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	02/25/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility had a census of 41 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety in one kitchen and two kitchenettes. Findings included:- On 02/23/26 at 08:35 AM, observation in the kitchen revealed a freezer with the following undated food items:A plastic bag with 4 filet steak patties.A plastic bag, approximately 1/4 full, grilled shrimpA plastic bag, approximately 1/4 full, of French fries.A plastic bag, approximately 1/4 full, chicken stripsA plastic bag approximately 1/4 full of popcorn chicken.A plastic bag full of taco meat.A plastic bag, approximately 1/4 full of tater totsA plastic bag, approximately 1/4 full of chicken patties.A plastic bag, approximately 1/4 full of breaded mushrooms.An unsealed, undated plastic bag of choriquesco. On 02/23/26 at 08:40 AM, Dietary Staff (DS) CC verified the above findings and stated she was unaware that the freezer food items needed to be labeled and dated. On 02/23/26 at 09:15 AM, observation in the small dining room kitchenette revealed DS DD (without a hair net) during the breakfast meal serving, with the bottom warming drawer open on the oven, with his head over the food items, plating food and serving them to the residents. On 02/24/26 at 11:00 AM, an observation in the large dining room kitchenette revealed DS EE, without a hairnet, opened the bottom warming drawer, had her head over the warming drawer, plating food items for the residents' noon meal. On 02/23/26 at 09:10 AM, CDM BB verified staff were not wearing hairnets in the kitchenettes during meal service and stated they are meal servers and do not have to wear hairnets. On 02/24/26 at 11:00 AM, observation in the kitchen revealed DS FF used a probed thermometer to check the temperature of smothered pork chops from the oven, then, without cleaning the probe between food items, placed it in the mixed vegetables and scalloped potatoes with the CDM overseeing the temperature checks. On 02/24/26 at 11:00 AM, CDM BB verified DS FF had not cleaned the thermometer between food items and stated she should have cleaned it. The facility's Labeling and Dating Food Policy, undated, documented staff would be trained on proper labeling and dating procedures for food items. The facility's Hair Restraints and Food Preparation Policy, undated, documented the facility would follow the 2022 FDA food code, which does not explicitly require the use of hair restraints for food service workers and does not mandate hair restraints for food preparation; however, the facility recognizes their potential benefit. The facility recommends the following: all food preparation staff involved in food preparation are encouraged to wear hair restraints, especially those with long hair or facial hair. Even if hair restraints are not worn by all staff, clean caps or hats are encouraged to minimize hair shedding. Staff with long hair must tie it back securely to prevent contact with food or food preparation surfaces.

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

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	02/25/2026

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility had a census of 41 residents. Based on observation, interview, and record review, the facility failed to develop a Facility Assessment to include the nursing resources necessary to care for the residents during the day-to-day operations, which has the potential to affect all residents in the facility. Findings included:- Review of the Facility Assessment revealed the document lacked specific staffing levels and number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, resident needs, and census. The assessment lacked the staffing levels required for each shift. On 02/24/26 at 09:34 AM, Administrative Nurse D reported the facility's minimum staffing pattern was two staff who could pass medications, one of which would be a licensed nurse, for both neighborhoods. Each neighborhood scheduled two CNA's (a total of four) for day and evening shifts. The night shift for both neighborhoods was scheduled with one licensed nurse and two nurse aides. Administrative Nurse D verified she participated in the Facility Assessment process and thought it was in the assessment. The facility did not provide a Facility Assessment policy, as requested.

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	02/25/2026

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 41 residents. The sample included 12 residents with one reviewed for hospice services. Based on observation, record review, and interview, the facility failed to ensure Resident (R)9's care plan, who admitted to hospice on 02/10/26, included a plan of care and a description of the services provided, which included contact information, visit frequency, medications, and medical equipment. Findings included:- R9's Electronic Health Record (EHR) revealed a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R9's Significant Change Minimum Data Set (MDS), dated [DATE], documented R9 had a Brief Interview of Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. The MDS document R9 required supervision with most activities of daily living (ADL) and R9 received hospice care services. The Cognitive Loss/Dementia Care Area Assessment, (CAA), dated 02/10/26, documented R9 had dementia. R9's Care Plan, revised 02/22/26, documented R9 required supervision with most ADLs. The plan documented R9 admitted to hospice services on 02/10/26. The plan directed the staff to administer pain and other medications for comfort as the physician ordered. The care plan lacked a contact number for hospice, what supplies, equipment, and medications hospice would provide, when hospice staff would be in the building, and what care they would provide for R9. A review of R9's clinical record revealed the resident admitted to hospice care on 02/10/26. The hospice agreement, dated 08/13/24, documented Hospice and the facility would jointly develop and agree upon a coordinated plan of care. On 02/24/26 at 08:00 AM, observation revealed R9 sat at a dining room table and independently ate her breakfast meal with no signs or symptoms of pain. On 02/25/26 at 12:19 PM, Administrative Nurse D verified R9's care plan lacked information regarding what hospice services were provided to R9, such as frequency of visits, contact information/phone numbers, and medical supplies. The facility's End of Life, Palliative, and Hospice Care Policy, revised 05/02/25, documented, when possible, the hospice program staff participated in each other's team meetings to promote regular professional communication, collaboration, and an integrated plan of care on behalf of residents and families.

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	02/25/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. The facility had a census of 41 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure a sanitary environment, to help prevent the potential development and transmission of communicable diseases and infections. when staff failed to change gloves when going from a dirty to clean area during incontinence care for Resident (R)15. Findings included:- On 02/24/26 at 10:00 AM, observation revealed R15 was in bed, with a urinal in place under his covers. Certified Nurse Aide (CNA) M and Licensed Nurse (LN) G entered R15's room. CNA M asked R15 if he was finished using the urinal, and he replied 'yes'. CNA M and LN G applied gloves, CNA M removed the urinal, and spilled urine on the bed pad and her gloves. CNA M then handed LN G the urinal. LN G poured the urine in the toilet and discarded her gloves and donned new gloves. CNA M provided perineal care to R15 and assisted LN G in positioning R15 on his left side, with the same soiled gloves. CNA M touched R15's bedding, oxygen tubing, and legs with the same soiled gloves. CNA M provided incontinent care to R15's buttocks, removed the wet incontinent brief and bed pad, touched the privacy curtain at the end of R15's bed, closed the lid on the incontinent wipe package, then retrieved a new incontinent brief and placed it under R15's buttocks, while wearing the same soiled gloves. CNA M assisted LN G with positioning R15 on his back, fastened the incontinent brief, touched R15's clothing and then removed and discarded the soiled gloves. On 02/24/26 at 10:30 AM, CNA M verified she had not changed her gloves after providing perineal care and stated she should have. On 02/25/26 at 11:54 AM, Administrative Nurse D stated she expected staff to change gloves after performing perineal care for a resident. The facility's Perineal Care Protocol Policy, revised 04/09/25, instructed staff to wash hands and don (put on) gloves, remove soiled brief, remove gloves, wash hands, don clean gloves, and after providing perineal care, remove gloves, wash hands or use alcohol-based hand sanitizer, and noted not to touch anything with the soiled gloves after the procedure.