

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165539	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Marian Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 Sixth Avenue North Fort Dodge, IA 50501	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy, the facility failed to notify the physician of a condition change for 1 of 1 residents reviewed (Resident #66). Resident #66 had complaints of shortness of breath with low oxygen saturation of 79% on 3 liters (L) of oxygen and a new productive cough with crackles in bilateral lower lungs. The facility reported a census of 72 residents. Findings include: Resident #66's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS also documented diagnoses of Alzheimer's disease, respiratory failure, a seizure disorder, malnutrition, anxiety, and depression. A review of the facility's progress notes on 5/14/26 at 4:41 PM revealed a nurse documented an assessment of Resident #66 regarding complaints of shortness of breath (SOB), difficulty breathing, and nausea. Resident #66 stated she felt dizzy and lightheaded. Staff noted the resident appeared diaphoretic (sweating heavily due to illness) and was shaking her legs, and Resident #66's hands appeared cyanotic (turning blue from lack of oxygen). Her vital signs were a temperature of 98.6, a pulse of 104 (average 60-100), a blood pressure of 153/65 (average 120/80), and an oxygen (O2) saturation of 79% (expected to be greater than 90%) on 3 liters via nasal cannula (NC). The nurse instructed Resident #66 to take deep breaths, and after 15 minutes, her O2 saturation returned to 90% and her pulse dropped to 84. Resident #66 returned to bed and reported no further nausea or dizziness. Resident #66 reported she didn't eat that day because she felt like crap. Resident #66 presented with a new productive cough (movement of fluids out of the lungs or airway) that started that morning, and crackles (abnormal sounds in the lungs) were heard in the bilateral lower lungs. A review of the facility's progress notes on 5/15/26 at 2:00 AM revealed a nurse documented an assessment of Resident #66's complaints of nausea. Resident #66's skin was noted to be pale; her pulse was 102, her blood pressure (BP) was 171/70, and her O2 saturation was 75% on 3 liters (L) via nasal cannula (NC). Resident #66's O2 saturation came up to 88% after 15 minutes. A review of the facility's clinical records revealed the facility failed to notify the physician of the change in condition for Resident #66. A review of the facility's progress notes on 5/15/26 at 6:58 AM revealed a nurse documented that at 5:30 AM, staff summoned her to the room due to the resident's complaints of SOB. Resident #66 had an O2 saturation of 70% on 3L of O2, and wheezes (abnormal lungs sounds due to decreased room in the airway) were noted throughout her lungs. The resident stated her cough was worse, noted she had not felt well for the last two days, and requested to go to the emergency room. A review of the facility's progress notes on 5/15/26 at 1:10 PM revealed a nurse documented the hospital admitted Resident #66 with an exacerbation of chronic obstructive pulmonary disease (COPD). On 6/18/26 at 9:00 AM, the Administrator acknowledged that there was no notification made to the physician. The facility policy titled Physician Notification, dated 10/10/23, (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
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the facility is to inform the physician of a resident's change in condition: Physicians will be notified promptly of the following: Any accident or incident which results in injury which may require physician intervention. ii. A significant change in resident condition which is life-threatening. A significant change in resident condition which has potential for clinical complication. A change in condition which requires a significant alteration in treatment. Death of a resident. Discharge or transfer of a resident. Any change in condition which requires immediate attention should be called to the physician immediately. Same-day written notification may be utilized for condition changes, accidents and incidents, and other events which do not require immediate attention. During an interview on 6/18/26 at 10:24 AM, Staff A, Licensed Practical Nurse (LPN), stated she expected the staff to notify the physician of the assessment.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical chart review and staff interview the facility failed to check placement for gastrostomy tube for 1 of 1 residents (Resident #66). The facility reported a census of 72 residents. Findings include: Resident #66's Minimum Data Set (MDS) (standardized clinical assessment tool) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS also documented diagnoses of Alzheimer's disease, respiratory failure (inability of lungs to exchange gases), a seizure disorder, malnutrition, anxiety, and depression. The MDS further documented Resident #66 received nutrition through a gastrostomy feeding tube (tube through abdomen for feeding). Resident #66's Care Plan dated 6/3/25 directed staff to check and record tube placement per facility protocol. On 6/16/26 at 2:20 PM observed Staff B, Registered Nurse (RN), flushed and administered an enteral feeding (feeding through a digestive tract tube) through the gastrostomy feeding tube. Staff B failed to check tube placement prior to the feeding. The facility policy titled Enteral Feeding Via Nasogastric or Gastrostomy, or Jejunostomy Tube, revised on 11/5/22, directed the following: Tube Placement Requirement: Tube placement shall be checked before each feeding, per physician order. Verification Procedure: Check for tube placement and residual gastric contents, as ordered: Using an appropriately sized syringe (20-60 mL), gently aspirate gastric contents and note the quality and quantity of any return. During an interview on 6/18/26 at 10:24 AM, Staff B, Licensed Practical Nurse (LPN), stated they expected the staff to check placement by checking the residual prior to the feeding.		