7:00 PM, the resident attempted to stand from her wheelchair and sustained a fall The resident was transported to the emergency room via ambulance, At approximately 11:43 PM the Director of Nursing was notified that the resident had multiple fractures and was life-flighted to [name of hospital redacted} for further evaluation and treatment. The resident returned to the facility on 10/10 [2025] at approximately 10:30 am.Review of a document titled, Major Injury Determination Form, dated 10/10/25 signed by the [physician name redacted] at 10:45 AM documented, in part: Participant name: [name reacted, Resident #1]. Date and time of the injury: 10/9/25, 1854 (6:54 PM) Notified of Injuries at 2343 (11:43 PM). Description of Injury: odontoid fracture (a small bone in the neck that connects the skull to the second cervical vertebrae), head injury nasal fracture, cervical fractures. Circumstances of the incident causing the injury: Fall. The physician checked the statement After reviewing the circumstances, injury and prognosis of the patient. I believe the injury sustained is a major injury pursuant to 481 Iowa Administrative Code 67.4(1)(a)(3). Review of a document, dated 10/5/25 at 11:50 PM titled, Fall revealed, in part: Resident: [name redacted Resident #1]. Incident Location: Dining Room. Nurse Description: At 2350 (11:50 PM) this nurse went to turn off commons area TV in hopes that resident will be redirected. This nurse hears chair legs moving on floor and observed resident falling backwards out of chair. Resident landed on back, chair landed on top of resident. This nurse running to resident in the process, Resident complaints of left elbow pain. Vitals obtained, apart from BP (Blood pressure) to which resident reuses and WNL (within formal limits) for resent. Neuros initiated and WNL for resident. PERRLA (pupils, equal, round, reactive to light, accommodation - an assessment for neurological changes). Active and passive ROM (Range of Motion) WNL. NO swelling or facial grimacing noticed while performing ROM to left arm. Resident continues to yell, spit and hit at this nurse and staff while assisting resident. Hoyer sling placed under resident, transferred to wheelchair, resident transferred into bed, Call light within reach. Will continue to monitor and support per facility protocol. Was this incident witnessed: N (no). Predisposing Environmental Factors: no boxes checked. Predisposing Physiological Factors: Confused, Non compliance, Agitated/Anxious, Delusions, Resident to care, Combative, Hallucinations boxes checked. Predisposing Situation Factors: no boxes checked. Other Info: Incident: observed on floor. why: Resident had self transferred to regular chair; why: Resident was scooted chair backward and chair tipped over with resident; why: Resident had had increased behaviors and hallucinations; why: cognitive status; why: Disease progression. Review of the electronic health record (EHR) revealed a General Progress Note entered on 10/8/25 at 3:03 PM by Staff E, Registered Nurse (RN)/Assistant Director of Nursing (ADON) which documented This nurse asked to sit with resident at the dining room table, Resident [Resident #1] attempts to stand up from her wheelchair. This nurse educates the importance of staying seated in her wheelchair. Resident voices understanding but becomes tearful. She starts tearing apart a Kleenex box and states I don't want to be part of this club anymore. They are just mean to me. This nurse comforts resident and resident calms down. This nurse continues to sit the resident until another nurse came back into the dining room. Review of October 2025 schedule revealed Staff A, RN (Registered Nurse); Staff B, CNA (Certified Nursing Assistant); Staff C, CNA and Staff D, [NAME] worked the evening of 10/9/25.During an interview on 10/22/25 at 11:14 AM, Staff A, Registered Nurse (RN) acknowledged she was working the night of 10/9/25 when Resident #1 fell in the dining room. Staff A explained she was starting her night time medication pass and was walking down the hall at the time of the fall. Staff A explained that Staff B, CNA and Staff C, CNA were