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 06/10/2026

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	INITIAL COMMENTS The following deficiency resulted from investigation of facility reported incident #2977546-I conducted June 08, 2026 to June 10, 2026. Facility reported incident #2977546-I resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0689 SS = D	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 staff interview, clinical record review, facility investigation review, and facility policy review the facility failed to ensure all staff responded appropriately to a sounding door alarm for 1 of 3 residents reviewed for inadequate nursing supervision (Resident #1). On 3/24/26 a confused, ambulatory resident (Resident #1), known to have exit seeking behaviors, exited the facility's East door unattended and was seen by staff walking in the road away from the facility. The facility failed to ensure the staff member who responded to the door alarm initiated resident checks to ensure all residents were accounted for after the door alarm sounded, and failed to communicate that no one was seen at and outside the door. The facility reported a census of 35 residents.	F0689	"Past Noncompliance - no plan of correction required"	

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

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F0689 SS = D	Continued from page 1 The facility corrected the deficient practice per past noncompliance through the following actions: -Hourly then 15 minute checks for Resident #1 upon return to the facility -Stop sign redirections added to doors -Staff education on door alarm response on 3/25/26 -Elopement drill 3/26/26 with repeat elopement drill on 3/27/26 -Addition of secondary louder alarms on 3/27/26 Findings include: Review of the Minimum Data Set (MDS) Assessment dated 4/16/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated severe cognitive impairment. The list of diagnoses included non-Alzheimer's dementia, anxiety disorder, Coronary Artery Disease (CAD), and Peripheral Vascular Disease (PVD). The MDS indicated Resident #1 transferred and ambulated independently without an assistive device and had 2 or more falls since the previous Assessment. Per this assessment, the resident had not wandered. Review of the Care Plan initiated 2/05/25 revealed a Focus area that Resident #1 experiences wandering. The Goal initiated 2/5/25 revealed Resident #1 would wander safely within specified boundaries. Interventions instructed the following, in part: a. Approach from the front. Walk in step with resident first before redirecting. Date initiated: 2/05/25. b. Assure resident has proper fitting and appropriate foot attire. Date initiated: 2/05/25. c. Avoid overstimulation (Noise, crowding, other physically aggressive residents). Date initiated: 2/05/25. d. Convey an attitude of acceptance toward the resident. Date initiated: 2/05/25. e. Develop a pathway for resident to follow. Keep pathway free from obstacles. Date initiated: 2/05/25. f. If resident looks for family/significant other, reassure that others know where to find him/her. Date initiated: 2/05/25.	F0689		

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F0689 SS = D	Continued from page 2 g. Maintain a calm environment and approach to the resident. Date initiated: 2/05/25. h. Monitor for signs/symptoms of Urinary Tract Infection (UTI) when increased attempts at going out the door(s) are noted. Date initiated: 2/05/25. i. Redirect resident from exit doors as needed. Date initiated: 2/05/25. j. Remove resident from other resident's room and unsafe situations. Date initiated: 2/05/25. k. Resident is exit seeking when wife requests to be taken to the casino. Toy slot machine bought to be used for wife upon casino request. Date initiated: 3/16/26. l. Resident is on 15 minute checks. Date initiated: 3/25/26. m. Stop signs to all doors for redirection. Date initiated 3/25/26. n. Motion sensor door bell put in place from 5:00 PM to 8:00 AM to alert staff when resident wanders at night. Date initiated: 5/15/26. Review of Wandering Risk Scale Assessments completed for Resident #1 revealed on 8/15/25 and 11/15/25, the resident scored 11 on the assessment, and was assessed at high risk of wandering. On 2/16/26, the resident scored 8 on the assessment, and was assessed at low risk of wandering. On 6/1/26, the resident scored 12 on the assessment, and was assessed at high risk of wandering. Review of Resident #1's Progress Notes dated March 2026 revealed, in part, the following: The Progress Note dated 3/2/26 at 2:39 PM revealed the resident put on his coat and tried to leave the facility, he stated he wanted to go to the bank. The Progress Note dated 3/4/26 at 11:03 AM revealed in part, staff asked Resident #1 if he would like to go outside for a walk, he said he would like that, and they walked around half of the building. The resident said he had a car here somewhere just did not know where. The Progress Note dated 3/11/26 at 10:41 PM revealed, the resident was caught exiting through the R wing door that he was heading to the back to withdraw money so his spouse can use it at the casino. The resident was redirected to meaningful activity. The Progress Note dated 3/18/26 revealed the resident tried to elope from the facility he stated he was going to the bank. The Progress Note dated	F0689		

