STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175494	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linn Community Nursing Home	612 Third St Linn, KS 66953

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 37 residents. The sample included two residents. Based on observation, record review, and interview, the facility failed to report Resident (R) 1's request to not be pushed by Maintenance Staff U as witnessed by staff to the State Agency (SA) as required. This placed R1 at risk for ongoing abuse and mistreatment. Findings included: - R1's electronic Medical Record (EMR) included diagnoses of hypertension (HTN - elevated blood pressure), pain, unspecified soft tissue disorder, generalized edema (swelling resulting from an excessive accumulation of fluid in the body tissues), low back pain, muscle weakness, retention of urine, and major depressive disorder (major mood disorder that causes persistent feelings of sadness). R1's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R1 had intact cognition, used a wheelchair or walker, required set up or clean up assistance with toileting hygiene, bathing, and upper body dressing. R1 also required set-up or clean-up assistance with rolling in bed, sitting to lying, and lying to sitting. The MDS further documented R1 required supervision or touch assistance with sit-to-standing, toilet transfers, walking, or using a wheelchair for 50 to 150 feet. R1 received a scheduled pain medication regimen, had pain occasionally, which occasionally interfered with day-to-day activities. R1's Care Plan, dated 03/25/25, documented daily tasks of manual wheelchair mobility, staff provide at least supervision, up to propelling R1. R1 used the wheelchair for most of her mobility to get to her destinations. The Progress Note dated 05/28/25 at 10:24 AM, documented R1 attended activities of her liking, able to walk with staff assistance using her walker, but most of the time R1 used the wheelchair to and from activities. On 07/02/25 at 12:59 PM, Certified Nurse Aide (CNA) M reported on 06/05/25 that he witnessed Maintenance Staff U pushing R1 from activities, when he heard R1 tell Maintenance Staff U to stop. CNA M asked R1 if she had needed anything. R1 stated, No, I just want him gone, not in a jovial way. CNA M turned to assist R1 back to activities when Maintenance Staff U stated, No, I got this and proceeded to wheel R1 away from the area. CNA M reported to Licensed Nurse (LN) G. CNA M reported he filled out a grievance about the event and had been informed to Let it go, but was not interviewed for what was witnessed. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/25 at 01:40 PM, Dietary Staff (DS) BB reported on 06/05/25, while in the dining room, he witnessed Maintenance Staff U pushing R1 around the building in her wheelchair, when R1 requested Maintenance Staff U several times to stop, because R1 wanted to go to the activity room. Dietary Staff BB reported Maintenance Staff U softly pushed R1 into him and another staff member, and R1 had put a foot on the ground to stop. Dietary Staff BB filed a grievance concern, but had not been interviewed or questioned about the occurrence. On 07/02/25 at 01:35 PM, Licensed Staff (LN) G reported staff had reported Maintenance Staff U had pushed R1 around the facility, with R1 objecting, wanting to go to the activity room. LN G reported that three staff had reported this, and staff filled out a grievance in writing, and LN G took it to Administrative Staff A. On 07/02/25 at 03:25 PM, Administrative Staff A reported she was told by staff that Maintenance Staff U had taken R1 and staff were unaware of R1's whereabouts. Administrative Staff A stated that when told of this, she witnessed R1 and Maintenance Staff U returning inside the building through the front doors. Administrative Staff A reported R1 and Maintenance Staff U usually sat in the front of the building. Administrative Staff A reported she later interviewed R1 in private regarding the interaction between her and the Maintenance Staff U. R1 stated it was all fun and games as both R1 and Maintenance Staff U had worked together at the facility. Administrative Staff A stated she briefly talked to staff in the hallway about the incident but had not written an investigation or talked to staff individually because R1 would not say she wanted Maintenance Staff U to stop, or other specifics related to the occurrence. Administrative Staff A stated she had not called the State Agency, nor completed a written investigation related to the staff grievance related to R1 and Maintenance Staff U. The facility's Abuse, Neglect, Exploitation policy, dated 06/05/25, documented it was policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representees in reporting any suspected acts or abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's medical symptoms. The Administrator/designee ensures that all alleged or suspected violations involving the mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property, are investigated and reported immediately to the State Agency Complaint Hotline.