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 _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF HAMPTON	700 SECOND STREET SE HAMPTON, IA 50441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 VKK	INITIAL COMMENTS Correction date: 12-18-19 The following deficiency relates to the annual health survey, complaint #86982, and facility reported incident #86995. Complaint #86982 and facility reported incident #86995 were substantiated. See code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and family interviews and observation, the facility failed to appropriately supervise one of five sampled (Resident #57) who fell from a lift chair and sustained cervical and left orbital fractures. The facility reported a census of 58 residents. Findings include: According to Minimum Data Set dated 8/21/19 Resident #57 had severely impaired cognitive skills for daily decision making, required extensive assistance of two staff to transfer, had	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/27/19

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 689	Continued From page 1 frequent bowel and bladder incontinence and diagnoses including Parkinson's Disease, urinary tract infection, chronic pain, arthritis and edema. The resident had one fall without injury. The MDS dated 10/5/19 revealed the resident transferred to acute hospital, long and short term memory impairment, delusions and one fall with no injury and one with a major injury. The Care Plan revealed Resident #57 had a risk for falls and directed the staff to ensure call light within reach, encourage to use call light for assistance, throws call light off my chest, explain importance of having call light within reach and remind me to use it. The Care Plan updated 5/4/19 directed the staff to use a total mechanical lift for transfers. The Care Plan updated 9/27/19 revealed Resident #57 elevated in the lift chair which caused her to slide out of the chair. Resident #57's family requested to allow Resident #57 independence with controls to the lift chair. The Care Plan updated 9/29/19 directed the staff to place dycem in wheelchair and recliner. The Care Plan updated on 10/8/19 revealed a plan to provide a manual recliner upon return to the nursing facility. Review of the Incident Report dated 7/4/19 1:45 a.m., revealed the staff found Resident #57 on the floor, sitting on her buttocks with both legs extended. Resident #57 fell out of recliner. No injuries noted at this time. All interventions in place. At 2:10 p.m., Resident #57 admitted to hospital with a urinary tract infection and sepsis. Review of the Incident Report dated 9/27/19 at 12:40 a.m., revealed the staff summoned Staff I	F 689		

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F 689	Continued From page 2 (Licensed Practical Nurse) to Resident #57's room. Staff I observed Resident #57 seated on the floor with her back and head against the cushion of the recliner. Head noted in full upright position. Chair also noted in full upright position. No injury noted, skin intact. Range of motion normal and no concerns voiced. Placed in bed for comfort. Family to be notified in morning due to late hour. Review of the Incident Report dated 10/5/19 at 8:40 p.m., Staff H (Licensed Practical Nurse) heard someone yelling. Staff H investigated and found the lights off and Resident #57 face down on the floor in front of the recliner. Staff H noticed a pool of blood under Resident #57's head and a laceration on her forehead. Resident #57 transferred to the Emergency Room. The Progress Note dated 10/17/19 revealed Resident #57 returned to the facility wearing a Philly Collar and unable to move neck due to cervical fracture. The Progress Note dated 10/23/2019 documented Resident #57 hospitalized for a week and returned to the facility. Resident #57 had the stitches removed from her face today. Resident #57 finds the neck brace difficult to adjust and served soft foods. A Late Entry at 10:28 p.m., revealed Resident #57 removed the Philly collar and found on the floor by the bed. The staff noticed the foam inserts removed from the collar numerous times in the night. The Progress Note dated 10/31/19 revealed Resident #57 started on puree diet and refused to open mouth to eat.	F 689		

