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	03/26/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and family interview, the facility failed to notify a resident representative of the risks and benefits of psychotropic medication use prior to administration of psychotropic medication, and failed to inform a resident representative of treatment alternatives to the medication prior to administration for 1 of 5 residents reviewed (Resident #5). The facility reported a census of 24 residents.Findings include: 1. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 6 out of 15, indicating severely impaired cognition. The MDS included diagnoses of dementia, depression, and peripheral vascular disease. Per this assessment, the resident took antidepressant medication. Review of the Physician Order dated 8/25/25 for the resident revealed, sertraline (antidepressant medication) 25 mg (milligram) by mouth daily for dementia with anxiety and major depressive disorder. Resident #5's Electronic Health Record (EHR) lacked documentation the facility notified the resident's representative in advance of the risks and benefits of the medication, treatment alternatives or other options, or to let them choose the option they preferred prior to administering the medication.Resident #5's Medication Administration Record (MAR) for August 2025 through March 2026 documented Resident #5 received sertraline daily since ordered in August. On 3/26/26 at 11:00 AM, the Administrator reported they facility didn't do a consent with the family for prior to giving. On 3/26/26 at 11:14 AM, the family representative reported the facility did not notify her of the risks and benefits of the medication, treatment alternatives or other options.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and resident interview, the facility failed to ensure a contracture of a resident's hand was addressed on the care plan for 1 of 1 resident reviewed for contractures (Resident #18). The facility reported a census of 24 residents. Findings include:Resident #18's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. The MDS documented he had an impairment to both upper and lower extremities on one side. The MDS included the diagnosis of a stroke. On 3/23/26 at 1:35 PM, observation of the resident's left hand noted severe contracture to left hand. The resident was unable to use the left hand. Resident #18 reported his hand had not worsened with the contracture. He reported therapy was trying to work with him, but it hurt and was uncomfortable so he made them stop. Resident #18's Physician Progress Note for a visit on 2/9/26 and on 6/6/24 revealed he had Dupuytren's contracture (contracture of one or multiple fingers towards the palm).Review of the care plan lacked any documentation of contracture to the hand and interventions. On 3/26/2026 at 9:40 AM, the Director of Nursing reported the contracture should have been on the care plan.