STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165302	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linn Haven Rehab & Healthcare	530 South Linn Avenue New Hampton, IA 50659

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on observation, staff interviews, record review and policy review the facility failed to check placement and elevate the resident's head of bed prior to flushing a g-tube for 1 of 1 resident reviewed (Resident #24); failed to follow physicians orders for insulin for 1of 1 resident reviewed (Resident #33); and failed to prime insulin pen prior to administering for 3 of 3 residents reviewed (Resident #24, #33 and #37). The facility reported a census of 42 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment for Resident #24 documented diagnoses of hypertension, cancer, malnutrition, gastrostomy status, and dysphasia. During an observation on 4/17/24 at 10:30 AM, Staff A, Licensed Practical Nurse (LPN) set up supplies on a barrier. She did hand hygiene and applied a gown and gloves. She then drew up 30 ml of warm water with the syringe, cleaned the port to the G-tube with an alcohol wipe, unclamped the tubing and flushed the line with syringe of warm water. She did not check placement of tube prior to doing so and resident was laying flat in bed with his head not elevated. Staff A, LPN reported she does need to check placement prior to flushing the tube. During an interview on 4/17/24 at 1:20 PM, the Director of Nursing reported she expects staff to elevate the resident to a semi-Fowler's position (elevated 30-45 degrees) and check the placement of the G-tube prior to flushing. Review of the Medication Administration Record for April documents the resident is to get his G-tube flushed twice a day with 30 milliliters (ml) of warm water. Review of the facility policy Medication Administration for enteral tubes dated 1/13 directed staff to verify that that the head of the bed is 30-45 degrees and to verify tube placement prior to flushing the tube. 2. 1. The MDS Assessment for Resident #33 dated 03/13/24 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented the resident diagnoses of hypertension, diabetes, and depression. During an interview on 4/15/24 at 12:26 PM, Resident #33 reports her blood sugars have been really high frequently. (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #33's February, March and April 2024 Medication Administration Records (MAR) document the resident's blood sugars are not consistent. It documented on 12 different occasions the resident either refused her insulin or the nurse held the insulin per nursing judgement. Review of Resident #33's Progress Notes lacked documentation of the physician being notified on the 12 different occasions of insulin refusal or being held. It further lacked any documentation of staff education of the risks of not taking the insulin as prescribed by the physician. During an interview on 4/16/24 at 2:10 PM Staff B, LPN reported Resident #33 is very noncompliant with her diabetes. Resident #33 will refuse meals but then snack on high sugar and high carbohydrate snacks in her room. She reported she has held Resident #33 insulin due to nursing judgement because the blood sugar level or she has refused to eat the meal. She documents the insulin being held on the MAR but not notify the physician. During an interview on 4/16/24 at 2:25 PM Staff C, Registered Nurse (RN) reports she will ask Resident #33 if she wants to take her insulin or not due to not always eating the meal. She reports she documents the refusal on the MAR. She reports any refusal or insulin being held the physician needs to be notified right away and documented. During an interview on 4/16/24 at 2:35 PM Staff D, LPN reports if a resident is refusing their insulin or the blood sugar is very low then she would notify the physician right away. The resident will need to be educated on the risks and it all needs to be documented. During an interview on 4/16/24 at 3:45 PM, the Nurse Consultant reports she expects staff to notify the physician right away if the insulin is not given or a resident refuse. It then should be documented in the resident's chart. During an interview on 4/17/24 at 9:08 AM, the DON reports the nurse should first look and see if the resident has parameters for holding the insulin. If it is held or the resident refuses then the physician needs to be notified right away and it should be documented in the resident's Progress Notes. Review of the facility policy Refusal of Medication or Treatment dated 5/14 directed staff to notify the Physician of the refusal. The policy lacked any direct to of holding medications per nursing judgement. 42441 3. The MDS dated [DATE] revealed Resident #24 had a diagnosis of type 1 diabetes mellitus (DM) and received insulin injections 7 out of the past 7 days. The Care Plan revised 3/19/24 revealed Resident #34 had DM and used insulin daily. The MAR dated April 2024 revealed Resident #24 had an order initiated 3/11/24 for Humalog (insulin) KwikPen solution 14 units subcutaneously in the morning. The MAR further revealed the resident had an order initiated 3/30/24 for 26 units subcutaneously solution pen-injector of Toujeo (insulin) one time a day (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 9:05 AM, observed Staff A, LPN inject Resident #24 with 14 units of Lispro insulin and 26 units of Toujeo insulin and utilized insulin pen injectors. Staff A did not prime either insulin pen prior to the subcutaneous injections and left the insulin pens in place for approximately 2 seconds after both injections. 4. The MDS dated [DATE] revealed Resident #37 had a diagnosis of DM and received insulin 7 out of the past 7 days. The Care Plan revised 3/25/24 revealed Resident #37 had a diagnosis of DM and received insulin daily. The MAR dated April 2024 revealed Resident #37 had an order initiated 4/10/24 for 20 units Glargine insulin subcutaneously using a pen injector. The MAR further revealed the resident had an order initiated 4/10/24 for 15 units Fiasp insulin subcutaneously using a pen injector. On 4/17/24 at 9:15 AM, observed Staff A, LPN inject Resident #37 with 20 units of Glargine insulin subcutaneously using a pen injector and inject 15 units of Fiasp insulin subcutaneously using a pen injector. Staff A did not prime either insulin pen prior to administration of the insulin and held each pen in place for approximately 2 seconds after administration. 5. The MDS dated [DATE] revealed Resident #33 had a diagnosis of DM and received insulin injections 7 out of the past 7 days. The Care Plan revised 8/31/23 revealed Resident #33 had DM and used insulin daily. The MAR dated April 2024 revealed Resident #33 had an order initiated 3/14/24 for 56 units of Toujeo insulin subcutaneously using an insulin pen injector one time a day. The MAR further revealed the resident had an order for 30 units of Aspart insulin subcutaneously initiated 4/15/24 using an insulin pen injector one time a day. On 4/17/24 at 9:30 AM, observed Staff A, LPN inject Resident #33 with 56 units of Toujeo insulin and 30 units of Aspart insulin and utilize insulin pen injectors. Staff A did not prime either insulin pen prior to the subcutaneous injections and left the insulin pens in place for approximately 3 seconds after administration. During an interview 4/17/24 at 1:00 PM, Staff A LPN acknowledged priming of the insulin pens should have been completed and that she has been educated and moving forward she will be priming insulin pens. During an interview 4/17/24 at 1:17 PM the DON revealed it is an expectation insulin pens are primed 2 units prior to administration and kept in place for 10 seconds after administration of insulin. During an interview 4/17/24 at 1:24 PM Staff A, LPN revealed the expectation is to keep the insulin pen 10 seconds after administration of the insulin and revealed now that she had the knowledge she would do so in the future. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 4/17/24 at 2:04 PM the DON revealed the 3 different insulin pens used for Residents #24, #33 and #37 had manufacturer's recommendations that mirrored one another. The DON provided a copy of the Levemir FlexPen manufacturer's recommendation. Review of the manufacturer's Quick Guide for the Levemir (insulin) FlexPen revealed the following: 3. Prime Your Pen: Before each injection, prime your pen by performing an airshot. Turn the dose selector to select 2 units. Holding your pen with the needle pointing up, tap the cartridge gently with your finger a few times to make any air bubble collect at the top of the cartridge. Press and hold the green push button. Make sure a drop of insulin appears at the needle tip. 5. Give your injection: Inject the dose by pressing the green push-button all the way in until the 0 lines up with the pointer. Keep the needle in the skin for at least 6 seconds, and keep the green push-button pressed all the way in until the needle has been pulled out.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 48003 Based on facility record review and staff interviews, the facility failed to ensure the facility's Dietary Service Manager had the required qualifications in the absence of a full-time dietician. The facility reported a census of 42 residents. Findings include: During an interview on 4/15/24 at 10:17 AM, the Administrator reported the Dietary Manager is not certified but currently enrolled in the course. During an interview on 4/15/24 at 1:38 PM, the Dietary Manager reported she is not certified, but currently enrolled in the course. She reported the dietician comes once a week.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48003 Based on observation, staff interviews and policy review the facility failed to maintain sanitary practices by improperly storing clean dishes and maintaining a clean kitchen. The facility reported a census of 42 residents. Findings include: During initial kitchen observation on 4/15/24 at 9:45 AM, the following findings were identified. The dishes were stored on open shelving next to the prep area not inverted. The shelves were covered in dust and soiled dark spots. The front of the oven covered in dry food spills and stove top covered in dry food particles. The window in front of the prep area open with build up of dirt and dried leaves with the breeze blowing on the food on the counter. The large mixer with dried food particles on it. The open shelving next to the steam table dirty with food particles and stored dishes in which half were inverted and half were not. During an observation on 4/16/24 at 10:52 AM, the kitchen dirty areas and dishes stored improperly on 4/15/26 remained the same with no changes. Dirty window open and breeze blowing on the prep area in which the Dietary Manager was preparing the pureed food. During an interview on 4/16/24 at 1:00 PM, the Dietary Manger reported the kitchen staff have a cleaning schedule. She showed the cleaning schedule book with checklist. The last documented completed cleaning was done on 4/9/24. She reported she expected staff to do the cleaning daily and document upon completion. She reported she expects staff to store the dishes on the open shelves inverted. She reported the facility lacked a policy on kitchen sanitation or storing of dishes. Review of the facility's undated cleaning list titled Night Cook Tasks documents staff are to clean the stove top and outside of the oven. It lacked any direction for the shelves, how to store dishes and cleaning the large mixer.