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F 689	Continued From page 3 The Progress Note dated 11/2/19 revealed Resident #57's family visited and inform of not eating or drinking well. Resident #57 passed away on 11/4/19 at 2:35 a.m. The History and Physical dated 10/6/19 included: Patient sent from nursing home after he/she sustained a fall. Patient was sitting in a chair and got up by self, lost balance and fell. Patient was sitting in a chair and got up by self, lost balance and fell on face. Patient was taken to emergency room and is on Coumadin. Neurosurgeon was called and recommended a C-collar. CT spine showed left posterior arch C 1 and C 2 transfers process fracture and oblique fracture of odontoid extending into the base posterior. The History and Physical also documented the resident had a left orbital floor fracture. The Death Record signed by the physician on 11/5/19 included: Principal Cause of Death - Parkinson's with dementia leading to fall. Additional contributing causes of death if any - C-1 fracture. During an interview on 12/4/19 at 7:30 a.m., Staff A (Director of Nursing) reported the facility had no particular lift chair policy, they reviewed residents case by case, therapy evaluates residents and would have brought it to the facility's attention if they felt the chair was not safe. On 9/27/19 when the resident fell, the case was discussed with family member. Staff noted the lift chair in the upright position and the resident slid out with no injury. The family member wanted to make sure the resident still had access to the remote. The facility has guidance as to what is considered a restraint. If the resident was up ad-lib, and they took away the remote, it would be considered a	F 689		

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F 689	Continued From page 4	F 689		

restraint. On 10/5/19 when the resident fell, the spouse had just left. Since January, 2019 the resident had three falls; 7/19, 9/19 and 10/19. The September and October fall reports indicated the resident had the call light within reach but not activated. When the resident fell on October 27, 2019 the family member wanted the resident to have access to the remote. The October 5 fall resulted in a cervical fracture and the resident wore a C-collar, received Occupational Therapy and Speech Therapy upon return to the facility and had to be assisted in the dining room. The resident stopped eating, received Hospice services and passed away.

Staff A was interviewed again on 12/4/19 at 3:15 p.m., along with Staff B (Corporate Nurse). In January, 2019 the family member asked the facility to remove the bed from the resident's room due to non-use. Physical Therapy assessed the resident for transfer assistance in May, 2019. In July the resident slid out of the lift chair, the husband sat with the resident throughout the majority of the time, and the facility provided frequent checks. The resident knew how to make her needs known, could pick out clothes. If a chair prevented a resident from rising, that would be considered a restraint. The resident would get angry if staff took away the remote, he/she wanted to be in control of it. The resident's falls from the lift chair occurred after the spouse had left. The resident thought he/she could walk and did not want to wait for staff assistance.

During an interview on 12/4/2019 at 8:00 a.m., Staff C (Co-Director of Nursing) revealed Staff C (Licensed Practical Nurse) discussed options with the family member after the September fall. The

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resident had room changes, the last room had high hall traffic and staff checked on the resident frequently. The resident often yelled at staff as they walked by if he/she wanted assistance. The resident received psych services to assist with dealing with loss of independence. The resident's BIMS score did not give an accurate reflection of the cognitive status as the resident refused to answer questions. The resident refused to cooperate with therapy.

During an interview on 12/4/19 at 4:00 p.m., Staff D (Care Plan Coordinator) reported when the resident re-admitted after the 10/5/2019 fall, Staff D and the resident's family member went around the facility and found a suitable chair. They found a push back recliner without a lever. The resident did not have enough strength to raise or lower it without staff assistance. The resident slept in the bed after that fall.

During an interview on 12/4/19 at 10:00 a.m., Staff E (Occupational Therapy) revealed every room is equipped with a recliner or lift chair. Staff E knew the resident a number of years. Therapy tends to look at the lift chair operation/control if the resident is going to be more independent. When residents admit to skilled, therapy screens and evaluates them for safe transfers and what their goal is. If they have a lift chair at home, they would work towards the goal of being able to return to that. The resident had a gradual decline due to Parkinson's disease. He/she had a lot of pain due to arthritis, the lift chair provided comfort and the resident required staff assistance for positioning. The resident was not realistic, demanded her husband help her and had a lot of barriers with Parkinson's. The resident frustrated easily and did not want to work on walking. They

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F 689	Continued From page 6	F 689		

had no lift chair policy, it depended on goals and abilities. The facility has since discussed the possibility of doing a screen. No staff or family reported a concern regarding the lift chair. Staff E indicated in January the resident could utilize the call light and lift chair remote. The resident also called out for help and the spouse sat with him/her most of the day.

During an interview on 12/4/19 at 9:30 a.m., Staff F (Minimum Data Set Coordinator) revealed the resident's family member frequently visited. The resident often refused therapies, had falls and frequent non-compliance. The resident could put the call light on and they had signs in the room reminding her. Staff did frequent checks. When a resident admits, if they have a lift chair in the room, they show them how to use it. They do not have a formal assessment tool. Staff F observed the resident raising the chair up and would remind him/her not to. The resident had Dycem in the chair and would call out for help. Initially the resident's spouse attempted to help the resident and wanted the resident to return to assisted living.

During an interview on 12/4/19 at 9:00 a.m., Staff G (Registered Nurse) reported speaking to the family member after the resident fell on 9/27/19. Staff G indicated she asked family if they wanted the resident to have the chair. The family member indicated he/she was fine with the resident keeping the lift chair. The resident could use the call light, the husband spent the entire day with the resident. Staff G had observed the resident raise the chair up late one night. The resident could make needs known. Staff G failed to recall if she discussed putting the remote out of reach, though it would be considered a restraint. Staff G

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F 689	Continued From page 7 did discuss whether the resident should keep the chair with the family member. During an interview on 12/4/2019 at 1:50 p.m., Staff H (Licensed Practical Nurse) reported working on 10/5/19 when the resident fell from the lift chair. Staff H observed the resident's spouse leave the facility at approximately 8:30 p.m. The spouse did not indicate the resident needed any assistance. Approximately ten minutes later, the resident screamed for help. Staff H failed to recall if the call light had been activated and had seen the resident prior between 7:00 p.m. and 8:00 p.m., during medication pass. Anytime Staff H observed the resident raise the lift chair, she would remind and educate her. The majority of the time the resident's spouse sat with the resident and failed to remind the resident not to raise it up. Staff had discussed the resident's lift chair in nurse to nurse report. The resident's memory had declined over the last few months. When Staff H called the family member to report the fall, she asked if the resident had the remote. Staff H told the family member the resident had the remote because it would be considered a restraint to place it out of reach. During an interview on 12/4/19 at 3:45 p.m., Staff I (Licensed Practical Nurse) reported working on 9/27/19 when the resident fell from the lift chair. The resident raised the chair in the upright position and slid out onto his/her buttocks. A Nurse Aide found the resident on the floor. The resident had a Dycem in the chair and had no injury. Staff I indicated her intervention was to remove the remote from reach. Staff I did not call the family as the fall occurred late at night, the resident had no injury, therefore day shift staff	F 689		

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F 689	Continued From page 8 notified the family. Staff I did observe the resident raise the chair on another occasion. During an interview on 12/4/2019 at 11:10 a.m., Staff J (Registered Nurse) reported the resident progressively declined during her stay. The resident refused cares, yelled at family and staff and progressive dementia. Staff J did observe the resident raise lift chair up. Staff would educate the resident and the spouse. Sometimes the spouse would notify staff that the resident had raised the chair up. Staff J indicated any chair would have been unsafe, she needed to raise her feet up due to bad circulation. The resident had been on fifteen minute checks and then had fewer attempts to get up unassisted. CNA's did report the resident did put his/her chair up. Staff J thought the resident knew she was not supposed to stand. The resident also had a custom wheel chair and had no falls from it. Staff educated and reminded the resident and spouse not to get up unassisted. Family was okay with the resident having the lift chair and the remote. The resident would not have been able to use the lever on a manual recliner. When the resident returned to the facility after the last fall, they found a manual recliner that the resident could lower the foot rest using his/her legs. During an interview on 12/4/19 at 11:30 a.m.., Staff K (Nurse Aide) reported working on 10/5/19 when the resident fell from the lift chair. The resident's spouse had left about ten minutes prior. Staff K did occasionally observe the resident raise the lift chair and at times the spouse was present. Staff K reported it to the charge nurse. The resident knew she required assistance but wanted to be independent. Staff checked on the resident frequently.	F 689		

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F 689	Continued From page 9 During an interview on 12/4/19 at 1:15 p.m.., Staff L (Nurse Aide) reported the resident admitted to the facility and required assistance of one to transfer and ambulate. During the resident's stay the resident declined and progressed to an E-Z stand and in the end, she required a Hoyer lift to transfer. The resident thought she could do things on his/her own, was non-compliant with using the call light or waiting for assistance. The resident slept in the lift chair and could make her needs known. At times the resident screamed for help. Staff had to keep an eye on the resident; she would raise the lift chair way up and wanted to get up to breathe easier. Staff discussed putting the remote out of reach; the spouse would give the remote to the resident and would have given the resident anything. The resident yelled at the spouse and staff if they did not give her what she wanted. The chair would not have been considered a restraint if the resident cannot walk independently. During an interview on 12/4/19 at 2:30 p.m.., Staff M (Nurse Aide) worked on 10/5/19 when the resident had her last fall from the lift chair. The nurse summoned staff to the room and Staff M responded. Staff M did at times observe the resident attempt to raise the chair up. Staff checked on the resident frequently, they walked by and kept the room door open. The resident preferred sleeping in the lift chair. Staff M indicated they provided incontinence cares after supper and then transferred the resident to the lift chair. Typically, they would check and change the resident again at approximately 9:00 p.m. after the spouse left for the night. Staff knew the resident raised the lift chair and rarely used the call light.	F 689		

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F 689	Continued From page 10 During an interview on 12/4/19 at 2:40 p.m., Resident #57's family member reported the resident used the lift chair for quite some time, and the facility provided the chair. The resident preferred sleeping in the lift chair. The last couple of years at the facility the resident became less mobile and had refused therapy at times. The end of October the resident had a fall from the lift chair due to raising the chair up. After that fall the family member asked staff if they could put the remote in the side pocket, and staff indicated that would be considered a restraint. He/she then asked if the resident could have a manual recliner and was told that would be considered a restraint since the resident would not be able to raise or lower the foot rest. There were times when family visited when the resident raised the chair up and the family had to remind the resident not to. The resident enjoyed the lift chair but they never offered the resident a safer alternative. The resident had dementia, and the family member did not think the resident knew the risk. They had discussed the chair at some point, most likely a care conference, and facility's solution was to have staff do frequent checks. During an interview on 12/4/19 at 12:50 p.m., Resident #57's spouse reported the resident sustained falls while at the nursing home. The spouse visited every day and stayed most of the day until approximately 8:00 p.m. The last fall occurred approximately 10 minutes after the spouse left for the night. The resident fell from the lift chair and had fractured vertebrae. The spouse told the facility to get rid of the lift chair. The facility Physical Restraint Usage policy	F 689		

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F 689	Continued From page 11 included each resident will attain and maintain the highest practicable well-being in an environment that prohibits the use of physical restraints unless warranted by medical symptoms. The Procedure described a physical restraint as any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts the freedom of movement or normal access to one's body. Physical restraints include but are not limited to placing a resident in a chair that prevents them from rising.	F 689		

Rehabilitation Center of Hampton
700 2nd St. SE • Hampton, IA 50441
(641) 456-4701 • www.abcmcorp.com
Enhancing Relationships

Date submitted: 12/27/19

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Hampton, IA 50441
Phone 641-456-4701
Fax 641-456-5186

Plan of Correction – Annual Survey ending December 5, 2019

F000 – Correction Date: December 18, 2019
Preparation and execution of this plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under State or Federal law.

F 689 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices
Each resident receives adequate supervision and assistance devices to prevent accidents.

The facility is disputing this deficiency, and is submitting a response with additional information in a separate document; however, for the required Plan of Correction the facility submits the following:

1. Resident #57 no longer resides at the facility.
2. Nursing staff will assess residents with electric lift chairs upon admission and as needed. Referrals to Occupational therapy will be completed if indicated. Certified Nursing Assistants and Licensed Nurses were educated on this process on December 18, 2019.
3. Co-Director of Nursing, or designee, will conduct random audits of assessments of residents who utilize electric lift chairs, monthly for 3 months. The audits will be reviewed as part of our on-going Quality Assurance process and the frequency of audits thereafter will be based on the outcomes and the subsequent recommendations.