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	09/18/2025

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

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on staff interviews, facility record review and facility policy review the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) process to address previously identified quality deficiencies, resulting in repeated deficiencies cited on the current survey and cited in previous surveys. The facility reported a census of 71 residents.Findings include:The Centers for Medicare and Medicaid Services (CMS) 2567 form dated 12/22/22 reflected deficiencies identified for infection control.The CMS 2567 form dated 9/12/24 reflected deficiencies identified for infection control .During the current recertification and complaint dated 9/18/25, the team identified same deficiency, Infection Control (F880).On 9/18/25 at 11:22 AM the Infection Preventionist, Registered Nurse (RN) stated she did attend quarterly quality assurance meetings. They discussed what infections were in the building and how many people were on antibiotics in the past quarter. Enhanced barrier precautions was not really discussed, and it was something the Infection Preventionist said should add to their report. She revealed she was unsure if they covered personal protective equipment in skills lab this year, and she would have to check with the Director of Nursing. Per the Infection Preventionist, after the infection control deficiency last year facility educated on laundry. The problem was found in the laundry area. On 9/18/25 at 11:32 AM the Director of Nursing (DON), RN stated had a full staff meeting in August, and talked about enhanced barrier precautions. The DON explained talked about the different types of isolation precautions and different types of personal protective equipment in that meeting, and she could not recall in the recent past that they had done any quality assurance on isolation or enhanced barrier precautions. She stated did not do anything with personal protective equipment during facility's skills fair this year. On 9/18/25 at 11:38 AM, the Administrator confirmed there were concerns with the pattern of same deficiency, and thought at this point would have more frequent audits, and had started the education related to the problem. The facility provided the Quality Assurance/Process Improvement (QAPI), undated, that included facility will monitor adherence to quality standards via site visits and ongoing review of complaints, adverse events and deficiencies. Audits will be performed to review clinical and administrative protocols/procedures, and clinical records to ensure we are in compliance with protocol procedures and rules and regulations. Appropriate corrective action will be taken with any noted inconsistencies until our goals are met.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and policy review the facility failed to update a resident's code status change in a timely manner to ensure their right to refuse medical treatment was respected for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 71 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #5 revealed the resident scored 3 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. The MDS revealed Resident #5 had diagnoses of cancer, non-Alzheimer's dementia, stage 3 chronic kidney disease, and hypertensive heart disease with heart failure.A review of the resident's Electronic Health Record (EHR) on [DATE] at 8:43 AM revealed the resident's code status as CPR (Cardiopulmonary Resuscitation), which indicated the resident wanted life sustaining measures performed if his heart and/or breathing were to stop. This was included on the admission record page and at the top of the EHR tab pages.During paper chart review on [DATE] at 10:01 AM, the resident's paper chart contained code status documents that contradicted each other. A document labeled CODE STATUS for: (Resident #5) signed by the resident and a witness on [DATE] indicated the resident wanted Cardiopulmonary Resuscitation (CPR) performed. The physician line labeled I HEREBY ISSUE A FULL CODE ORDER was signed [DATE]. The physician line labeled I HEREBY ISSUE A DO NOT RESUSCITATE ORDER (DNR) was signed [DATE].Another document titled Iowa Physician Orders for Scope of Treatment (IPOST) dated [DATE] and signed by the resident's Power of Attorney documented the resident's status as DNR/Do Not Attempt Resuscitation. Medical interventions identified comfort measures only and declined artificially administered nutrition. The Nurse Practitioner signed the IPOST [DATE].On [DATE] at 10:06 AM Staff B, Licensed Practical Nurse (LPN) reached for the paper chart when asked where he would look for code status. He showed the surveyor the CODE STATUS document, and pointed to the DNR line