STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165565	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawkeye Care Center Dubuque	5575 Pennslyvania Avenue Asbury, IA 52002

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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 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** 37072 Based on record review, staff interview and facility policy review the facility failed to notify a family of an area of skin breakdown in 1 of 3 residents reviewed for pressure sores (Resident #16). The facility reported a census of 70 residents. Findings include: The Minimum Data Set, dated dated dated [DATE] revealed Resident #16 had a Brief Interview for Mental Score (BIMS) of 6 which indicates severe cognitive impairment. The MDS indicated the resident required substantial to moderate assistance with repositioning in bed and transfers. Review of the Progress Notes dated 4/24/24 at 4:57 AM revealed Resident #16 had a 4 centimeter by 5 centimeter open blister on left lateral ribs 6-8. Superficial wound bed, pink with clear drainage. Covered area with non-adherent dressing and mepilex dressing. The nurse practitioner was notified via facsimile. The family needs notification. During an interview on 05/02/24 at 8:39 AM the Director of Nursing (DON) stated she did not find any documentation that family was notified of the change in skin condition for Resident #16. There was documentation of communication with the family on the chart but nothing specific to the new skin area. My expectation is they would notify family of any change in condition including any new skin areas. During an interview on 05/02/24 at 8:50 AM Staff E, Registered Nurse (RN) stated Resident #16 had an open area of skin on his side by his ribs. I know the nurse before me had told me she had found an open skin area on his rib. Usually if you find a skin area you do a risk management for new skin area and then notify the nurse practitioner and the family. I did not see the area or do an assessment. I did not talk to the family about it at all. Usually the person who finds it notified the family, even if it is on third shift. (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	The facility provided an undated policy titled Nurse Notification of Physician, Resident and Representative of Changes, it directed staff it is the responsibility of licensed nurses employed at this facility to notify the resident's physician/designee, the resident and the representative if/when the resident's clinical condition may require or requires physician intervention to consult with the resident's physician when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; any significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly or a decision to transfer or discharge the resident from the facility. When making notification, the facility will ensure that all pertinent information is available and provided upon request to the physician, the resident and/or the resident's representative.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072 Based on record review, staff interview and facility policy review the facility failed to follow up with interventions for a skin problem for 1 out of 3 residents with pressure sores (Resident #16). The facility reported a census of 70 residents. Findings include: The Minimum Data Set, dated dated dated [DATE] revealed Resident #16 had a Brief Interview for Mental Score (BIMS) of 6 which indicates severe cognitive impairment. The MDS indicated resident required substantial to moderate assistance with repositioning in bed and transfers. Review of the Progress Notes dated 4/24/24 at 4:57 AM revealed Resident #16 had a 4 centimeter (cm) by 5 centimeter (cm) open blister on left lateral ribs 6-8. Superficial wound bed, pink with clear drainage. Covered area with non-adherent dressing and mepilex dressing. The nurse practitioner was notified via facsimile. The family needs notification. Review of the Change in Condition report sent to the nurse practitioner 4/24/24 revealed the facility notified the nurse practitioner of a 4 cm by 5 cm open blister on left lateral ribs. The nurse practitioner signed the report but did not include an order for treatment of the wound. During an interview on 05/02/24 at 10:05 AM the Director of Nursing (DON) stated when a wound is found staff should fill out the skin sheet and notify physician and family. We would review myself or admission nurse would review the skin sheet. The admission nurse follows all the skin areas on the transitional care unit. I am wondering if it could have been more of a friction area from the gait belt. It typically is reviewed at the morning meeting. I saw Resident #16 wound in the report the morning it was identified, looking back I am not sure what happened in the morning meeting. The nurse should fax the physician