

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER Heartland Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 604 East Fenton PO Box 608 PO BOX 608, Marcus, Iowa, 51035		
(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 X DC	INITIAL COMMENTS Correction date: <u>11/25/25</u> The following deficiencies resulted from investigation of complaints #1801716-C, #1801706-C, conducted September 23, 2025 to September 25, 2025. Complaints #1801716-C and #1801706-C resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000	F695 Respiratory/Tracheostomy and Suctioning 1. Resident # 3 was discharged from the facility 2. An audit of residents that have oxygen orders were reviewed for current and signed orders with family notification and vitals for assessment.	
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record and policy review the facility failed to provide adequate respiratory care for 1 of 3 residents reviewed. Resident #3 required supplemental oxygen. The staff failed to increase monitoring and failed to consult with the resident and family before requesting a change from scheduled oxygen to an as-needed (PRN) order. The resident experienced low oxygen saturations, increased lethargy and was hospitalized. The facility reported a census of 29 residents. Findings include: According to the Minimum Data Set (MDS), dated 4/10/25,	F0695	3. Licensed Nurses were educated on 9.25.2025 on the requirement to call the provider on any telephone order and responsible party is notified. Follow up vitals will be monitored with any change in oxygen orders. 4. An audit will be completed on the 3 residents that use oxygen/ PRN order for oxygen for current order, vitals and family notifications by the DON or Designee weekly for 4 weeks and then 1-time monthly times 2. The results of these audits will be presented to the QAPI committee monthly for 3 months for review and recommendations as needed. The DON is responsible for monitoring and follow-up as needed.	11/25/25

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 Administrator	(X6) DATE 11/26/25
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F0695 SS = D	<p>Continued from page 1 Resident #3 was admitted to the facility on 4/4/25. He had a Brief Interview for Mental Status (BIMS) score of 13 (intact cognitive functioning) and required partial assistance with toileting hygiene, and transfers. The resident had shortness of breath with exertion and was on continuous oxygen therapy. His diagnoses included: atrial fibrillation, coronary artery disease, renal insufficiency, pneumonia, respiratory failure and sarcoidosis of the lungs.</p> <p>The Care Plan initiated on 4/4/25, showed Resident #3 had altered respiratory status related to respiratory failure. Staff were to observe for signs and symptoms of respiratory distress and report to the doctor on increased respirations, decreased pulse oximetry, increased heart rate, lethargy, cough and skin color change. The oxygen settings were at 2 liters (L), to be increased to 3.5 liters with ambulation.</p> <p>According to National Institute of Standards and Technology, U.S. Department of Commerce (NIST), most people have a normal resting pulse oximetry reading between 95% and 100% oxygen saturation (O2). Below 90% indicated oxygen deficiency (hypoxia) and may require immediate medical attention. Retrieved on 9/25/25 at 10:40 AM from: How Do You Measure Blood Oxygen Levels? NIST</p> <p>The Medication/Treatment Administration Record (MAR/TAR) for Resident #3 in the month of April showed an order for oxygen at 2L, increase to 3.5L when ambulating. O2 was documented three times a day on the April MAR/TAR.</p> <p>On Saturday, 5/10/25 at 11:24 AM, Staff C, Registered Nurse, completed a communication to the physician to change the oxygen order for Resident #3 from continuous, to PRN. The discontinue/change reason: "Resident maintains oxygen (O2) above 89% on room air. O2 is not needed at all times" The communication document indicated that the change was approved verbally by Physician #1, the Primary Care Physician (PCP) for Resident #3.</p> <p>On 9/24/25 at 7:30 AM The Director of Nursing (DON) said that on the weekends, the doctor on call depended on who the PCP was for the particular resident. The nurses were to call the emergency department for the PCP, and orders would then be entered with the name of the doctor who verbally approved the order.</p> <p>On 9/24/25 at 10:00 AM The scheduler for Physician #1 checked the weekend of 5/10/25 and found that Physician #2 was on call. Nurses would talk to the House</p>	F0695		

