STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165565	A. BUILDING _____ B. WING _____	**07/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAWKEYE CARE CENTER DUBUQUE	**5575 PENNSLYVANIA 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 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** Based on clinical record review, staff interview and policy review the facility failed to provide weekly measurements, assessments, and accurate documentation for a non-pressure skin integrity injury for 1 of 1 residents reviewed (Resident #8). The facility identified a census of 66 residents. Findings include: 1. The Minimum Data Set (MDS) quarterly assessment dated [DATE] documented the resident with a Brief Interview for Mental Status (BIMS) score of 4 which indicated severe cognitive impairment The MDS documented the resident required extensive assistance of two staff for bed mobility, dressing, toileting and personal hygiene and was totally dependent on two staff for transfers. The MDS documented the resident was non-ambulatory and had range of motion limitation to one side of the body. The MDS documented the resident had a significant weight loss and had no pressure ulcers or skin injuries. The resident admitted to hospice care 2/17/20. The MDS identified the following descriptions of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. The Physician order [REDACTED]. The Care Plan dated 9/14/18 documented actual skin impairment due to diabetes and incontinence of bowels. The care plan documented this concern as resolved on 12/4/18. Review of the Care Plan initiated on 8/27/19, identified a concern for chronic excoriation on the buttocks due to moisture. The Care Plan failed to identify a new skin wound found on 5/5/20. A goal noted for the resident included to regain skin integrity dated 6/23/20. The care plan documented discontinuation (due to death) on 6/23/20. Interventions for the skin concern included apply barrier cream to the resident's buttocks after each stool or with daily activities and monitor the skin area on non-pressure skin sheet weekly and monitor skin area weekly on non-pressure skin sheet-initiated 6/23/20. Clinical record review for the nursing notes revealed the following: -5/5/20: new skin issue identified to the resident's buttocks. -5/8/20: received signed change in condition assessment regarding the area on the resident's buttocks. -5/19/20: Hospice nurse here with a change in medications. The resident denied pain to the compromised area on the buttocks. -6/2/20: Documentation of a new open area on the left side of coccyx. Non-Pressure skin Assessment Reports revealed the following: - 5/5/20: a non-pressure area identified as moisture associated skin damage (MASD) on the resident's coccyx (not identified on the buttocks). [MEDICATION NAME] cream applied and measurements documented. The care plan on the report was marked current and up-to-date is blank. -5/14/20: a non-pressure area identified as moisture-associated skin damage area on the resident's coccyx with measurements and cream applied. The report showed the care plan current and updated. -5/22/20: non-pressure assessment completed with measurements to the coccyx and now Staged as a III. (Non-pressure skin injuries are not staged.) The care plan current and update documented. -6/2/20: non-pressure assessment showed 2 areas on the coccyx marked as a Stage III. The new area is located next to a larger old area and is scabbed (eschar). Measurements completed and cream was applied to both areas. The care plan was documented as current and updated. -6/20/20: non-pressure skin assessment showed 2 areas on the resident's coccyx and both are marked as a Stage III. The second area remained scabbed. Measurements completed and cream was applied to both areas. The care plan was documented as current and updated. The Wound Care/Quality Assurance Nurse completed a Skin Integrity Investigation Report on 5/5/20 when the area was noted. Documentation revealed (MASD) moisture associated skin damage noted on the resident's upper buttocks. The breakdown to the skin area is due to bowel incontinence, poor appetite and declining condition. The Investigation report showed a weekly skin sheet initiated. The Wound Care /Quality Assurance (QA) Nurse did a Skin Integrity Investigation on 6/2/20 noted MASD area on the resident's upper buttocks. The moisture associated skin damage on the buttocks due to bowel incontinence, poor appetite and actively dying status. The Investigation report showed a weekly skin sheet initiated. During an interview on 7/23/20 at 2:50 p.m., Staff B, Licensed Practical Nurse (LPN), stated the resident had 2 skin injuries to the upper inner buttocks. Staff B did not think they were on the coccyx itself, and noted there is a difference between the coccyx area and the buttocks area. Staff B also noted one of the areas had a scab present. During an interview on 7/23/20 at 3:00 p.m.,. Staff A, Registered Nurse (RN), Wound Nurse and Quality Assurance Nurse, reported skin assessments were completed weekly and sometimes could be done during the calendar week, indicating it could be over 7 days for completion. Staff A reported receiving updates daily and notification when skin concerns are be be measured and assessed. He then sends a notice to the assigned staff nurse to do those assessments and measurements. He noted according to the gaps in the weekly assessments, staff must have failed to complete the tasks. When asked, as a wound care nurse, why didn't he follow up to ensure these tasks were completed, Staff A had no answer. He did report being on vacation one of those weeks of assessments. Staff A acknowledged the different assessments with coccyx and/or buttocks and that non-pressure skin assessments are not staged. Staff A stated it appeared staff needed more instruction on skin assessments and documentation. Staff A reported doing investigations for the skin assessments and showed the 2 dates completed. When asked, as the facility wound care nurse, if there were more observations completed by him, he acknowledged that he had observed the areas at different times but had no documentation for those observations. Staff A reported he brought skin concerns to the weekly QA meeting every week for discussion on status and interventions. During an interview on 7/23/20 at 4:30 p.m., the Director of Nursing (DON), reported Staff A is responsible for following and tracking skin concerns for the residents. She stated skin issues, wounds/injuries are to be assessed and measured every 7 days and noted the gaps on the skin sheets for this resident. The DON also stated the care plan should be updated with the new skin concerns. The DON stated the wound care nurse, who is also the QA (Quality Assurance) nurse, brings concerns to the weekly QA meeting and should have been updating and tracking the assessments for skin issues. During an interview on 7/23/20 at 4:45 p.m., the DON noted the QA Nurse Job Description dated 2/2016 failed to note the responsibility also included acting as the facility's Wound Care Nurse, and stated this would be updated to include that position. The facility's protocol for Skin Injury Assessment/Documentation Process, undated, directed the standard process included providing weekly assessments of all skin injuries, to help prevent infection and other complications, and to provide thorough documentation of skin assessments. The protocol included the following: - all skin conditions, such as skin tears, rashes, bruises, open areas, pressure sores or stasis ulcers are to be assessed and documented on a non-pressure skin sheet or pressure skin sheet every 7 days. - document a skin/wound Progress Note and complete appropriate non-pressure injury weekly skin sheet. All forms must be completed, no blank boxes. - progress of skin injury area will be monitored and evaluated on a weekly basis every 7 days. Nurse assigned to the wing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) is held accountable to check skin assessment record to be sure it is completed every 7 days, - care plan will be updated to identify interventions to promote healthy skin by the MDS nurse. - the QA nurse will notify staff of interventions and do random audits to ensure staff adherence. - the DON or designee will provide staff instruction regarding skin injury and quality care to heal and attempt to prevent further skin issues on a yearly basis and as needed specific to resident care by the QA nurse. The facility's Quality Assurance (QA) Nurse Job Summary, updated on 2/2016 directed: with oversight from the Director of Nursing, the QA Nurse assists the day to day nursing activities and assumes the accountability for quality services and nursing care. The QA Nurse assists in maintaining a physical, social, and psychological environment which will be conductive to the best interest and welfare of the resident in conjunction with our Core Value. The Quality Assurance Nurse Essential Functions and Responsibilities included: - establish and maintain tracking systems for data collection and recommendations related to quality assurance. - perform duties of staff nurse whenever and wherever required but not limited to completing health assessments, developing and evaluation of care plans, and reviewing, implementing and evaluating resident's medication, treatment and other charting requirements. - performs other duties as assigned.