the wound information and typically as in this case they should clarify if there is no treatment. I would expect staff to obtain a treatment for a new wound. During an interview on 05/02/24 at 10:13 AM Staff F, Licensed Practical Nurse (LPN), Admissions Nurse stated she is responsible for skin issues in the transitional care unit. She stated she does remember something about Resident #16 and a skin issue on his side. She stated usually the nurse that finds it gets an immediate treatment and then from there I just monitor it weekly. I did not look at the area or assess it. I just make sure they have an order to check/measure the wound every week and make sure there are no changes. On a new admission I will get new orders. The nurse who found the wound will do the assessment. The nurse should start a risk management. We check the risk management every morning, if its a skin issue we don't look for an order for a treatment, I assume the floor nurse did it because that is their job. I put it on the Care Plan and when they heal I remove it. I also make sure weekly measurements are being done. The facility provided an undated policy titled Skin Assessments which directed staff all impairments will be noted and addressed by the facility and resident physician.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976 Based on clinical record review, policy review, and staff and family interviews the facility failed to provide adequate supervision and assistance with transfers which led to a fall that caused a resident harm for 1 of 3 residents reviewed (Resident #29). The facility reported a census of 70 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #29 documented the presence of short and long-term memory impairment. The MDS indicated the resident required assistance of 2 staff for toileting. It documented diagnoses including osteoporosis (lack of bone density), right leg below knee amputation, and generalized muscle weakness. The resident's Care Plan initiated 8/18/23 identified a focus area for dependence on staff for transfers. It directed staff to provide an assist of 2 with transfers. On 11/17/23 the intervention changed and directed staff to transfer with a Hoyer lift and assistance of two staff. The Fall Incident Note dated 11/8/23 at 8:53 AM indicated Staff B, Registered Nurse (RN) was called to the resident's room where the resident was found on the floor with her left leg in front of her, leaning back against her wheelchair with Staff C, Certified Nursing Assistant (CNA). Staff C reported she eased the resident to the ground during a transfer to the toilet. The resident complained of pain in the lower left leg. Staff B assessed the resident and noted a 9 cm x 5 cm hematoma (pooling blood under the skin) on the lower left leg and a 1 cm x 2 cm skin tear on top of the hematoma. The Emergency Department report dated 11/08/23 at 12:19 PM documented the resident had significant swelling and pain in the left lower leg. The hematoma measured 10 cm x 8 cm. Staff were instructed to elevate and ice the leg. The Fall Follow-up Note dated 11/09/23 at 4:46 AM documented the hematoma was dark red, black, and purple with bruising around the width of the leg. It measured 14 cm x 10 cm beginning at the lower leg to the top of the ankle. The skin tear was dark red in color and the area surrounding it swollen. The Non-pressure Skin Assessment v2 dated 11/17/23 documented the skin tear as 2.5 cm x 2.0 cm. The hematoma was 10 cm x 12 cm. The resident complained of tenderness to the area when standing and with touch. The Physician's Order Note dated 11/20/23 by the Wound Nurse documented the wound as a necrotic (dying) scab that measured 1 cm x 2 cm with a raised wound measuring 4 cm x 6 cm and very tender to the resident. She referred the resident to the Primary Care Provider or Surgeon for further evaluation and treatment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Surgeon's Note dated 11/30/23 documented the resident complained of leg pain during the assessment. A 4 cm x 4 cm x 2 cm area was surgically debrided (removal of damaged tissue) and a large clot was removed. The wound was then packed and wrapped. The resident was placed on an antibiotic for 7 days. The Health Status Note dated 12/3/23 documented the resident had a remaining hematoma above the surgical site that measured 3 cm x 4 cm. The note dated 12/6/23 documented an abrasion above the hematoma. The Change of Condition Form v1 dated 12/11/23 documented the shin had two open areas. The top portion had two open areas measuring less than 5 cm with white/yellow exudate (leaking fluid) with a large black area on top. The bottom portion was quarter sized, open, with white/yellow exudate and black tissue encircling the area. The Health Status Note dated 12/18/23 documented a follow-up appointment with the surgeon on that date, again on 1/25/24, and 