STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165511	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linn Manor Care Center	1140 Elim Drive , Marion, Iowa, 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓ KG	INITIAL COMMENTS Correction Date: 11/10/25 The following deficiencies resulted from investigation of facility reported incident #2621990 -I conducted October 13, 2025 to October 16, 2025. Facility reported incident # 2621990 -I resulted in deficiencies. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interviews, and facility policy review the facility failed to provide adequate supervision to prevent a fall, resulting in a hip fracture for one out of three residents reviewed (Resident#1). The facility reported a census of 35 residents. Findings include: The Minimum Data Set Assessment dated 8/14/25 for Resident #1 listed diagnoses of dementia, heart failure, Atrial fibrillation (irregular heart beat), malnutrition, adult failure to thrive. The MDS included a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicted severe cognitive impairment.	F0689		11/10/25

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 reverse for further 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
[signature]	ADMINISTRATOR	11/10/25

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F0689 SS = G	Continued from page 1 Per the MDS, the resident had falls since admit, entry, reentry, or prior assessment, and had two or more with no injury. The Care Plan dated 1/15/25 identified Resident #1 at risk for falls. Interventions dated 1/15/25 included, Assess resident for needs prior to leaving the room. Ensure resident always has proper footwear when transferring, i.e. gripper socks or shoes. Keep personal items and frequently used items within reach. Provide toileting assistance before and after meals, at HS (evening), and as needed. Resident's call light to be within reach and encourage it to use it for assistance as needed. Transfers with assistance of one staff, gait belt, and walker. The Fall Scale Completed 8/29/25 reflected Resident #1 at high risk of falling. The facility provided the Accident reports for Resident #'1 falls dated 1/12/25, 1/16/25, 3/9/25, 5/12/25, 5/28/25, 6/2/25, 9/7/25, and 9/8/25. The Unwitnessed Fall report dated 1/12/25 at 8:00 PM revealed staff found on floor in his room, assessment completed, gait belt applied, assisted into wheelchair. The Unwitnessed Fall report dated 1/16/25 at 2:20 PM revealed, nurse called to Resident #1 room by Physical therapist, resident found on the floor sitting upright with legs and arms stretched out. Resident #1 stated that he slid in his buttocks. The Unwitnessed Fall report dated 3/9/25 at 12:00 AM reflected, Resident #1 found on the floor near his bed with his wheelchair behind him and his walker in front of him. The Witnessed Fall report dated 5/12/25 at 12:00 AM revealed, Resident was walking to wheelchair and fell before staff reached him. Resident #1 reported he was going to dinner. The Unwitnessed Fall report dated 5/28/25 at 4:35 PM revealed, Resident found sitting on the floor in front of his wheelchair in his room. Resident unable to give description of event. The Unwitnessed Fall report dated 6/2/25 at 5:20 PM, reflected Resident #1 found by Certified Nurse Aide (CNA) in the bathroom doorway in his room. Resident sitting with back against bathroom door, fully clothed. Resident #1 said he was coming from the bathroom.	F0689		

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F0689 SS = G	Continued from page 2 The Progress Note dated 6/4/25 at 9:31 PM revealed the new intervention placed following the incident: Resident#1 can't be left in a w/c (wheelchair) in his room. The Unwitnessed Fall report dated 9/7/25 at 11:16 AM revealed, Resident #1 found yelling for help in his bathroom. Resident #1 sat on the bathroom floor with his back up against the wheelchair, wheelchair propped in the door frame. Resident#1 pants were on, he reported he already took himself to the bathroom but fell trying to turn back around to sit in the wheelchair. The report revealed, Resident #1 should not be left alone in his room in a wheelchair. The Unwitnessed Fall report dated 9/8/25 at 6:15 AM revealed a CNA heard Resident #1 yelling for help and found him in his room laying on his left side, he was between the bed and the bathroom, his wheelchair was at his side, wheels locked. Resident #1 complained of 10 out of 10 pain to his left hip. Resident had self-transferred Resident failed to have anything on his feet. Resident #1 stated this was the worst pain he had ever had. Resident #1 transferred to the ER (Emergency Room) for evaluation. The Facility Incident Summary dated 9/08/2025 reflected the ER notified the Director of Nursing (DON) of a left hip fracture and Resident #1 would remain at the hospital for surgical repair. The summary revealed staff checked on the resident in his bathroom shortly prior to the fall, and cued him to use his call light when finished. The summary identified none of the staff assisted Resident #1 off the toilet. The facility investigation read Resident #1 took himself to the bathroom and fell attempting to go back to his bed from his wheelchair. The Health Status Note dated 9/11/25 at 1:33 PM revealed, in part, Report received from [Hospital Name Redacted]; Resident is to be transferred to [Facility Name] around 1400 (2:00 PM) today. He has a closed left hip FX (fracture), post surgery. On 9/14/25 at 9:01 AM Staff E, CNA revealed she did rounds with Staff A and they found him in the bathroom on the toilet. She said she asked him if he needed help, but he declined. She stated he took himself into the bathroom. She stated she reminded to use the call light and she and Staff A finished rounds on the hall. She reported Staff D alerted her of the fall when Staff D found Resident #1 on the floor. On 10/13/25 at 4:09 PM Staff A, CNA reported at shift	F0689		

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F0689 SS = G	Continued from page 3 change on 9/8/25 6 AM, she and Staff E found Resident #1 in his bathroom. She reported she failed to help him into the bathroom. She stated she left him with Staff E to care for him. She confirmed Resident #1 attempted to self transfer before. She stated they used a touch call light, placed it next to him in bed, so they would know if he was getting up the light would come on. On 10/14/25 at 1:29 PM Staff H, Licensed Practical Nurse (LPN) reported Resident #1 had several falls they were due to him getting up from the wheelchair. He reported he's seen him (resident) attempt to get out to the wheelchair a few times. On 10/14/25 at 1:58 pm, Staff D, CNA reported on 9/8/25 he got to work at 6 AM and went to help a resident that called out for help further down the hall then Resident #1. He reported he heard Resident #1 calling out for help and went to find Resident #1 on the floor in his room. He alerted the nurse of the fall. He reported the other CNA assigned to the hall got report from the off going shift. He said he failed to know Resident #1 was out of bed before finding him on the floor. Staff D reported he would never leave Resident #1 on the toilet alone. On 10/14/26 at 9:45 AM Staff F, Licensed Practical Nurse reported after the fall Resident #1 had on 9/7/25, she wouldn't have left him sitting on the toilet. On 10/15/25 at 9:15 AM, the DON reported the intervention from the fall on 9/7/25 day before he fell and fractured his left hip, directed staff do not leave unattended in his room in the wheelchair. She stated she failed to know the difference from leaving him in the w/c or on the toilet in his room unattended. She failed to know staff used the do not leave unattended intervention on the fall from the w/c in Jun 25, 2025. She reported when staff found him on the toilet on 9/8/25, the staff should not have left him on the toilet. The Facility provided a policy titled Fall Prevention, undated, revealed the following: Risk factors for falls include: Previous falls, problems with mobility and walking, fear of falling, irregular heart beat, blood pressure that drops significantly upon standing, dizziness, confusion, problems with seeing or hearing, multiple medications, inappropriate footwear, pathological fractures. Over 40% of nursing home residents fall each year. Five percent of these falls can result in a serious injury...After each fall, complete an incident report. Look for trending.	F0689		

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F0689 SS = G	Continued from page 4 Identify the possible reason for the fall and make appropriate changes to the plan of care.	F0689		
F0742 SS = D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interviews and facility policy review the facility failed to provide individualized Care Plan interventions to address resident trauma one out of one resident reviewed (Resident #1). The facility reported a census of 35 residents. Findings include: The Admission Minimum Data Set Assessment dated 1/12/25, listed diagnoses of Atrial fibrillation (irregular heart beat), pneumonia, urinary tract infection (UTI), malnutrition, adult failure to thrive. The MDS included a Brief Interview for Mental Status (BIMS) score of 5 (severe cog impairment). The MDS revealed Resident#1's behaviors were physical behavioral symptoms directed towards others and verbal behavioral symptoms directed towards others 1 to 3 days in the 7 day look back period. Wandering, and rejection of care1-3 days. The Trauma Informed Care assessment dated 1/9/25, revealed Resident#1 reported repeated disturbing memories, thoughts or images of a stressful experience from the past and he confirmed upsetting dreams about the event. The note on the assessment stated Resident#1 repeatedly talked about his time in the military special forces and how his memories are very vivid. He stated he saw "some pretty bad things" during his time, he chooses not to talk much about it, however reports remembering them is all he likes to do. He denied triggers, he just remembered what happened.	F0742		11/10/25

