

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Denison Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family interview, staff interview, and policy review the facility failed to notify the Long-Term Care Ombudsman of a transfer to a hospital for 1 of 3 residents (Resident #18) reviewed. The facility reported a census of 27 residents.</p> <p>Findings include:</p> <p>Review of Resident #18's Minimum Data Set (MDS) dated [DATE] revealed Resident #18 had reentered into the facility from a short-term general hospital stay 5/6/25. The MDS further revealed a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment.</p> <p>Review of Resident #18's Electronic Healthcare Record (EHR) revealed that Resident #18 was in the hospital from [DATE] through 5/6/25. Further review of the EHR page titled Clinical Census, confirmed that Resident #18 was in the hospital on these dates.</p> <p>Interview 7/1/25 at 12:29 PM with Resident #18's family member revealed that Resident #18 had gone to the hospital for surgical repair of the right femur.</p> <p>Review of a facility provided document titled, Notice of Transfer Form to Long Term Care Ombudsman dated April 2025 revealed that Resident #18 was not on the form.</p> <p>Interview 7/1/25 at 1:59 PM with Social Services, and the Administrator confirmed Resident #18 was not on the Ombudsman Notification, and that their expectation would be for the Ombudsman to be notified when residents are transferred or discharged .</p> <p>Interview 7/2/25 at 7:58 AM with the Administrator revealed the facility does not have a policy for reporting to the Ombudsman. The Administrator then revealed the facility just abides by the state and federal regulations.</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
---	-------	-----------