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F0695 SS = D	<p>Continued from page 2 Supervisor at the hospital to get a message to the on-call doctor, or they could contact the doctor directly. The scheduler checked the file for Resident #3 and the weekend of 5/10/25 and did not see any scanned communication sheet or nurses note related to a request to change an order.</p> <p>The electronic record titled: O2 Sats Summary showed the oxygen level for Resident #3 was checked twice on 5/10/25 at 11:21 AM, at 92% on Room Air (RA), and at 2:41 PM, at 90% on RA. The O2 was not checked again until 5/11/25 at 7:14 AM, when he was 91% on RA, and at 2:42 PM, at 90% on RA. His O2 was not checked again until 19 hours later, on 5/12/25 at 10:08 AM, when it was 91% on 2L of oxygen. The chart lacked documentation of the O2 level before the oxygen had been reapplied.</p> <p>On 9/23/25 at 3:30 PM, Staff C, RN, had some difficulty remembering Resident #3 but she did recall that she went into his room one day and the oxygen concentrator had been turned off. She said she checked his oxygen level at that time, and it was above 90% so she continued to check throughout the day and he was doing fine without the supplemental O2. Staff C said that the resident had been doing well with therapy without the oxygen also. Staff C said that she didn't remember requesting the change in order from scheduled to PRN, but when asked if the family agreed, she said she talked to the resident and his wife and they were fine with the change.</p> <p>A Service Note dated 5/9/25, from Occupational Therapy showed that Resident #3 tolerated exercises that day for 3-4 minutes at a time with a significant drop in O2 while on 1L oxygen. The O2 dropped in the low 80s.</p> <p>A Service Note from Physical Therapy dated 5/7/25, showed that the resident ambulated without the supplemental oxygen and O2 decreased to 84%. It took him a little over a minute to recover to 92%. On 5/8/25, the resident ambulated with oxygen on 1L for 200 feet and his O2 was 84% following ambulation and recovered to over 90% in about a minute.</p> <p>A Nursing Progress Note dated 5/12/25 at 11:21 PM, showed that the oxygen level for Resident #3 was in low 70s, that evening. Supplemental oxygen was administered to bring levels back up into the 90s. The resident and the family requested to leave on continuously to prevent from dropping back down below 90s.</p> <p>A communication to the physician was sent on 5/13/25 at 7:06 AM, verbal order, to change the oxygen order from a PRN to continuous oxygen 2 to 5L to keep O2 sats</p>	F0695		

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F0695 SS = D	<p>Continued from page 3 greater than 90%.</p> <p>Nursing Progress Notes included the following: On 5/13/25 at 12:25 PM, lung sounds diminished, on 3 liters oxygen. On 5/13/25 at 12:11 PM, the resident was out of the facility for an appointment. On 5/13/25 at 5:26 PM, the resident was hospitalized.</p> <p>A History of Present Illness note from nephrologist showed that on 5/13/25 at 1:30 PM, the patient came in with complaints of shortness of breath and weakness, on continuous oxygen, and he had a cough. The doctor recommend admission to the hospital for work up and treatment.</p> <p>The Hospital Emergency Department Note, dated 5/13/25 at 5:10 PM, showed that the oxygen saturation for Resident #3 had been in the low 70s at triage. He reported feeling worn out with low energy and low appetite and he had bilateral crackles in his lungs. A chest x-ray showed bilateral pulmonary congestion suggestive of pulmonary edema.</p> <p>On 9/23/25 at 11:21 AM, a Family Member (FM) said that in the days leading up to his hospitalization, Resident #3 wasn't getting enough oxygen, he was shaking and had low energy. She said that he was taken off the supplemental oxygen "cold turkey" on a Saturday and this decision was not discussed with him or the family. She said she came in to see him on 5/12/25, he was in his room shaking and purple. A staff member came in with his supper and she asked her to get the nurse. When the nurse came back with finger monitor, she found his O2 was in the lower 70s. FM said that when they changed the order they were checking on him less often.</p> <p>On 9/23/25 at 2:00 PM, Staff B, RN said that she came to work the 6 PM shift on 5/12/25 and Resident #3 was struggling to eat, and his lips were blue. She put oxygen on him for the rest of the night. Staff B said she didn't know why the order had been changed on a Saturday without a trial titration.</p> <p>On 9/24/25 at 9:12 AM, Staff E, Licensed Practical Nurse (LPN) said her experience with Resident #3 was that he had trouble keeping his oxygen up so they made sure he always had it on. There were times that she would find him without the mask on, but she directed him to put it on, and he would without resistance. She was not sure why the order would have been changed on a weekend.</p> <p>On 9/24/25 at 10:30 AM, Staff D, RN, said she changed the oxygen order from PRN back to continuous because he</p>	F0695		

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F0695 SS = D	<p>Continued from page 4 wasn't tolerating being on RA very well and his oxygen was running low. She remembered that this was just before he had been hospitalized.</p> <p>On 9/24/25 at 12:03 PM, Staff F, RN, said that Resident #3 was non-compliant and was always taking his oxygen off so she could see why a request for PRN oxygen would have been appropriate. She said that they continued to check his oxygen frequently and he always maintained above 90%. She said that with a titration in oxygen, she would expect increased monitoring.</p> <p>On 9/24/25 at 2:15 PM, Physician #1 said that he was not very familiar with Resident #3 and hadn't actually even seen him while he was at the nursing home. He said that he typically did not like to make any major changes on a resident if he hadn't actually seen them.</p> <p>On 9/25/25 at 7:30 AM, the DON acknowledged that the documentation of the oxygen monitoring had decreased after the order change on 5/10/25. She said that the nurses could have possibly documented the oxygen levels on their communication sheets that they use to write on and keep track of hot charting.</p> <p>According to the facility policy titled: Nursing Policy for Receiving and Noting New Orders, the nurse was to inform resident and/or family of new orders, especially orders received due to change in resident condition.</p> <p>The policy titled: Policy and Procedure of Oxygen Therapy, showed that the nurse should observe for signs of shortness of breath, rapid, shallow breath, cyanosis of lips assess lung sounds, pulse, respiration rates and SAO2 to determine if oxygen was appropriate.</p>	F0695		