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F0742 SS = D	Continued from page 5 The bottom of the form held a blank area for the Physician to complete, if psychological services are needed. The Care Area Assessment (CAA) for Resident#1 undated identified Resident noted to be resistive to cares between 1 and 3 days during the lookback period (See Point of Care (POC) behavior documentation and nurses' notes). Contributing factors include newly admitted to facility, dx of pneumonia, UTI, malnutrition, failure to thrive, and impaired cognition, and the use of antidepressant medications (See PCC dx list, ARNP notes, nursing notes and assessments, dietician notes and assessments, social work notes and assessments, POC documentation, and January 2025 MAR). The CAA reflected behavior symptoms addressed in the Care Plan and listed the impact on the resident. Resident#1 is at risk for unmet needs, depression and/or anxiety, frustration, agitation, physical or verbal behaviors, falls, decline in ADL functions, social isolation, and decreased quality of life related to behavioral symptoms. The Care Plan for Resident#1 dated 1/20/25, reflected the goal behavioral symptoms not directed to others (e.g. hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). The Care Plan interventions dated 1/20/25 included: Assess whether the behavior endangers the resident and/or others. Avoid over-stimulation (e.g. noise, crowding, other physically aggressive residents). Convey an attitude of acceptance toward the resident. Maintain a calm environment and approach to the resident. Remove resident#1 from group activities when behavior is unacceptable. The updated Care Plan intervention dated 7/21/25, directed when Resident#1 becomes socially inappropriate/disruptive, move to a quiet, calm environment. An updated Care Plan intervention dated 8/13/25,	F0742		

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F0742 SS = D	Continued from page 6 reported Resident#1 to use plastic silverware for mealtimes. The Care Plan updated 7/14/25, reflected Resident#1 received psychotropic medications (antianxiety). Resident is prescribed psychotropic medications for behaviors that included: Aggressive actions such as raising fists in the air towards staff, swinging butter knife in the air directed towards staff, cursing, refusing care, medications, and medical treatments, agitation, and restlessness. The Behaviors documented by the Certified Nurse Aid (CNA) on 10/4/25, 9/26/25, 9/23/25, and 9/20/25, 9/15/25, 9/2/25 included grabbing others, kicking others, hitting others, scratching others, accusing others, cursing, screaming, threatening, physically aggressive to others and expression of frustrations or anger at others. Agitated, anxious/restless, screaming not at others, panic and wandering. On 10/15/25 at 9:15 AM the Director of Nursing (DON) reported with Resident#1's combativeness, the approach needs to be delicate related to his PTSD. On 10/14/25 at 9:34 AM Staff J, CNA stated Resident#1's behaviors include hitting and yelling. She reported he has PTSD from war. On 10/14/26 at 09:45 AM Staff I, LPN reported Resident#1's showed combative behaviors with care. On 10/14/25 at 1:29 PM Staff H, LPN reported Resident#1 showed combative behavior when staff tried getting him ready for bed, especially when doing cares. Staff H reported Resident#1 thinks he needed to kill Staff H. Staff H stated he's confused and doesn't know what he was talking about. On 10/14/25 at 1:38 PM, Staff G, Registered Nurse (RN) reported Resident#1 experienced PTSD-like symptoms when he acted out at the staff while they cared for him. She reported he failed to like other men near him much. 10/15/25 at 2:03 PM Staff E, CNA reported Resident#1 slapped at the staff with cares. She reported he does better with male staff. She reported the facility failed to train them to stop when he has the behaviors. On 10/15/25 at 3:03 PM The Registered Nurse Consultant (RNC) provided the Tasks and confirmed they listed a lot of behavior types not specific or detailed of the situation.	F0742		

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F0742 SS = D	Continued from page 7 On 10/15/25 at 3:53 Staff B, CNA reported Resident #1's behaviors are when things trigger him. She said the staff think it's related to the war. Staff B said he asked if they heard the gun shot or bang. She revealed one time he grabbed her hand when he was mad but they redirected him. She stated she squatted down to look him eye to eye and talk to him before she does anything with him. She said the facility told the CNAs a while ago when Resident #1 hit to get the nurse. She said if he started talking about the war, they needed to try to calm him down and not irritate him more. She reported he is strong. On 10/16/25 at 10:12 AM the Social Service staff reported she completed the Trauma Informed Care assessment and it was filed in the record. She reported the nursing department completed most of the Care Plan, she completed the Care Plan related to Advanced Directive and discharge. She reported some of the staff told her about his combative behaviors but no one directly told her about his comments related to war and guns. She reported she completed the Patient Health Questionnaire (PHQ9) (assess the severity of depression) and if that score is over 5 she will let the provider know, but that is the only time she sends things to the provider. She reported the facility noticed Resident #1 did better with a group of staff go into care for him. She thought that was related to his history of military service. On 10/16/25 at 11:00 AM the Director of Nursing (DON) reported there was no formal policy for Care Plans. She reported updates are mentioned in individual policies as applicable. Care Plans are developed in accordance with guidance for Comprehensive Person-Centered Care Planning. The Facility Policy titled Care Plan-Baseline dated 5/2024 revealed, in part, The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: Initial goals based on admission orders and discussion with the resident/representative; Physician orders; Dietary orders; Therapy services, Social services; and Behavioral interventions...The baseline care plan is used until the comprehensive assessment and development of an interdisciplinary person-centered comprehensive care plan is created (no later than 21 days after admission).. The baseline care plan is updated as needed to meet the resident's needs until the	F0742		