signature. When asked about the conflicting information on that document, he checked the code status in the computer and stated the resident wanted CPR. When showed the IPOST, the LPN stated that was confusing and called the Assistant Director of Nursing (ADON).At 10:12 AM on [DATE] the ADON pointed out the dates on the documents and said that whoever got the new IPOST did not enter it into the EHR. During a follow up at 11:02 AM, the ADON stated they needed to go through the charts to remove tabs, stickers, and documents that would be confusing. She indicated they made adjustments to the resident's record to correct the error.During a follow up review of the chart on [DATE] at 10:54 AM the resident's Profile tab listed the resident's code status as DNR at the top of the page. Under the Custom Information section, the advance directive was listed as CPR.A policy titled Resuscitative Measures re-reviewed and updated 11/2024 documented CPR will be initiated and emergency personnel summoned by calling 911 in the event that a resident has a cardiopulmonary arrest, unless (1) there is the presence of obviously clinical signs of irreversible death (dependent lividity or rigor mortis); or (2) the resident or surrogate has indicated that resuscitation is not desired and the physician has issued a do not resuscitate (DNR) order which is located in the resident's clinical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, clinical record review, staff and resident interviews and facility policy review the facility failed to use Personal Protective Equipment (PPE) as directed for two out of five residents reviewed (Resident #43 and Resident #66). The facility reported a census of 71 residents. Finings include: 1.The Brief Interview for Mental Status (BIMS) assessment for Resident #66 dated 7/9/25 reflected a score of 15 out of 15, which indicated intact cognition. The Medical Diagnoses list dated 9/17/25, included diagnoses of personal history of Methicillin-resistant Staphylococcus aureus (MRSA) infection, pressure ulcer, sepsis, and urinary tract infection (UTI). Review of Hospital Medicine History and Physical paperwork for the resident dated 9/1/25 revealed the following for the resident: significant past medical history or recurrent UTI, multiple drug-resistant organism infections in the past. The Medication Administration Record (MAR) dated 9/2025, directed Cefepime HCl Intravenous (IV) Solution 2 GM 2 gram three times a day for UTI/Sepsis for 13 Days. The Care Plan for Resident #66 dated 9/16/25 identified compromised skin areas related to Intravenous (IV)s and lab draws and cellulitis. The Intervention dated 9/16/25 revealed, Provide Enhanced Barrier Precautions (EBP) outlined by CMS (Centers for Medicare and Medicaid Services). The sign posted on Resident #66's room door read, Stop Contact Precautions Everyone Must: clean their hands, including before entering and when they leave the room. Providers and staff must also: Put on gloves before room entry the room and discard gloves before exiting the room. Put on a gown before room entry and discard gown before exiting the room. On 9/16/25 at 8:58 AM, Staff A, Registered Nurse (RN) nurse entered Resident #66's room, gave her medications and failed to use a gown or gloves. Staff A gloved touched the resident face and administered eye drops to both eyes and exited the room went back to the medication cart. On 9/16/25 at 9:38 AM, Staff A gloved as she entered Resident #66's room. Staff A appeared to move around the left arm and provide care to the left arm. Staff A failed to wear a gown. On 9/16/25 at 10:44 AM, Resident #66 wore an elastic net over her left elbow area. Resident #66 confirmed the net held her IV. On 9/18/25 8:34 AM Resident #66's room door continued to hold the sign that identified contact precautions. Resident #66 reported not all the staff put on the gown, and gloves when they come in to help her. She reported it depended on who it was. On 9/18/25 at 10:26 AM, the Infection Preventionist reported Resident #66 needed Enhanced Barrier Precautions (EBP) and contact precaution related to her the infection in her urine and the IV line. The IP identified Resident #66's history of multidrug-resistant organism, (MDRO)s. She reported she expected the staff with hands on contact they needed to put on the personal protective equipment (PPE) that the sign directed. The IP reported the facility had provided the education to the staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS for Resident #43 dated 6/26/25 documented diagnoses of ulcerative (chronic) pancolitis, Crohn's disease of the large intestine, and non-Alzheimer's dementia. Her Brief Interview for Mental Status score of 13/15 indicated intact cognition. On 9/11/25 a focus area was added that the resident was on contact