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F0689 SS = D	Continued from page 3 3/23/26 at 12:58 PM revealed, in part, the resident was upset about not getting mail, he wanted to go to the post office and stated a building outside was the post office, it was explained that was not the post office. Review of a Progress Note dated 3/24/26 at 12:54 PM revealed the following: Resident is yelling at staff and peers, he was trying to run over other residents with his wife in her wheelchair, stated they were in his way, staff had to glide his wife's wheelchair around the other resident. He got mad at staff and tried to hit staff, he did not make contact, staff explained that they were trying to help. He refused his PRN (as needed medication), he got mad because he did not get mail and thought staff was stealing his mail and glasses. Staff found his glasses under his pillow. Review of an Incident Report completed by the Assistant Director of Nursing (ADON) dated 3/24/26 at 4:20 PM described the following: At about 4:00 PM, I [ADON] clocked out and was walking out the back door when Staff A, former facility Administrator, asked me to go with him to pick up Resident #1 because he saw him walking outside the building without any of our staff. I [ADON] got in [Staff A's] car and we drove around the block. We met Resident #1 in [redacted] restaurant parking lot at about 4:05 PM...We kindly asked him to get in the car so that we can give him a ride home. He refused and insisted that he wanted to go to [Store Redacted]. I [ADON] walked with him across the street, with Staff A drove to [Store Redacted] and waited on us...Resident #1 felt guilty and agreed to let us take him home...Staff A drove us back to the facility and Resident #1 went to talk to his wife. He seemed very sad about what he did and apologized to us on the way back. Upon return to the facility at about 4:15 PM, we met Staff C, CNA, in the hall and told her what had happened and asked her to let the other staff know so they can all keep an eye on him every hour. Review of a facility provided email from Staff A, dated 3/25/26 at 1:17 PM, documented the following witness statement for Staff A: On Tuesday March 24th at about 2:30 PM, in the afternoon, [Resident #1] was wanting to go outside to go to his bank. He was at the door in the front of the building. I took him outside, we walked around the front of the facility and watched the construction that was going on at the time. He talked about going inside to get his coat as it is cool outside, we walked back into the building. Resident #1 seemed calm as he walked down to his room. At about 4:00 PM, I heard the	F0689		

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F0689 SS = D	Continued from page 4 door alarm go off, I went to the window to see Resident #1 walking in the street, I grabbed my coat and ran after him asking our ADON to come with me as I left the building. We drove up the street and brought Resident #1 back to the building. He was cooperative as we returned to the facility. Review of a facility provided document dated 3/25/26 at 1:15 PM titled, Phone Interview with [Staff B], CNA revealed the following questions asked by the Director of Nursing (DON) and answers provided by Staff B: -Question (Q): You were seen on camera on R- Hall (East) checking the exit around 4:00 PM on 3/24/26. Did you hear a door alarm? Answer (A): Yes. -Q. Did you check outside the door? A. Yes, I opened it and looked outside. I thought it was a delivery. -Q. Did you see a resident outside? A. No, I didn't see anyone. -Q. Did you do anything after that? A. I reset the door alarm but no, I did not do anything else. During an interview on 6/09/26 at 3:30 PM, Staff C, CNA, said she was told by ADON that Resident #1 had been outside and to start checks, on the evening of Resident #1's elopement. Staff C stated she was unable to remember if there was a door alarm sounding prior to being told Resident #1 was outside. Staff C reported that if a door alarm is heard, staff are expected to go and check the door, open the door and look outside and if no one is outside, then do a head count of residents to ensure all are present. During an interview on 6/10/26 at 11:25 AM, Staff D, CNA, reported that Resident #1 had increased exit seeking behaviors around the time he exited the facility. When queried about interventions in place to prevent elopement, Staff D stated that staff would try to redirect Resident #1 but there were times that it took 3 to 4 staff to get him turned around. Resident #1 would grab at staff and hold onto their arms. Staff D said when Resident #1 was trying to go out the front door, staff would go with him out to the patio and stay with Resident #1. Staff D explained typically when working on the North Hall it had been difficult to hear the East Hall door alarm, and explained that another, louder, alarm was added to the hallway exit doors following this incident. Staff D explained that when a door alarm was heard, staff were expected to go to the door and check for residents, and if no	F0689		

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F0689 SS = D	Continued from page 5 one is seen, a resident count was done to ensure all residents were present in the facility. During an interview on 6/10/26 at 2:19 PM, Staff E, CNA recalled coming in to work on 3/24/26 around 5:00 PM and stated she was not aware until the next day 3/25/26 at a 2:00 PM stand up meeting that Resident #1 had an elopement, and did a training. Staff E stated that around the time Resident #1 had exited the facility he had more persistent exit seeking behaviors. During an interview on 6/10/26 at 2:23 PM, the ADON confirmed telling only Staff C, CNA, that Resident #1 had been outside and to start hourly checks on Resident #1. During an interview on 6/10/26 at 2:45 PM, the Director of Nursing (DON) said she was notified by ADON on the morning of 3/25/26 that Resident #1 had left the facility on the evening of 3/24/26. The DON stated following knowledge of elopement she implemented 15 minute checks on Resident #1 and began to collect staff statements of the incident. The DON revealed expectation that staff immediately respond to door alarms, and communicate via walkie talkies when door alarms are answered. If no one is seen when checking the door alarm, staff need to initiate a resident count to ensure all residents are present. The DON stated that if staff were to see Resident #1 outside, were to immediately go to him and stay with him, communicating via walkie talkie for assistance. Review of the facility policy titled Door Alarms, dated 1/2024, revealed the policy intent to provide guidance related to responding to door alarms. The Section titled, Procedure, instructed the following: 1.Staff will immediately respond to all door alarms. 2.Staff should assume that a resident exiting the facility caused the alarm to sound and investigate as if a resident has left the building. Open the door and check if a resident is in sight. Walk outside and check the grounds and scan the surrounding area. a. Do not assume that if a staff member or visitor is in sight that they caused the alarm, consider that a resident could have exited the building at the same time as someone else. Ask appropriate follow up questions such as, “Did your exit sound the door alarm?” and “Did anyone else exit with you?”	F0689		

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F0689 SS = D	Continued from page 6 3. If the cause for the door alarm cannot be determined, or if there is any doubt in what caused the alarm, staff will immediately initiate a head count. 4. If a resident is unaccounted for, staff will immediately search the entire building room to room and the facility grounds. The charge nurse should remain inside and coordinate staff including a communication plan during the search (i.e. the use of walkie talkies). 5. If the missing resident cannot be located inside the facility or the property, the staff should proceed to steps in The Elopement Policy. 6. If nursing management or administration is not on site, both will be notified by staff as soon as possible.	F0689		