STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165146	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kahl Home for the Aged & Infirmed	6701 Jersey Ridge Road Davenport, IA 52807

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to intervene and inform the provider a pressure ulcer worsened which resulted in a hospitalization for treatment for 1 of 3 (Resident #1) residents reviewed for pressure ulcers. The facility reported census was 106. Findings include: The MDS (Minimum Data Set) assessment definition of pressure ulcers included the following: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue), may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. (continued on next page)

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS), dated [DATE], for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The MDS list of diagnoses included peripheral vascular disease, renal insufficiency, diabetes mellitus, paraplegia, pressure-induced deep tissue damage of other site, and malnutrition. The MDS indicated Resident #1 dependent for transfers and mobility. The MDS identified Resident #1 at risk for developing pressure ulcers, and documented Resident #1 with 1 unstageable pressure ulcer/injury at the time of the assessment. Review of the Care Plan, dated 5/8/25 revealed a Focus area to address The resident has unstageable area to left buttock r/t (related to) Hx (history) of pressure injuries, bowel incontinence and immobility. Present upon readmission from hospital. Interventions included, in part: Assess/record/monitor wound healing weekly and PRN (as needed). Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing process. Report improvements and declines to the MD (medical doctor). Revision Date: 5/8/25. Review of the electronic health record (HER) revealed the following: a. Health Status Note entered on 4/17/25 at 5:20 PM documented Resident returned from hospital via transporter in wheelchair at 17:05 (5:05 PM). b. Health Status Note entered on 4/18/25 at 5:35 AM documented Wound Care Buttock Fold. Prior to hospitalization Care to buttock and coccyx skin was for house barrier Cream BID (twice daily). admission skin assessment on 4/17/25 found two open areas, slits, bleeding, to the buttock skin fold. Two wound forms completed. Wrote new wound care order until seen by Wound Nurse. c. Physician/Nurse Practitioner/Physician Assistant note entered on 4/21/25 at 4:36 PM documented, in part . Chief Complaint: FOLLOW UP ON HOSPITALIZATION for right foot osteomyelitis .INTEGUMENTARY (skin): .Exam: Findings: see nsg (nursing) documentation on skin assessment. documented left and right heel wounds. protective boots in place. Buttocks wound. PLANS: Buttocks wound not addressed. d. Physician/Nurse Practitioner/Physician Assistant note entered 4/22/25 at 2:39 PM documented, in part . Reason for visit: Routine .Skin: Several wounds followed by wound dr, healing ulcer on right dorsum (back or upper surface) 2nd digit (finger or toe). Assessment/Plan: No new orders. e. Structured Progress Note entered on 4/23/25 at 9:27 AM documented [name redacted] wounds were evaluated. Resident has Four wounds. Locations/Left Heal Right Heal Left Buttock Sacral Refer to weekly wound form. 1. Weekly Wound Documentation, dated 4/23/25, in part: Wound Three. Anatomical Location: Left buttock. Type of Altered Skin Integrity: Pressure Injury. Pressure Injury Stages: Stage 3. Length: 2.5 cm. Width: 1.5 cm. Depth: 0.1 cm. Granulation tissue 100%, pink/red 100%; Exudate amount: light (less than 10% on dressing), serosanguineous (combination of body fluid and blood, which appears light pink to red in color). Wound odor: Not applicable. Wound Progress: New. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	f. Physician/Nurse Practitioner/Physician Assistant note entered on 4/28/25 at 5:02 PM documented, in part . Chief Complaint: FOLLOW UP ON HOSPITALIZATION for right foot osteomyelitis .INTEGUMENTARY (skin): .Exam: Finding see nsg documentation on skin assessment .buttocks wound. PLANS: Buttocks wound not addressed. g. Structured Progress Note entered on 4/30/25 at 11:33 AM documented [name redacted] wounds were evaluated. Resident has Four wounds. Locations/Left Heal Right Heal Left Buttock Sacral Refer to weekly wound form. 1. Weekly Wound Documentation, dated 4/30/25, in part: Wound Three. Anatomical Location: Left buttock. Type of Altered Skin Integrity: Pressure Injury. Pressure Injury Stages: Stage 3. Length: 4.0 cm. Width: 3.0 cm. Depth: 0.1 cm. Granulation tissue 50%, pink/red 100%; Slough: 50%, white, adherent. Exudate amount: Moderate (50% on dressing), serous (straw colored body fluid). Wound odor: Not applicable. Wound Progress: Worse. 2. Review of the EHR from 4/30/25 to 5/6/25 lacked documentation the facility notified the MD Resident #1's pressure ulcer worsened. h. Structured Progress Note entered on 5/7/25 at 11:53 AM documented [name redacted] wounds were evaluated. Resident has Three wounds. Locations/Left Heal Right Heal Left Buttock Refer to weekly wound form. 1. Weekly Wound Documentation, dated 5/7/25, in part: Wound Three. Anatomical Location: Left buttock. Type of Altered Skin Integrity: Pressure Injury. Pressure Injury Stages: Stage 3. Length: 2.5 cm. Width: 3.0 cm. Depth: 0.1 cm. Granulation tissue 10%, pink/red 10%; Slough 90%, white and adherent. Exudate amount: moderate (50% on dressing), serous. Wound odor: Not applicable. Wound Progress: Worse 2. Review of the EHR from 5/7/25 to 5/13/25 lacked documentation the facility notified the MD Resident #1's pressure ulcer worsened. i. Structured Progress Note entered on 5/14/25 at 10:09 AM documented [name redacted] wounds were evaluated. Resident has Three wounds. Locations/Left Heal Right Heal Left Buttock Refer to weekly wound form. 1. Weekly Wound Documentation, dated 5/14/25, in part: Wound Three. Anatomical Location: Left buttock. Type of Altered Skin Integrity: Pressure Injury. Pressure Injury Stages: Stage 3. Length: 2.5 cm. Width: 4.0 cm. Depth: 0.1 cm. Granulation tissue 5%; Slough 95%, white, tan and adherent. Exudate amount: moderate (50% on dressing), serous. Wound odor: Not applicable. Wound Progress: Worse 2. Review of the EHR from 5/14/25 to 5/20/25 lacked documentation the facility notified the MD Resident #1's pressure ulcer worsened. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	j. Structured Progress Note entered on 5/21/25 at 9:27 AM documented [name redacted] wounds were evaluated. Resident has Three wounds. Locations/Left Heal Right Heal Left Buttock Refer to weekly wound form. 1. Weekly Wound Documentation, dated 5/21/25, in part: Wound Three. Anatomical Location: Left buttock. Type of Altered Skin Integrity: Pressure Injury. Pressure Injury Stages: Stage 3. Length: 2.5 cm. Width: 3.5 cm. Depth: 0.1 cm. Slough 100%, white, adherent. Exudate amount: Light (less than 10% on dressing), serous. Wound odor: Not applicable. Wound Progress: Stable/No change. k. Structured Progress Note entered on 5/28/25 at 11:52 AM documented [name redacted] wounds were evaluated. Resident has Four wounds. Locations/Left Heal Right Heal Left Buttock Sacrum Refer to weekly wound form. 1. Weekly Wound Documentation, dated 5/28/25, in part: Wound Three. Anatomical Location: Left buttock. Type of Altered Skin Integrity: Pressure Injury. Pressure Injury Stages: Unstageable. Length: 6.5 cm. Width: 3.5 cm. Depth: 0.1 cm. Eschar 100%, black, adherent, soft. Exudate amount: Moderate (50% on dressing), serous. Wound odor: Not applicable. Wound Progress: Not documented. 2. Health Status Note entered on 5/28/25 at 9:30 PM documented pt wound care done tonight left buttock wound is necrotic was cleaned and dried and a clesan [clean] dry dressing was applied and covered with triad gel, sacrum was clean and a clean dry dressing was applied she tolerated her treatment well. 3. Review of the EHR from 5/28/25 to 6/3/25 lacked documentation the facility notified the MD Resident #1's pressure ulcer worsened. l. Structured Progress Note entered on 6/4/25 at 7:04 AM documented [name redacted] wounds were evaluated. Resident has Four wounds. Locations/Left Heal Right Heal Left Buttock Sacrum Refer to weekly wound form. 1. Weekly Wound Documentation, dated 6/4/25, in part: Wound Three. Anatomical Location: Left buttock. Type of Altered Skin Integrity: Pressure Injury. Pressure Injury Stages: Unstageable. Length: 4.0 cm. Width: 2.0 cm. Depth: 0.1 cm. Eschar 100%, black, adherent, soft, boggy. Exudate amount: Light (less than 10% on dressing), serous. Wound odor: Not applicable. Wound Progress: Worse. 2. Review of the EHR from 6/4/25 to 6/10/25 lacked documentation the facility notified the MD Resident #1's pressure ulcer worsened. m. Health Status Note entered on 6/5/25 at 5:59 PM documented Treatment with [provider name, clinic name. address, and phone number redacted] June 16th 2025 13:30 (1:30 PM) and June 26th 2025 at 14:00 (2:00 PM). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	n. Structured Progress Note entered on 6/11/25 at 12:51 PM documented [name redacted] wounds were evaluated. Resident has Three wounds. Locations/Left Heal Right Heal Left Buttock Refer to weekly wound form. 1. Weekly Wound Documentation, dated 6/11/25, in part: Wound Three. Anatomical Location: Left buttock. Type of Altered Skin Integrity: Pressure Injury. Pressure Injury Stages: Unstageable. Length: 4.0 cm. Width: 2.0 cm. Depth: 0.1 cm. Eschar 100%, black, adherent, soft, boggy. Exudate amount: Light (less than 10% on dressing), serous. Wound odor: Not applicable. Wound Progress: Worse. 2. Health Status Note entered on 6/16/25 at 10:47 PM documented, in part .treatment done to buttock foul smelling small amount of drainage. The lacked documentation the MD notified of foul smell noted during the treatment. 3. Review of the EHR from 6/11/25 to 6/17/25 lacked documentation the facility notified the MD Resident #1's pressure ulcer worsened. o. Physician/Nurse Practitioner/Physician Assistant note entered on 6/17/25 at 2:20 PM documented, in part . Reason for Visit: Routine. Patient complaints: None .Skin: Several wounds followed by wound dr . Assessment/Plan: No new orders. p. Structured Progress Note entered on 6/18/25 at 2:58 PM documented [name redacted] wounds were evaluated. Resident has Three wounds. Locations/Left Heal Right Heal Left Buttock Refer to weekly wound form. 1. Weekly Wound Documentation, dated 6/18/25, in part: Wound Three. Anatomical Location: Left buttock. Type of Altered Skin Integrity: Pressure Injury. Pressure Injury Stages: Unstageable. Length: 7.5 cm. Width: 4.4 cm. Depth: 1.5 cm. Eschar 100%, black, adherent, soft, boggy. Exudate amount: Light (less than 10% on dressing), serous. Wound odor: Foul. Wound Progress: Worse. 2. Review of the EHR from 6/18/25 to 6/24/25 lacked documentation the facility notified the MD Resident #1's pressure ulcer worsened. q. Physician/Nurse Practitioner/Physician Assistant note entered on 6/19/25 at 3:14 PM documented, in part . Encounter Type: Comprehensive Progress Note .INTEGUMENTARY: .Exam: Finding: see nsg documentation on skin assessment .buttocks wound. Plan: stable. next wound clinic appt on 6/26/25 please schedule weekly visits with wound clinic for now per their recommendations. Continue offloading measures. r. Health Status Note entered on 6/24/25 at 5:12 PM documented This nursing supervisor received a call from the wound clinic notifying that the resident is being transferred to the ER (emergency room) for the ischium (a paired bone forming the lower and back part of the hip bone) wound . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Provider Progress Note, Service: Wound Care dated 6/24/25 at 2:30 PM revealed the following Wound Assessment for Pressure Injury Left Ischium Unstageable (active): Site Assessment: Necrotic; Eschar. Length: 7.5 cm. Width: 7 cm. Depth: 1.3 cm. Drainage Amount: Small. Wound Drainage Description: Malodorous (unpleasant smell); Serosanguineous. The Provider Progress Note Assessment included, in part: a. Complicated wound infection verses cellulitis (bacterial infection of skin and underlying tissues) to her left ischium, patient sent to [hospital name redacted] emergency room in [name of town redacted]. b. Unstageable pressure ulcer to left ischium with no subcutaneous tissue exposed covered with slough/necrosis, nonhealing with evidence of infection. During an interview on 7/1/25 at 1:30 PM Staff I, Registered Nurse (RN), facility wound nurse, stated Resident #1 pressure ulcer started as two open slits that started during a hospital stay (4/17/25) and grew a little over the next two months. Staff I stated Resident #1 was eventually referred to the wound clinic when they felt they needed help treating the wound. Staff I noted Resident #1 had heel wounds [diabetic ulcer] which the wound clinic managed, but she had not been referred to the wound clinic for her buttocks until 6/5/25. Staff I stated she last saw Resident #1's buttocks wound on 6/18/25 and at that time she changed the order to include Dakin's (name brand of a topic antiseptic used for wound care) to help dry out the wound. Staff I stated she relies on her staff to inform her of a wound worsening or getting infected. During an interview on 7/3/25 at 11:40 AM, the Director of Nursing (DON) stated the hospital wound clinic had been involved with Resident #1's buttocks wound prior to her April hospitalization and was to resume care after her hospitalization. The DON stated she believed it was the resident or family that said something about Resident #1's buttock wound on 6/5/25. The DON stated the wound clinic chose not to look