isolation for C-diff (Clostridium difficile, a bacterium that can cause an infection of the colon/large intestine) and received Vancomycin (antibiotic). The goal was to remain on isolation precautions as long as she had symptoms and was still on medication for C-diff. The Intervention dated 9/11/25 revealed, Staff to wear proper PPE when taking care of [Resident #43]. On 9/16/25 at 9:40 AM signs observed on Resident #43's door for contact precautions and enhanced barrier precautions. The contact precautions sign documented everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also put on gloves before room entry and discard them before room exit; put on a gown before room entry and discard gown before room exit; and use dedicated or disposable equipment. Staff were directed not to wear the same gown and gloves for the care of more than one person. There was a white cart outside the door which contained red hazard bags, white gowns, 2 packets of germicidal cleaning wipes, and regular garbage bags. The cart did not contain gloves, hand sanitizer, or masks. During an interview on 9/16/25 at 9:45 AM Resident #43 stated she had an infection but could not explain it. She said that she mostly kept to her room due to the infection. Room observations on 9/16/25 included: At 10:06 AM the resident was seated in her wheelchair in her doorway. Staff came out of another resident's room, heard her ask for help ,and entered Resident #43's room to turn on her call light. At 10:07 AM Staff D, Certified Nurses Aide (CNA) went in to the resident's room to turn her call light off without gown or gloves and brushed up against the resident's wheelchair when passing her. At 10:09 AM Staff D and Staff E, CNA used hand sanitizer available on the white cart, gowned, wore masks they were already wearing, and then took the resident in to her room. They did not put gloves on outside of the room. At 10:14 AM while Staff D and Staff E were providing cares, Staff C, CNA entered the resident's room to see if she needed ice water. She left the room, went to the cart to get the water, and re-entered the resident's room with ice water. Staff C did not wear gown or gloves. She did not wash her hands with soap and water. At 11:52 AM Staff E entered the resident's room to answer her call light without a gown or gloves. Observation revealed there were not gloves in the cart. She did not wash her hands with soap and water. During an interview with Staff C on 9/17/25 at 10:49 AM, she stated she knew C-diff was a bacterial infection of the colon that was contagious and required enhanced barrier precautions for all cares. She stated the facility provided education and that staff entering Resident #43's room should have a gown, mask, and gloves before going in. Staff C stated they should wash their hands or sanitize them when coming out of the room. She stated she was told that anyone going into Resident #43's room should wear a gown and gloves because they could carry C-diff out with them. She acknowledged that she had seen staff enter the room without proper PPE. Staff B stated on 9/17/25 at 11:01 AM the Director of Nursing (DON) provided staff training about (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C-diff and the Assistant Director of Nursing (ADON) stocked the carts. He again stated staff should gown and glove no matter their reason for entering the room.During an interview on 9/17/25 at 11:09 AM the ADON stated she and the DON worked together to receive and provide training about enhanced barrier precautions and contact precautions. She reported the process for entering the resident's room was to wash with soap and water, wear gowns and gloves, and to dispose of them before exiting the room. She was aware that some of the staff didn't gown and glove to answer the call light or bring the resident water. The facility policy titled Infection Control Manual revised 4/2025 documented contact precautions should be used for residents who are known or suspected to be infected or colonized with epidemiological organisms. Barriers included gloves when entering the room and gowns when entering the room if contact with the resident, environmental surfaces, or items in the resident's room were anticipated. The policy noted contact precautions may be considered for Clostridium difficile (C-Diff). The policy section on Clostridium Difficile (also known as C. Difficile or C. Diff) revealed, Gloves should be worn to enter the room of a resident who has diarrhea caused by C. Difficile. A gown is needed to enter the room of a resident who has diarrhea caused by C. difficile if substantial contact with the resident or the environmental surfaces is anticipated. Gloves and gown should be removed before leaving the resident's room and hands must be washed immediately with an antiseptic soap.