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 37 residents. Based on observation, record review, and interview, the facility failed to fully investigate an allegation of abuse for Resident (R) 1. This placed the resident at risk for ongoing abuse. Findings included: - R1's electronic Medical Record (EMR) included diagnoses of hypertension (HTN - elevated blood pressure), pain, unspecified soft tissue disorder, generalized edema (swelling resulting from an excessive accumulation of fluid in the body tissues), low back pain, muscle weakness, retention of urine, and major depressive disorder (major mood disorder that causes persistent feelings of sadness). R1's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R1 had intact cognition, used a wheelchair or walker, required set up or clean up assistance with toileting hygiene, bathing, and upper body dressing. R1 also required set-up or clean-up assistance with rolling in bed, sitting to lying, and lying to sitting. The MDS further documented R1 required supervision or touch assistance with sit-to-standing, toilet transfers, walking, or using a wheelchair for 50 to 150 feet. R1 received a scheduled pain medication regimen, had pain occasionally, which occasionally interfered with day-to-day activities. R1's Care Plan, dated 03/25/25, documented daily tasks of manual wheelchair mobility, staff provide at least supervision, up to propelling R1. R1 used the wheelchair for most of her mobility to get to her destinations. The Progress Note dated 05/28/25 at 10:24 AM, documented R1 attended activities of her liking, able to walk with staff assistance using her walker, but most of the time R1 used the wheelchair to and from activities. On 07/02/25 at 12:59 PM, Certified Nurse Aide (CNA) M reported on 06/05/25 that he witnessed Maintenance Staff U pushing R1 from activities, when he heard R1 tell Maintenance Staff U to stop. CNA M asked R1 if she had needed anything. R1 stated, No, I just want him gone, not in a jovial way. CNA M turned to assist R1 back to activities when Maintenance Staff U stated, No, I got this and proceeded to wheel R1 away from the area. CNA M reported to Licensed Nurse (LN) G. CNA M reported he filled out a grievance about the event and had been informed to Let it go, but was not interviewed for what was witnessed. On 07/02/25 at 01:40 PM, Dietary Staff (DS) BB reported on 06/05/25, while in the dining room, he witnessed Maintenance Staff U pushing R1 around the building in her wheelchair, when R1 requested Maintenance Staff U to stop several times, because R1 wanted to go to the activity room. Dietary Staff BB reported Maintenance Staff U softly pushed R1 into him and another staff member, and R1 had put a foot on the ground to stop. Dietary Staff BB filed a grievance concern but had not been interviewed or questioned about the occurrence. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/25 at 01:35 PM, Licensed Staff (LN) G reported staff had reported Maintenance Staff U had pushed R1 around the facility, with R1 objecting, wanting to go to the activity room. LN G reported that three staff had reported this, and staff filled out a grievance in writing, and LN G took it to Administrative Staff A. On 07/02/25 at 03:25 PM, Administrative Staff A reported she was told by staff that Maintenance Staff U had taken R1 and staff were unaware of R1's whereabouts. Administrative Staff A stated that when told of this, she witnessed R1 and Maintenance Staff U returning inside the building through the front doors. Administrative Staff A reported R1 and Maintenance Staff U usually sat in the front of the building. Administrative Staff A reported she later interviewed R1 in private regarding the interaction between her and the Maintenance Staff U. R1 stated it was all fun and games as both R1 and Maintenance Staff U had worked together at the facility. Administrative Staff A stated she briefly talked to the staff in the hallway about the incident but had not written an investigation or talked to the staff individually because R1 would not say she wanted Maintenance Staff U to stop, or other specifics related to the occurrence. Administrative Staff A stated she had not called the State Agency, nor completed a written investigation related to the staff grievance related to R1 and Maintenance Staff U. The facility's Abuse, Neglect, Exploitation policy, dated 06/05/25, documented it was policy of the facility to encourage and support all residents, the staff, families, visitors, volunteers and resident representees in reporting any suspected acts or abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's medical symptoms. The Administrator/designee ensures that all alleged or suspected violations involving the mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property, are investigated and reported immediately to the State Agency Complaint Hotline.