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	05/09/2024

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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on interview and record review, the facility failed to issue the bed hold policy to 2 out of 2 residents reviewed for recent hospitalization s (Resident #9 and Resident #21). The facility reported a census of 28 residents. Findings include: A Census Page for Resident #9, documented that Resident #9 had Hospital Paid Leave that started on 10/28/23. It documented that Resident #9 returned to the facility on [DATE]. A Census Page for Resident #21, documented that Resident #21 had Hospital Paid Leave on 7/13/23. It documented that Resident returned to the facility on [DATE]. On 5/7/24 at 12:19 p.m., the Assistant Director of Nursing (ADON), stated the facility did not issue the bed hold policy for Resident #9 or Resident #21 for their most recent hospitalization stays. A Bed Hold Prior To Transfer policy dated 1/2017, directed staff that prior to transferring a resident to the hospital, the facility will provide written information to the resident and/or resident representative regarding bed hold. The facility will provide to the resident or resident representative, written notice at the time of transfer to hospital Bed Hold information which specifies the duration of the Bed Hold.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44972 Based on observation, record review, staff interviews, and written education review, the facility failed to provide services that met professional standards regarding medication administration for 1 of 1 residents observed for insulin administration (Resident #5). The facility reported a census of 28 residents. Findings include: During the Medication Pass Task, an observation on 5/7/24 at 8:15 AM revealed Staff A, Licensed Practical Nurse (LPN) administered Resident #5's insulin. Staff A, LPN obtained a Humalog (insulin) flex pen from the medication cart, put a needle on the tip of the pen, primed the pen with 2 units then dialed up to 10 units and proceeded to administer the insulin. Staff A, LPN failed to keep the needle under the skin for a full count of 10 to ensure the full dose was injected before removing. During the same observation, Staff A, LPN obtained a Lantus (insulin) flex pen from the medication cart, put a needle on the tip of the pen, primed the pen with 2 units then dialed up to 20 units and proceeded to administer the insulin. Staff A, LPN failed to keep the needle under the skin for a full count of 10 to make sure the full dose was injected before removing. In an interview following the insulin injections on 5/7/24 at 8:15 AM, Staff A, LPN stated she was not aware of a need to leave the needle under the skin for several seconds after injecting but stated she would check on it with administration and report back. In an interview on 5/7/24 at 9:59 AM, Staff A, LPN stated she had checked and learned that she was to leave the needle injected under the skin for the count of 10 prior to removing the needle. She stated she had just learned this but would implement the practice from here on out. In an interview on 5/7/24 at 3:39 PM, the Director of Nursing (DON), stated it was the expectation the licensed staff ensure the insulin pen needle be left under the skin after injecting insulin from a flex pen for the full count of 10 before removing the needle from the skin to ensure all the insulin is administered. A facility provided care giver education titled How to Use an Insulin Pen stated after pushing the injection button down firmly to inject the insulin, count to 10 then pull the needle straight out of the skin.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 40907 Based on observations, interviews, and record review, the facility failed to obtain parameters for oxygen administration for 1 of 1 resident reviewed with oxygen (Resident #2). The facility reported a census of 28 residents. Findings include: On 5/6/24 at 1:58 p.m., Resident #2 was laying in his bed. He had oxygen on per nasal canula at 1 1/2 liters. His respirations were non-labored. On 5/8/24 at 9:57 a.m., Resident #2 was sitting in the common area. Respirations were non-labored. He was not receiving oxygen. A Doctor's Order dated 5/2/24, documented oxygen as needed for comfort. A Treatment Administration Record for May 2024, documented that this resident received oxygen on 5/3/24 and 5/7/24. It did not specify the liter flow. It lacked documentation of the oxygen he received on 5/6/24. On 5/8/24 at 3:03 p.m., the Director of Nursing (DON), stated that this resident's oxygen order should specify the liter flow. She verified it did not. She stated she would call the provider to see what her order was to be. When told the only criteria for when to apply oxygen was for comfort, no pulse oximetry checks (non-invasive test that measures oxygenation level in the blood) and that Resident #2 was receiving oxygen on 5/6/24 but this was not documented on the Treatment Administration Record, the DON acknowledged the concerns. On 5/9/24 at 8:45 a.m., the DON stated she talked with the provider who ordered the oxygen. The DON stated the provider thought this resident was actively dying at the time she wrote the order. The DON stated that the provider said she would be sure to clarify all oxygen orders in the future. An undated Oxygen Administration by Oxygen Concentrator policy, directed staff to administer oxygen to residents when insufficient oxygen is being carried by the blood to the tissues. The facility will administer oxygen to residents when prescribed by a physician to accomplish the following objectives: to relieve hypoxemia (oxygen tension in arterial blood below normal), to relieve hypoxia (insufficient amount of oxygen available to supply the body need), relieve congestion and respiratory distress, to relieve pain and discomfort, and to normalize rate, rhythm, depth, and quality of respirations.