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F0742 SS = D	Continued from page 8 comprehensive care plan is developed. The Care Planning Procedure, undated, revealed the following: MDS coordinator will be responsible for creation of the care plan. Other staff that may make changes to the care plan include the restorative nurse, dietitian, activities staff, social services and charge nurses. Staff will be notified of changes to the care plan via a communication tool...Any triggering CAA you determine needs addressed should be included. The Care Planning Procedure included a list that may be used as a guide for comprehensive care planning and is not all inclusive. The list included PTSD and trauma informed care.	F0742		

Linn Manor Care Center Plan of Correction

Survey Conducted: 10/13/2025-10/16/2025

F0689- 481-58.28(135C) Safety

1. Resident #1's care plan updated to indicate staff should stay with him while toileting after fall on 9/11/2025 and his care plan was updated with change in transfer status on 10/6/2025.
2. Facility implemented "stay with me" program through a QAPI project following Resident #1's fall on 9/8/2025 and subsequent investigation (See Below)

QAPI Project: Stay with Me

Process

1. Residents will be evaluated for this program on admission and with each quarterly review and fall, DON and ADON will be responsible on an ongoing basis.
2. If a resident has been noted by staff to self-transfer when they are care planned for assistance the IDT will immediately implement a "stay with me" program. IDT is responsible, ultimate responsibility to DON and ADON.
3. If a resident has a high fall risk score on the Morse Fall Risk assessment and is severely cognitively impaired the IDT is strongly encouraged to put that resident on a "stay with me" program unless there is a strong indication as to why that resident is safe without supervision while toileting. If stay with me is not implemented, DON or ADON will document why this decision was thought to be safe in the progress notes.
4. In addition to the evaluations noted in #1 residents can be reassessed and removed from or added to then program whenever they have a change that results in them requiring more supervision or that the IDT determines they are safe with less supervision.
5. When resident is on a "stay with me" program a sign will be placed in their bathroom with resident initials if they have a roommate.
6. Signs will read in large bold print "Hello Staff Member! Please stay with me for my safety" with resident initials below.
7. **No resident** who requires mobility assistance will be left alone in the shower rooms. Signs placed in both shower rooms as a reminder to staff.
8. Implementing or discontinuing a "stay with me" program will be documented in the progress notes and updated on both the care plan and care sign.
9. Stay with me program is added to the CNA and Nurse training programs.

10. The IDT will complete periodic observations of staff with routine rounds to ensure staff are following stay with me program. This will be documented as part of QAPI notes.

Program Goal Timelines:

9/11/25 Begin education at staff huddles regarding stay with me program. Add to training program sheets.

Education & training revision completed for all staff 9/18/25.

Staff education will include:

- Details of the program
- Expectations of supervision of a stay with me resident
- What the bathroom signs mean
- Expectation of remaining with any resident who they know self-transferred or has a history of doing so
- Notifying leadership of observed self-transferring

9/11/25 All residents evaluated and signs will be in place. **Completed 9/11/2025**

9/18/25 Programs fully implemented with all care plans updated, progress notes made and staff educated- **Goal Met**

10/27/2025- Confirmed program continues to be in place for all residents, process in place for continuing to evaluate residents with changes and routine assessments. Staff are able to explain program when asked and are consistently observed staying with residents when audited by management and nurse consulting on rounds.

F0742 – 481-58.39(135C) Residents' rights in general

1. Resident #1's care plan will be updated by **10/30/2025** to include trauma history and interventions specific to trauma related behaviors. A revised trauma informed care assessment will be completed **10/30/25** that includes interviews from staff.
2. Facility revised the "Trauma Informed Care" Assessment includes a section for staff interviews related to behaviors and trauma. Assessment will be completed on admission and quarterly or with significant changes. Assessment includes an action step for the Social Service Designee to care plan any trauma and associated interventions or to notify nursing of a need to care plan these concerns and actions.
3. Trauma Informed Care Planning policy created 10/29/25 with process above.

4. Social Service Designee to complete new Trauma Informed Care Assessment on all residents **by 11/10/2025**. Any updates to care plan to be completed by **11/10/2025.**
5. New interventions for residents will be communicated to staff via staff huddle and the communication book by **11/10/2025.**
6. MDS and Social Services will monitor this process and complete it on an ongoing basis with quarterly, significant change and admission assessments