

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2024
NAME OF PROVIDER OR SUPPLIER Rehabilitation Center of Hampton		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452</p> <p>Based on clinical record review, resident interviews, staff interviews, and policy review the facility failed to ensure residents were transported within the facility in a safe manner. Residents #10 and #8 were pushed in the dining room and hallway in their wheelchairs without foot pedals in place for safety. The facility reported a census of 42 residents.</p> <p>Findings include:</p> <p>1. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. Resident #10 required partial to moderate assistance with bed to chair transfers. The MDS indicated Resident #10 used a walker or wheelchair for mobility.</p> <p>The Care Plan Focus with a target date of 9/2/24 reflected Resident #10 had a risk for falls related to confusion, aggressive behaviors towards staff, and dementia. The Interventions instructed the staff to ensure he wore appropriate food when transferring or mobilizing in his wheelchair.</p> <p>On 7/5/24 at 5:27 PM observed Staff A, Dietary Aide, push Resident #10 through the dining room in his wheelchair without foot pedals. Resident #10 attempted to stay at the speed using his feet in a quick walking motion along the floor. His blue gripper socks caught on the floor 3 times as he tried to keep up, pulling that foot backwards.</p> <p>On 7/6/24 at 2:41 PM Staff D, Nurse Consultant, stated the facility trained staff on safe wheelchair transportation at the skills fair annually and during orientation. She said the policy directed to have foot pedals in place if staff pushed a resident. If a resident usually self-propelled, they should keep the pedals connected to the wheelchair but not engaged, ensuring the pedals are available as needed.</p> <p>On 7/7/24 at 9:23 AM Staff C, Administrator in Training, stated they discussed wheelchair safety in stand up meetings and thought the staff sometimes forgot that when residents can self-propel they still needed pedals on the wheelchairs prior to pushing them.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2024
NAME OF PROVIDER OR SUPPLIER Rehabilitation Center of Hampton		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #8's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #8 required total staff assistance with bed to chair transfers. The MDS indicated Resident #8 used a manual wheelchair for mobility.</p> <p>The Care Plan Focus with a target date of 8/11/24 indicated Resident #8 had a risk for falls related to weakness and occasional poor safety awareness. The Interventions instructed to ensure she wore appropriate footwear while she transferred or mobilized in her wheelchair.</p> <p>On 7/5/24 at 6:17 PM observed Staff B, Registered Nurse, offer to push Resident #8 to her room, she agreed. Staff B pushed her wheelchair down the hallway from outside of the dining room, around the corner, and half way down another hallway to her room without foot pedals on the chair.</p> <p>On 7/7/24 at 9:18 AM Resident #8 stated staff didn't put foot pedals on her wheelchair, and they never did because she didn't like them.</p> <p>On 7/7/24 at 11:06 AM the Administrator stated staff attended in-services earlier in the year regarding wheelchair safety.</p> <p>On 7/7/24 at 11:14 AM the Administrator provided a document titled CNA Orientation Checklist which included use of foot pedals at all times when pushing a resident in their wheelchair. Additional documents provided titled In-Service Training Report and dated 2/16/24, 2/23/24, 3/8/24, 4/12/24, and 5/24/24 revealed both Staff A and Staff B attended training that addressed wheelchair safety.</p>