STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165354	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Hampton	700 Second Street SE Hampton, IA 50441

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility policy review, the facility failed to appropriately implement interventions to protect 1 out of 1 resident (Resident #3) reviewed from financial exploitation. The facility reported a census of 45 residents.The facility corrected the noncompliance prior to the start of the survey by conducting staff in-services on 6/12/25, 6/16/25, and 6/17/25 regarding accepting gifts or payments from the residents.Findings include:The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 showed the Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented diagnoses of depression, post-traumatic stress disorder, hypertension, and diabetes mellitus. Review of the facility self-report revealed the facility was made aware of the incident on 6/12/25 by Resident #1's family members. The family member sent a video of a woman entering Resident #1's residence to the Director of Nursing (DON). The DON was able to identify the woman as Staff A. Staff A worked at the facility as a housekeeper. Review of the facility investigation self-report incident occurring on 6/12/25 at approximately 11:00 AM revealed the following:According to an interview conducted with Staff A, Housekeeper, she reported that Resident #1 asked her to clean his house and gave her a key to get in. Staff A stated she went twice and looked at the house but never took anything. Staff A stated she did not clean because the house was in rough shape. The Administrator questioned Staff A if Resident #1 paid her for anything and she responded he gave her $35 for gas money. On 10/6/25 at 1:00 PM the Administrator, stated she got a call from the DON and Assistant DON (ADON) stated Resident #1's family member said she saw on video surveillance someone go into Resident #1's home. The Administrator stated the family member sent the video to the facility where they were able to identify Staff A going into the house. The Administrator stated they called Staff A in to interview her, Staff A stated that Resident #1 gave her around $30 in gas money to go clean his house so he could go home. The Administrator stated that she explained to Staff A that she was an employee of the facility and that she was not able to accept payment from Resident #1. The Administrator stated Staff A returned the key to Resident #1's house to the facility and stated she didn't give a specific date on when the money or key was exchanged. Staff A stated she had gone to his house twice. The Administrator stated Staff A didn't do any cleaning, due to the house being in rough shape. On 10/7/25 at 3:30 PM Staff A stated that Resident #1 had asked her to clean his house because he wanted to go home. Staff A stated that he had given her a key to his house, but that key didn't work. Staff A stated she had given the key back and Resident #1 gave her another key. Staff A stated that the key worked and she was able to get into the house. Staff A stated Resident #1 had given her $35 for gas money to go to the house. Staff A stated that she took another person with her because it was scary for her to go by herself. Staff A stated the first time she went she also took someone with her, but she could not remember who it was, but they couldn't get into the house at that time. Staff A stated that she did not clean Resident #1's house, she stated that it was in rough shape. Staff A stated she told Resident #1 she wasn't going to clean it because of the condition of the house, she stated Resident #1 explained to her his family member is going to take care of it. Staff A stated she did not take anything from the (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	house. Staff A stated that she didn't think of this as anything as she needed the money and she wanted to help him out because he wanted to go home. She stated she didn't give the money back because she put it in her car for gas to go to his house. Staff A stated she would give the $35 back to the facility. Staff A stated that she had not been to his house or taken any money previously from him or any other resident prior to this incident. She stated I wasn't aware that this was so serious. She stated my job was to clean houses. Staff A stated that she did not tell anyone about this because she didn't think it was such a serious matter, she thought she was helping him out. She stated that Resident #3 had called her a couple of months ago and she told him no because she had gotten in trouble for this last incident. Review of the facility policy named Patient Protection Guidelines Abuse Prevention, Reporting, and Investigation dated September 2025 revealed the purpose is to provide professional care and services in an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The definition of misappropriation of resident property - the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a patient's belongings or money without the patient's consent. In response to allegations of abuse, neglect, exploitation, or mistreatment, injuries of unknown origin, or misappropriation the facility must:- Have evidence that all alleged violations are thoroughly investigated.- Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.- Report all allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections, Appeals and Licensing and any other required state agency if applicable (ie: law enforcement). Reports of abuse or if there is resulting bodily injury, the facility should report immediately and not later than two (2) hours. Allegations of neglect, exploitation, misappropriate of resident property, or mistreatment to be reported not later than two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury.