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	05/28/2026

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 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 clinical record review, facility policy review, staff and family interviews, the facility failed to have a clear and accurate code status across all documentation records for 1 of 16 residents reviewed for Advanced Directives (Resident #34). The facility reported a census of 39 residents.Findings include:Resident #34's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. The Care Plan Focus initiated [DATE] listed Resident #34's Advanced Directives Status - Pursuant to resident rights, personal choices, and their desire to retain control over their health decisions, Resident #34's Representative chose Full Code. The Intervention dated [DATE] directed staff to go to the Electronic Medical Record (EMR) chart to identify Code Status. The Staff updated the Care Plan on [DATE] to Do Not Resuscitate (DNR). The Clinical Physician Orders printed [DATE] included an order dated [DATE] for DNR. The admission Record dated [DATE] identified an Advanced Directive of DNR. Resident #34's [DATE] Medication Administration Record (MAR) listed a code status of DNR. Resident #34's Iowa Physician Orders for Scope of Treatment (IPOST) signed [DATE] by Resident #34's Power of Attorney (POA) indicated they desired Full Code status if her heart stopped beating. The physician signed the IPOST on [DATE]. The IPOST book at the nurse's station contained the IPOST signed [DATE]. The IPOST book lacked the updated order from [DATE]. During an observation on [DATE] at 10:08 AM, Resident #34 didn't have an IPOST in the IPOST book. Resident #34's Progress Notes lacked a note after [DATE] on their Advanced Directives. On [DATE] at 8:15 AM, Staff A, Licensed Practical Nurse (LPN), stated she knew many residents' code statuses, but if she didn't know, she'd look in the EMR, if she logged on. If she didn't log on, she'd look at the IPOST in the IPOST book. On [DATE] at 11:50 AM, Staff B, Registered Nurse (RN), stated if she needs to know someone's code status, she looked in their EMR. The other option included looking in the IPOST binder. On [DATE] at 12:15 PM, Resident #34's brother, who acts as the Durable Power of Attorney (DPOA), stated Resident #34 should've been DNR on admission as that's what his paperwork stated. What he signed on admission for Full Code didn't reflect the correct choice, and he recently corrected it with the nursing staff. He didn't sign anything for the correction. On [DATE] at 12:50 PM, the Director of Nursing (DON) stated she recently talked with Resident #34's brother, and Resident #34 shouldn't have a Full Code status since that didn't match what he wanted. She switched it to DNR on [DATE]. She thought she put in a progress note, but she noticed she didn't when she checked. She stated she should've also updated the IPOST in the IPOST book and the Care Plan, but the staff hadn't updated either one. She'd take care of it as soon as possible. The Code Status Identification and CPR policy revised [DATE] instructed physician's orders related to a resident's code status and/or DNR/limited treatment documentation get completed by the licensed nurse or social services director/designee and entered into the EMR as part of the resident's electronic medical record. It directed that direct care staff with EMR access receive education during orientation and as needed on system identification of patient code status. If the center experiences an EMR failure or utility loss, staff must follow backup procedures and the EMR failure plan. The policy directed to identify code status on the paper MAR/Treatment Administration Record (TAR).

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