3/25/24 with instructions to return as needed. The Non-Pressure Skin assessment dated [DATE] documented the surgical site measured 0.6 cm x 0.5 cm. The skin was pink with no active drainage. An observation of the resident on 4/30/24 at 12:55 PM revealed her attempting to self-propel in the wheelchair down the hallway with her left leg. The dressing was present on her left lower leg. During an interview on 4/30/24 at 12:50 PM Staff B reported Staff C was with the resident when she fell . Staff C was transferring her alone and lowered her to the floor during the fall. Staff B did a full head-to-toe assessment and notified the doctor & family. She noted the resident was sent to the surgeon to debride it and one small open area remains but the bottom one is healed. She noted the resident only complained of pain with dressing changes and was premedicated with Tylenol. Dressing changes were daily then changed to twice a day. She reported the skin areas are measured weekly until completely healed, and the top wound is still receiving treatment. During an interview with the Director of Nursing (DON) on 4/30/24 at 2:17 PM she produced a signed statement from Staff B that documented she knew she looked in the wrong place for resident transfer status and did not ask questions about it. She knew where to look and looked at the resident name above Resident # 29 instead. The document titled Fall Witness Statement completed by Staff C reported she attempted to transfer the resident to the toilet by herself. The resident's knees wobbled and she hit her leg on the side of the toilet. She started to fall back and Staff C eased her to the floor. She documented she needed to verify the resident was an assist of two but read the transfer sheet incorrectly and attempted an assist of 1. During an interview on 5/01/24 at 2:26 PM the DON explained her expectation is for staff to keep up to date on the Kardex (care guide) to make sure and follow the right transfer status. She further expected staff to be aware of the transfer status listed on the communication board in the Electronic Health Record and use gait belts for transfers. She expected staff to follow facility policies. The facility policy titled Use of Transfer Belt/Gait belt, updated 10/23 instructed staff to always follow the resident's interim or comprehensive care plan as more than one staff may be needed for assistance.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42134 Based on observation, document review and staff interview the facility failed to keep hands off of the drinking rim of cups for 2 of 3 dining rooms observed and failed to contain hair during meal preparation and serving for 2 of 5 staff observed. The facility reported a census of 70 residents. Findings include: During an observation of the noon meal on 4/29/24 from 11:17 AM through 11:53 AM in the Transitional Care Unit (TCU), Staff D, Dietary Aide was noted to have hair outside her hairnet on the side in front of her ears. She was serving residents food and drink from the steam table. During the same observation, Staff D was observed serving 18 cups to 11 residents while touching the drinking rim of the cups. During an observation on 5/1/24 at 11:49 AM Staff E, Dietary Aide, did not have his facial hair contained or covered while preparing and serving food. During an interview on 5/1/24 at 12:06 PM, the Dietary Manager explained the cups could not be touched at the top, where the resident would drink, the cups needed to be handled by the side or the bottom. She further explained hair nets are to be worn from the beginning to the end of the shift and all facial hair should be covered. 49976 2. During an observation of the noon meal on 4/29/30 at 11:04 AM Staff A, Dietary Aide served 5 glasses with her hand on the side of the glass and fingers touching the drinking rim surface of the glass. She served 4 glasses with her hand over top of the glass and fingers touching the drinking rim surface of the glass. This affected 9 residents.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 42134 Based on record review and staff interview the facility failed to submit Payroll Based Journaling (PBJ) data to the Centers for Medicare and Medicaid Services (CMS) as required for the quarter of October 1 through December 31, 2023. The facility reported a census of 70 residents. Findings include: The CMS PBJ Staffing Data Report for Federal Year (FY) Quarter 1 2024 (October 1- December 31) triggered for failure to submit data for the quarter. During an interview on 4/30/24 at 11:40 AM, the Administrator confirmed the corporate office did not submit the data. The corporate office submits the data to CMS. This time the corporate office was waiting for additional information from a 3rd party and submitting the facility data slipped her mind. The Administrator was not aware the data was not submitted until 4/29/24.