

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165511	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Linn Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1140 Elim Drive Marion, IA 52302	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>41537</p> <p>Based on record review, staff and physician interviews, and policy review the facility failed to document routine assessment and interventions completed by the facility for 1 of 6 residents reviewed (Resident #8). The facility reported a census of 34 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) for Resident #8 dated 11/24/2023 documented a Brief Interview for Mental Status (BIMS) of 14 indicating he was cognitively intact. The MDS informed he was independent with toileting and walking. The MDS documented a primary diagnosis of other neurological conditions and also diagnoses of diabetes, anemia, malnutrition, and Parkinson's.</p> <p>Record review of Resident #8 Assessments in his Electronic Health record (EHR) lacked documentation of complete assessments related to a decline in condition from 12/13/23 to 12/17/23.</p> <p>Record review of Resident #8 Progress Notes and Point of Care Records in his EHR revealed the following:</p> <p>12/13/23 - Resident #8 had a medium formed bowel movement.</p> <p>12/14/23 - Resident #8 had an emesis and the facility notified his Doctor of his decline with no new orders.</p> <p>12/15/23- Resident #8 abdomen was assessed and soft. Resident #8 had a medium loose bowel movement.</p> <p>12/16/23 - Resident #8 had a headache</p> <p>12/17/23 - Facility gave him magnesium laxative in the morning, and sent him to the local hospital to be evaluated due to a decline in condition.</p> <p>Record review of the local hospital Emergency Department (ED) Provider Note on 12/17/2023 at 10:14 AM revealed he was diagnosed with a small bowel obstruction, acute respiratory failure, acute renal failure, aspiration pneumonia due to gastric secretions, and sepsis.</p> <p>(continued on next page)</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
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/22/24 at 9:45 AM the Director of Nursing (DON) revealed the facility would notify the physician if adverse symptoms occurred depending on the severity, if there was a further change in condition like a decline, they would either call or fax the physician depends on the situation.</p> <p>During and interview on 5/22/24 at 3:30 PM With Staff E, Licensed Practical Nurse (LPN) revealed Resident #8 would always tell staff if there was a problem and he was normal all night the last night she worked with him on 12/16/23 going into 12/17/23. Last time I was with him, he was acting normal and went out to church. Last night I worked with him and he was normal all night long. He was very with it, but was slow to act, I think he would have told someone if he wasn't having BM's because he would always tell someone.</p> <p>During an interview on 5/22/24 at 4:35 PM With Staff D, Registered Nurse (RN) revealed resident #8 was independent around the facility and able to take himself to the bathroom. He would let us know if he went, his normal bowel movements were loose and large. She then revealed he had a previous bariatric surgery and if he ate too much of the wrong food it could upset his stomach and make him kind of sick. She informed his symptoms would be lots of phlegm, upset stomach, and dry heaving. She then informed he would not normally vomit food substance, just saliva not bile. She revealed she was working on 2/16/23 before he went to the hospital and assessed him. He was under the weather, but very adamant he didn't want to go to the hospital and just wanted to wait it out. She then informed on 12/17/23 she went and check on him in the morning and he had sunken in eyes and a low blood pressure and she suspected he was dehydrated, she informed she attempted to keep him comfortable in the beginning, she then informed he would want to go to the hospital if his POA was ok with it.</p> <p>During an interview on 6/4/24 at 11:04 AM with Staff C, Physician revealed in his line of work bowel obstructions can form very rapidly and sometimes in a matter of hours (3-4 hours). He then revealed a bowel obstruction does not have to evolve slowly over days. He revealed Resident #8 Advance Directives was comfort care (control pain and other symptoms so the patient can be as comfortable as possible) while living at the facility.</p> <p>Record review of the facilities undated policy titled Bowel Management Program instructed the following:</p> <ul style="list-style-type: none"> <li>a. Each resident will use the toilet/commode/urinal bedpan as per care plan.</li> <li>b. The nursing staff, (CNA's) will record the bowel movements. Residents that are independent with toileting will be asked if they have had a bowel movement (BM) by the CNA's every shift. If the resident does not have a bowel movement, that will be documented.</li> <li>c. The 10:00 - 6:00 AM nurse will run a BM list towards the end of his/her shift. Residents will be identified who have not had a bowel movement in two (2) or more days.</li> <li>d. The 6:00 - 2:00 PM Nurse or Certified Medication Aide (CMA) will administer an oral laxative or stool softener as ordered to the residents who have been identified as not having had a bowel movement in two days.</li> <li>e. Following administration, Nurse/CMA will monitor which residents have not had a bowel movement.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>f. If a resident has not had a BM by morning of the 3rd day, the night shift or day shift Nurse will administer a suppository or an additional laxative aide as ordered for elimination needs.</p> <p>g. If no results from the second intervention, the nurse will complete an abdominal assessment. Document assessment. Notify the physician in a timely manner.</p> <p>h. Nurses and CMAs are to document any medication or treatment interventions given on the Medication Administration Record or Treatment Record.</p> <p>i. Document on the 24-hour Nurse Hand off sheets and communicate in change of shift nurse report when bowel aides are needed and given as well as the results.</p> <p>j. Residents who are getting PRN bowel management medications on a frequent basis should be considered to have any scheduled bowel management medications re-evaluated.</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41537</p> <p>Based on record review, staff interviews, and policy review the facility failed to ensure safe transfers for 2 of 5 residents reviewed for mechanical lift transfers (Residents #5 and #11). The facility reported a census of 34 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] for Resident #5 documented a Brief Interview of Mental Status of 3, indicating severely impaired cognition. The MDS documented she was dependent on staff to assist her with transfers, toileting, moving herself in a wheelchair, and dressing. The MDS also documented her primary diagnosis of stroke and also has dementia, depression, and anxiety.</p> <p>Record review of an untitled fall report document for Resident #5 dated 4/12/24 documented she had a fall with two (2) staff present during a mechanical lift transfer. During the transfer Resident #5 sat up and leaned through the lift straps and fell out head first. She was taken to the local hospital due to a head laceration.</p> <p>Record review of Resident #5 Care Plan with a print date of 5/20/24 documented the facility implemented fall interventions for previous falls.</p> <p>During an interview on 5/22/24 at 9:45 AM, with the Director of Nursing (DON) revealed during her investigation Resident #5 was being transferred by Staff A, Certified Nursing Assistant (CNA) and Staff B (CNA) from her bed to her wheelchair and jerked forward and fell through the side. She revealed this is the first fall Resident #5 had from a mechanical lift and she never expected she would do that. She then revealed she had sustained a laceration to her head as a result of the fall.</p> <p>2. The MDS for Resident #11 dated 3/3/24, documented a BIMS of 15 indicating no cognitive impairment. The MDS informed he was dependent on staff for transfers, dressing, and bathing. The MDS documented primary diagnosis of traumatic brain dysfunction and diagnoses of dementia, quadriplegia, and bladder disorder.</p> <p>Record review of an untitled fall report document for Resident #11 dated 4/14/24 at 9:30 PM revealed Staff F, CNA altered a nurse that Resident #11 fell out of a mechanical lift during a transfer she performed with his family member.</p> <p>During an interview on 5/22/24 at 9:45 AM, the DON revealed Resident #11 was being transferred by Staff F and Resident #11 family. She revealed Staff F was a newer employee and Resident #11 family members insisted she could do the mechanical lift transfer. She revealed Staff F assisted Resident #11 family member and Resident #11 fell out the side of mechanical lift sling because it wasn't placed properly by Resident #11 family. She then revealed Resident #11 family did not want Staff F to tell the facility staff and said she could get him up.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/22/24 at 4:55 PM, Staff F revealed on 4/14/24 Resident #11 family member was aggressive and grabbed the Hoyer mechanical lift and said she needed to help her transfer him. When we were raising him up in the air it didn't feel safe and I told her we needed to lower him down, he then fell on to his right side and hit his head. She revealed she was so scared and was told she couldn't tell anyone. She then informed during the transfer she initially thought Resident #11 family member was an employee of the facility with the way she was acting.</p> <p>During an interview on 5/22/24 at 9:45 AM, the DON revealed Interventions were put in place for Resident #5 and Resident #11 after fall from mechanical lifts and did a very thorough education with all employees. She also informed them they updated the facilities policy to ensure employees were to hold one hand on the residents back and one hand on the residents chest.</p> <p>Record review of the facilities policy titled, Falls, last updated 4/2024 revealed the facility failed to follow their policy for Residents #5 and #11 with falls from mechanical lifts.</p>