STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165397	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Care Center	604 East Fenton Po Box 608 Marcus, IA 51035

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], Resident #3 was admitted to the facility on [DATE]. 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.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.According to National Institute of Standards and Technology, U.S. Department of Commerce ([NAME]), 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? [NAME] 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.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.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.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 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.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.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. 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. 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.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 A communication