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	05/22/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886 Based on observation, record review, staff interviews, and policy review, the facility failed to use appropriate infection control practices during urinary catheter care and wound care for 2 of 4 residents reviewed (Residents #14 and #32). The facility reported a census of 42 residents. Findings include: 1. Resident #14's Minimum Data Set (MDS) assessment dated [DATE], reflected a Brief Interview for Mental Status (BIMS) didn't get completed as Resident #14 is rarely/never understood. The MDS listed Resident #14 had an indwelling urinary catheter. The MDS included diagnoses of medically complex conditions, neurogenic bladder (impaired bladder control), and diabetes mellitus. The Care Plan with a target date of 7/22/25 included the following Focuses: a. Resident #14 had an indwelling catheter due to a neurogenic bladder from a previous stroke. The Intervention directed: i. The Care Plan instructed staff to provide catheter care. b. Resident #14 required enhanced barrier precautions (EBP) related to the use of an indwelling catheter, pressure wounds, and MDRO ESBL (a multidrug-resistant organism that breaks down certain antibiotics, making them ineffective). The Intervention directed: i. Staff to wear a gown and gloves while performing high-contact care activities (high contact care activities include: bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, caring for or using an indwelling medical device such as: urinary catheter and feeding tube care). On 5/20/25 at 2:50 PM, observed Staff A, Certified Nursing Aide (CNA), perform Resident #14's catheter care. During the entire catheter care process, Staff A failed to wear a gown. During an interview on 5/20/25 at 3:54 PM, Staff A reported she understood EBP. They explained the process, including wearing a gown. Staff A acknowledged she didn't wear a gown during Resident #14's catheter care. She verified she should wear a gown to be compliant with EBP guidelines and protocols. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 10:54 AM, the Director of Nursing (DON) stated they expected staff to wear a gown during Resident #14's catheter care for compliance with EBP and infection control practices. 2. Resident #32's MDS assessment dated [DATE], identified a BIMS score of 5, indicating severe cognitive impairment. The MDS included diagnoses of progressive neurological conditions, coronary artery disease and diabetes mellitus. The MDS listed Resident #32 had a pressure ulcer/injury and had a risk of developing pressure ulcers/injuries. The Care Plan with a target date of 8/6/25, included the following focus areas: a. Resident #32 had a risk for altered skin integrity related to incontinence and limited mobility. On 11/4/24, the staff found a stage 2 pressure ulcer to his left buttock. The Interventions directed the following: i. Administer treatment per physician orders. b. EBP related to pressure area on his left ischial (area on the buttock) area. i. Staff to wear a gown and gloves while performing high-contact care activities. Resident #32's Order Entry dated 5/7/25 included an order for Dr. [NAME] paste to apply to his wound bed and surround the area with vitamin A&D ointment three times a day for his left ischial buttock wound. The Secure Conversations progress note dated 5/20/25 regarding Resident #32's Weekly Skin Assessment. The Progress Note documented his ischial area measured 7.5-centimeter (cm) x 11.2 cm. The wound contained no open areas, measured the pink/red area instead. The note reflected they would continue with the treatment orders and continue to monitor the area. On 5/21/25 at 7:15 AM, observed Staff B, Licensed Practical Nurse (LPN), perform Resident #32's wound care him to his right side. As Staff B cleaned the area with a wipe, witnessed the area on the left ischial as red/pink with excoriation (a superficial loss of skin, often caused by trauma, scratching, or rubbing. It can result in a raw, irritated lesion or a thin crust forming after blood and fluids emerge from the skin's surface) with several unhealed pinpoint areas. Staff B removed her gloves, did hand hygiene, and applied new gloves. Staff B applied the Dr. [NAME] paste to wound bed with a q-tip, then with a new q-tip applied A and D ointment around the outside of the wound. She then placed a clean brief under Resident #32 and rolled him back. Staff B removed her gloves and did hand hygiene. During the process Staff B didn't use full EBP for the wound care, as she didn't wear a gown during the treatment of the wound. During an interview on 5/21/25 at 10:00 AM, Staff B reported the facility put EBP on the door either on the outside or inside of the residents' room. She reported Resident #32 didn't need EBP anymore due to his wound only being excoriated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 10:54 AM, the DON stated during Resident #32's skin assessment the day before they believed the wound closed and added they wound wasn't open. They sent a secure communication to the Primary Care Physician (PCP) regarding the skin assessment. The DON explained as the skin assessment didn't show the wound open, they believed staff didn't need to wear a gown during wound care. She reported they started the process of stopping doing EBP with Resident #32 that morning and stopping it on the Care Plan. The DON acknowledged his Care Plan still contained EBP. The DON stated if a resident had a chronic wound they followed all precautions for EBP, or if the resident had an open wound. On 5/21/25 at 1:10 PM, observed Resident #32's wound area with Staff D, facility Nurse Consultant. The observation revealed Resident #32's wound remained the same as that morning with excoriation noted with several pinpoint areas and a scant amount of blood coming from the pinpoint areas. The facility's Infection Control Policy, reviewed September 2022 defined EBP as an approach of a targeted gown and glove use during high contact resident care activities. The policy instructed EBP could be implemented for residents with any of the following: a. Wounds - Generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. i. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous status ulcers. b. Indwelling medical devices, regardless of MDRO colonization status. Examples of indwelling medical devices include, but are not limited to indwelling urinary catheters.