| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165511 | A. Building<br>B. Wing | 02/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Linn Manor Care Center | 1140 Elim Drive<br>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) |
|---|---|
| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>Based on clinical record review, staff interview and policy review, the facility failed to obtain informed consent for psychotropic medications that have black box warnings (safety warning used by the Food and Drug Administration (FDA) and requires the healthcare provider to have a comprehensive discussion with the resident/representative about the risks, benefits and alternatives for use) for 2 of 5 resident reviewed for psychotropic medications (Resident #12, and Resident #13). The facility reported a census of 36 residents.Findings include:1. Review of the Minimum Data Set (MDS) assessment, dated 11/27/25, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. Resident #12's diagnoses included anxiety disorder, depression, and non-Alzheimer's dementia. The MDS identified that Resident #12 received antidepressant medication.<br><br>Review of the Order Summary Report revealed an order for antidepressant medication Zoloft (sertraline), increased from 50 milligrams (mg) every morning to 100 mg every morning, started on 9/27/25.<br><br>Review of Resident #12's medical records lacked documentation of informed consent for psychotropic medication provided to Resident #12 or resident representative.<br><br>2. Review of Resident #13's Social Service Note dated 12/18/25 revealed a BIMS score of 14 out of 15, which indicated intact cognition. Review of Resident #13's Medical Diagnosis sheet in the electronic health record included diagnosis of generalized anxiety disorder, added 4/20/24, and major depressive disorder, recurrent, moderate, added 1/26/24.<br><br>The review of Resident #13's physician orders included an order to increase her antidepressant medication (venlafaxine) starting 1/22/26.<br><br>The Electronic Health Record (EHR) for Resident #13 lacked documentation related to psychotropic consents.<br><br>On 2/11/26 at approximately 1:30 PM, Staff B, Nurse Consultant stated that they did not have consents for Residents #12 and Resident #13 when their psychotropic medications were increased.<br><br>The Policy titled Psychotropic Medication Management dated 2025 stated that before initiating or increasing a psychotropic medication, the facility must ensure that the resident, or their legal representative, is fully informed of and has the right to participate in or refuse treatment. |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and policy review, the facility failed to update and revise the care plan to reflect the presence of an indwelling catheter, Enhanced Barrier Precautions (EBP) and Transmission Based Precautions (TBP) for 2 of 12 residents reviewed for Comprehensive Care Planning (Residents #24 and Resident #29). The facility reported a census of 36 residents.Findings include:1. The Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #24 had diagnoses of traumatic spinal cord dysfunction, C5-C7 incomplete quadriplegia, and kidney stone.The Nurse's Progress Notes dated 2/8/26 indicated Resident #24 returned to the facility from the hospital with an indwelling catheter for infected kidney stone until follow-up appointment with her Urologist.On 2/10/26 at 7:32 AM, observation revealed the resident had a catheter. The Care Plan initiated 9/18/19 lacked documentation that Resident #24 had an indwelling catheter or that she was in EBP. On 2/11/26, the resident's Care Plan was updated to include both after the Director of Nursing (DON) was questioned about it.2. The MDS assessment dated [DATE] revealed Resident #29 scored 10 out of 15 on a Brief Interview for Mental Status exam, which indicated moderately impaired cognition. The Nursing Progress Notes indicated that Resident #29 was diagnosed with Respiratory Syncytial Virus (RSV) on 2/7/26. During on observation on 2/9/26 at 11:32 AM, a droplet isolation sign was noted on Resident #29's door, indicating that he was in TBP. The Care Plan initiated 8/3/23 lacked documentation that Resident #29 was in TBP. The Care Plan was updated to include TBP of droplet isolation on 2/11/26, after the DON was questioned about it. In an interview on 2/11/26 at 3:43 PM the DON stated that EBP, TBP and an indwelling catheter should be documented on the Care Plan.The Facility Policy titled Care Planning Procedure, undated, indicated a guide to comprehensive care planning which included catheters, infections and isolation precautions. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, staff interview, and clinical record review the facility failed to apply foot pedals to the wheelchair when transporting 1 of 3 residents reviewed for accidents (Resident #27). The facility reported a census of 36 residents. Findings include: Review of the Admission/readmission Nursing Assessment, dated 2/02/26, revealed that Resident #27 was readmitted to the facility for skilled nursing services post fall with right hip fracture and surgical repair. Resident #27 required assistance of 2 staff for bed mobility and toileting, 1 staff assistance to transfer. Review of the Care Plan, date initiated 8/21/25, revealed that Resident #27 was at risk of falling and listed an intervention to utilize wheelchair for mobility. During an observation on 2/11/26 at 2:32 PM, Resident #27 asked a Certified Nursing Assistant (CNA) to push her in the wheelchair, resident stated she could hold her legs up if that was okay, CNA responded okay. The CNA pushed Resident #27's wheelchair, without foot pedals attached to the wheelchair, as Resident #27 held legs up above the ground. The CNA transported Resident #27 from her room, located near end of C hallway, through the hallway to the common area, approximately 150 feet. Upon arrival to common area, Social Services Designee approached Resident #27, removed foot pedals from a bag hung on the back of wheelchair, and applied the foot pedals to wheelchair. During an interview on 2/11/26 at 2:40 PM, Social Services Designee reported that she intervened with Resident #27's wheelchair transportation because foot pedals were not on the wheelchair. Social Services Designee stated that transportation of residents in wheelchair without foot pedals was not allowed because a resident could fall out or get injured if their feet go down. During an interview on 2/12/26 at 2:11 PM, Director of Nursing (DON), stated that Resident #27 would not be able to safely hold her legs up due to weakness of lower extremities following recent hip fracture. The DON reported that the CNA who transported Resident #27 without foot pedals attached to the wheelchair had been provided with education. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, and facility document review, the facility failed to ensure an opened insulin vial was not expired prior to administration for 1 of 1 resident (Resident #12) reviewed for insulin. The facility reported a census of 36 residents. Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The list of diagnoses included diabetes mellitus. The MDS indicated that Resident #12 received insulin injections for 7 out of 7 days during the look back period. Review of the Care Plan, initiated on [DATE], revealed of Focus area for diabetes mellitus with the goal that Resident #12 would have no complications related to diabetes. Review of the Order Summary Report revealed an active order, started on [DATE], for Novolog (insulin Aspart) 100 units per milliliter (mL) solution with instructions to inject subcutaneously per sliding scale, as follows: a. For a blood sugar readings between 150 and 199, give 2 units.b. Blood sugars 200-249, give 4 units.c. Blood sugars 250-299, give 6 units.d. Blood sugars 300-349, give 8 units.e. Blood sugars 350-399, give 10 units.f. Blood sugars [PHONE NUMBER], give 12 units.The order additionally instructed to hold the medication if not eating and administer dose per pre meal blood sugar for diagnosis of type 2 diabetes mellitus. Review of the Medication Administration Record (MAR) dated February 2026 revealed on [DATE], Resident #12 had a blood sugar reading of 194 and was given 2 units of Novolog (insulin Aspart) sliding scale for the resident's 11:30 AM dose. During an observation on [DATE] at 11:32 AM, Staff F, Licensed Practical Nurse (LPN), prepared and administered Novolog insulin, injecting the insulin subcutaneously into Resident #12's right lower quadrant abdomen. The Novolog insulin had an opened date of [DATE], written on the outside of box which vial was stored inside. Following administration of Novolog insulin, Staff F returned the insulin vial and box to the medication cart. During an interview on [DATE] at 12:00 PM, Staff F reported that a document to identify medication expiration dates was kept on front of a binder on top of each medication cart. Staff F reviewed medication expiration document and stated that Novolog insulin would be expired 28 days after opening. When queried about the opened date for Resident #12's Novolog insulin, Staff F checked the box and confirmed that the opened date was [DATE]. Staff F stated she would get rid of the insulin and obtain an new vial of Novolog insulin for Resident #12 due to being expired. During an interview on [DATE] at 2:11 PM, the Director of Nursing (DON) revealed the expectation of nursing staff to check open date of insulin prior to administration to ensure it had not expired. The DON reported that Resident #12's Novolog insulin had been discarded and replaced with a new vial and stated that the provider was notified of incident. Review of the facility provided document titled, Suggested Drug Storage Policies (per manufacturer specifications), updated [DATE], revealed Novolog insulin vial would expire 28 days after opened or removed from the refrigerator. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>Based on facility record review, staff interview, and policy review, the facility failed to have the minimum required members at the Quality Assessment and Assurance (QAA) meetings to identify issues with respect to which quality assessment and assurance activities were necessary. The facility identified a census of 36 residents. Findings include:Review of the facility QAA sign in sheets revealed the Administrator, Medical Director, Director of Nursing (DON), and at least two other staff were present at the meetings. The Infection Preventionist was not present at the April 2025 or the December 2025 quarterly meetings. On 2/12/26 at 12:40 PM, Staff E, Corporate Nurse reported at the quarterly meetings in April and December there was no Infection Preventionist present at the meeting. She reported that the previous Assistant Director of Nursing (ADON) was the Infection Preventionist in April 2025 but she was not listed on the April QAA sign in sheets either.The facility's Quality Assurance and Performance Improvement (QAPI) Plan lacked information that indicated the Infection Preventionist should be at the quarterly meetings. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff and resident interviews, and policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) for 1 of 2 residents reviewed for EBP (Resident #24) and demonstrate proper hand hygiene practices to prevent cross contamination for 1 of 12 residents reviewed for infection control (Resident #24). The facility reported a census of 36.Findings include:The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had diagnoses of traumatic spinal cord dysfunction and C5-C7 incomplete quadriplegia.The Nurse's Progress Notes dated 2/8/26 indicated that Resident #24 returned to the facility from the hospital with an indwelling catheter for infected kidney stone until follow-up appointment with her Urologist.The Care Plan initiated 9/18/19 lacked documentation that Resident #24 had an indwelling catheter or that she was in EBP. The Care Plan was updated to include both on 2/11/26 after the Director of Nursing (DON) was questioned about it.During an observation on 2/10/26 at 10:04 AM, Staff A, Certified Nursing Assistant (CNA) was in Resident #24's room and made the bed. She then leaned over her and placed her flat call light in reach. Extra trash bin noted in room and EBP sign now on the wall next to room. She was not wearing a gown or gloves.During an observation on 2/11/26 at 3:01 PM with the DON present, Staff C, CNA touched Resident #24's bed linen, shirt and pants without gloves. She then went out of the room for a pad still without gloves on, touching various things without hand hygiene. She went out again for a new battery for mechanical lift again without hand hygiene. She then performed hand hygiene and applied gloves. Staff C then drained Resident #24's catheter. After draining the catheter, she had gloves on and touched various items and went into the bathroom twice with the same gloves on. Staff D, CNA performed catheter care and changed gloves twice without performing hand hygiene prior to donning a new pair.In an interview on 2/10/26 at 10:05 AM, Staff A questioned about new trash bin in Resident #24's room. She didn't answer and then looked out of the room door and motioned Staff B, Nurse Consultant into the room. Staff B stated she wasn't sure about the trash bin but observed the EBP sign on the door and stated she would ask the DON. The DON stated she was in EBP for her catheter and that was the reason for the trash bin. Added that Resident #24 had just returned from the hospital.In an interview on 2/10/26 at 10:10 AM, Resident #24 stated that staff were not wearing gowns during her morning cares but did not feel they needed to. She added that the trash bin was also new and had not been there before.In an interview on 2/11/26 at 3:18 PM the DON stated that Staff A should have had gloves on to begin Resident #24's cares. She also stated that hand hygiene should be performed between doffing and donning gloves. Finally, she stated that gloves should be changed after performing a procedure like emptying a catheter, and hand hygiene should be performed.The Facility Policy titled Enhanced Barrier Precautions (EBP) revised 10/2024 indicated the Personal Protective Equipment (PPE) required for EBP would be a gown and gloves with high-contact activities including any care activities that place caregivers in close physical contact with a resident and/or secretions which may include: bathing, dressing and hygiene, linen changes, transfers, wound care, device care, and therapy services requiring close contact. |