STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165603	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver Sunset Home	235 North Mill Street Denver, IA 50622

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41537 Based on record review and staff interview the facility failed to provide Notice of Medicare Non-Coverage (NOMNC) Form CMS-10123 at least two days before the end of a Medicare covered Part A stay for 1 of 3 residents reviewed (Resident #9). The facility reported a census of 27 residents. Findings include: Record review of Resident #9 NOMNC instructed her services would end on 10/28/2024, the form lacked documentation of family notification until it was signed on 10/30/24 indicating at least two days of notice was not provided. During an interview with the Administrator on 3/26/25 at 2:04 PM revealed there is no documentation of family notification for Resident #9 she can find prior to the 10/30/24 date. During an interview on 3/27/25 at 11:38 AM with the Director of Nursing (DON) revealed she knows she talked to Resident #9 family but did not document it anywhere.

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 41537 Based on record review and staff interviews the facility failed to accurately code 1 of 2 residents Preadmission Screening and Resident Review (PASRR) on their annual Minimum Data Set (MDS) (Resident #1). The facility reported a census of 27 residents. Findings include: The MDS for Resident #1 dated 6/13/2024 documented he was not considered by the state as needing a Level II PASRR. Record review of Resident #1 PASRR dated 6/13/21 documented he required a Level II PASRR. During an interview with the Director of Nursing (DON) on 3/27/25 at 11:36 AM revealed she is not sure why she coded Resident #1 6/13/24 PASRR inaccurately she is aware he required a PASRR level II.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, staff interview, and policy review the facility failed to create and implement upon admission a Baseline Care Plan for 1 of 6 residents reviewed (Resident #11). The facility also failed to implement Baseline Care Plans that included goals residents wanted to archive while living at the facility, significant diagnoses, and symptoms to monitor for, medications and significant medication side effects to monitor, and signatures that the resident and/or Power of Attorney (POA) were aware and agreed for 5 of 6 residents reviewed. The facility reported a census of 27 residents. Findings include: 48452 1. The MDS (Minimum Data Set) for Resident #11 dated 1/16/25, with an admitted [DATE], indicated the resident had diagnoses of coronary artery disease, renal failure, and depression. The orders tab of the resident's electronic health record (EHR) revealed the resident took Escitalopram (depression), Acetaminophen (pain), and Hydrocodone (pain). A Progress Note on 10/15/24 documented the resident also took Methocarbamol (muscle spasms) and Tramadol (pain) when he was admitted , for pain in his hips. During an interview with the Director of Nursing on 03/27/25 at 11:21 AM she reported she didn't know where to locate the Baseline Care Plan for Resident #11. It was not located in the resident's paper chart or in the electronic health record. 2. The EHR for Resident #126 included an admission record with an initial admitted [DATE]. It documented diagnoses of pulmonary fibrosis (scarring/thickening of lung tissue), chronic systolic heart failure (left ventricle weakens and can't pump blood effectively), and type 2 diabetes mellitus. The orders tab of the EHR included Acetaminophen (pain), Eliquis (anticoagulant), Lorazepam (anxiety), Citalopram (depression), and Lasix (diuretic). The Baseline Care Plan for Resident #126 did not include goals based on admission orders and the goals of the resident; a summary of medications and diagnoses; pain goals or interventions; mental health diagnoses, medications, or side effects; diabetic management; or monitoring for diuretic and anticoagulant symptoms and side effects. 3. The EHR for Resident #127 included an admission record with an initial admitted [DATE]. It included diagnoses of acute respiratory failure with hypoxia (lungs fail to deliver enough oxygen to the blood), major depressive disorder, anxiety disorder, and repeated falls. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The orders tab of the EHR included Metformin (high blood sugar), Acetaminophen (pain), Gabapentin (pain), Hydrocodone (pain), Methenamine (UTI prevention), Lispro and Lantus (insulin), and Warfarin (anticoagulant). Progress Notes for Resident #127 documented falls 3/20/25 at 1:35 AM, 3/23/25 at 2:35 AM, and 3/26/25 at 3:15 AM. The Baseline Care Plan for Resident #127 did not include fall history, goals, or interventions; goals based on admission orders; resident goals; a summary of medications and diagnoses; pain goals, medications, or interventions; mental health diagnoses, medications, or side effects; diabetic and insulin management; discharge planning; or monitoring for anticoagulant symptoms and side effects. An interview with Resident #127 on 03/25/25 at 09:24 AM determined she hoped to go home. She did not think staff provided her with a copy of her Baseline Care Plan. 4. The EHR for Resident #128 included an admitted [DATE]. Their diagnoses included dementia, peripheral vascular disease, and transient cerebral ischemic attack (temporary interruption of blood flow to the brain). On 03/24/25 at 12:41 PM the surveyor observed a certified nurses aide (CNA) walk to a dining room table with the resident. The resident did not have a gait belt on. Another CNA came over to put one on her and explained that she needed it for safety. The first CNA said it wasn't on the resident's Care Plan or you better believe it would have been on her. The Baseline Care Plan for Resident #128 included a sentence that indicated the resident was up with one assist and her walker. It did not address the need for a gait belt; goals based on admission orders and resident goals; a summary of medications; pain goals or interventions; or monitoring for anticoagulant symptoms and side effects. 5. The Minimum Data Set (MDS) for Resident #12 documented diagnoses of fracture, anxiety, depression, and hypertension. The orders tab included Cyclobenzaprine (muscle relaxant), Acetaminophen (pain), Protriptyline (depression), and Lorazepam (anxiety). On 03/24/25 at 12:02 PM the surveyor observed the resident folded over in her wheelchair, head down on the table. The resident was not easily redirected by staff. The Baseline Care Plan for Resident #12 did not include mental health diagnoses, medications, behaviors, or side effects; goals based on admission orders and the goals of the resident; range of motion interventions; a summary of medications and diagnoses; or pain goals, medications, and interventions. During an interview on 03/25/25 at 11:14 AM Staff B, CNA stated Resident #12 had been there about 2 months. Since admission she had refused to talk or work with some staff. When asked about folding herself in her chair, Staff B stated she did that to avoid things. She thought the resident was using it as a coping mechanism, something she could control when she felt anxious. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/25 at 12:51 PM the DON corroborated Staff B's statement and added that family had reported a history of depression, possible PTSD, and electroshock therapy. Later that day, at 03:06 PM, the DON provided Baseline Care Plans for residents that consisted of a single sheet of paper. She confirmed they were the Baseline Care Plan for a resident until the Comprehensive Care Plan was completed, and stated they had until 7 days after the MDS was completed to finish them for a total of 21 days. She acknowledged the documents provided did not include diagnoses, medications, mental health information, behavior concerns, code status, signatures, involvement of the interdisciplinary team, or confirmation a copy had been given to the resident or responsible party. During a follow up interview on 03/27/25 at 11:21 AM the DON showed the surveyor a form the facility used to use for Baseline Care Plans that included most of the items missed on the current documents. She stated she didn't know why they stopped using them and thought they could start using them again. An undated facility policy titled Care Planning - Interdisciplinary Team documented baseline care plans would be posted at admission in the nurse's station until the comprehensive care plan was completed. The resident, resident's family, and/or the resident's legal representative were encouraged to participate in the development and revisions to the resident's care plan. The care planning/interdisciplinary team included the physician, registered nurse, dietary manager/dietician, social services, therapists, consultants, DON, charge nurse, nursing assistants, and others as appropriate to meet the needs of the resident.