at it at that time and instead scheduled a routine visit on 6/16/25. The DON stated Resident #1 was seen by her primary care physician (PCP)on 6/17/25 and the NP (Nurse Practitioner) on 6/19/25. The DON was not sure whether the PCP looked at the buttocks wound. The DON stated the reason for a referral to a wound clinic or hospital is to get a higher level of expertise when treating wounds, but noted they have successfully treated wounds much worse than Resident #1's. The DON stated she knew of no one at the facility that was in contact with the wound clinic or who sought out a higher expertise during the time the buttocks wound continued to deteriorate and the time she was admitted with an infected wound and sepsis. Review of ED (Emergency Department) Provider Notes, dated 6/24/25 at 4:47 PM revealed Chief Complaint: Wound Check .Physical Examination: Skin: Comments: Erythema (redness) extensively over sacral coccyx with pressure ulcer over the left ischial tuberosity. Wound is malodorous, with drainage Summary/Medical Decision Making: Differential Diagnoses: Infected pressure ulcer, osteomyelitis, sepsis . Review of a hospital Infectious Disease Progress note, dated 7/1/25 revealed the following Assessment/Plan, in part: a. Patient is s/p (status post, meaning after) surgical debridement of left ischial wound on 6/29[2025] with [physician name redacted]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	b. Wound culture from 6/24[2025] of left ischial wound positive for pseudomonas (type of bacteria). Review of the policy titled, Wound and Skin Care-Pressure Injury Prevention and Management, dated 5/31/23 revealed a Policy statement which declared This home is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. The Definitions section of the policy included: Avoidable means that the resident developed a pressure ulcer/injury and that the home did not do one or more of the following: evaluate the residents clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. The Policy Explanation and Compliance Guidelines sections of the policy included, in part: 5. Monitoring b. The attending physician will be notified of: i. The presence of a new pressure injury upon identification ii. The progression towards healing, or lack of healing, of any pressure injuries weekly and as needed. iii. Any complications (such as infection, development of a sinus tract, etc) as needed.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to ensure two staff transferred a resident with a mechanical lift and positioned the resident appropriately in a Broda chair resulting in an injury for 1 of 2 residents (Resident #2) reviewed for safety. The facility reported census was 106. Findings include: Review of the Minimum Data Set (MDS), dated [DATE], revealed Resident #2 had a Brief Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The MDS indicated Resident #2 required maximal to dependent assistance with transfers and mobility. The MDS list of diagnoses included Non-Alzheimer's dementia, congestive heart failure, and arthritis. During an interview on 7/1/25 at 4:50 PM Staff J, Certified Nurse Aide (CNA), queried regarding a transfer of Resident #2 on 5/13/25, stated they were busy because the day shift did not get their showers completed. At around 5:00 PM he and his partner, Staff N, Registered Nurse (RN) were getting residents up for supper. Resident #2 was one of the last to get up. Staff J stated he went into her room and placed the mechanical lift sling under her and attached it to the lift on his own. After waiting some time for his partner, he decided to lift Resident #2 by himself. While she was lifted, Staff J stated he had a hold of her right foot and was attempting to unfold the foot rest on the Broda chair (a brand name of a specialized wheelchair), when he accidentally dropped her foot on the foot rest, resulting in the cut to her right 5th toe. Staff J stated he reported the incident to his nurse, Staff M, RN Unit Manager. Review of the Non-Pressure Skin Condition Record, dated 5/13/25, completed by Staff N, RN Resident #2 had a 3 centimeter by 1 centimeter by 0.1 centimeter skin tear to her right 5th toe. During an interview on 7/2/25 at 11:37 AM, Staff O, CNA, stated she knew of Resident #2's right foot injury on 5/13/25. Staff O stated they were very busy on the night of 5/13/25 and she was giving a resident a shower when the incident occurred. Staff O stated Resident #2 was a full body mechanical lift and required two staff to transfer residents safely. She assumed Staff J, CNA transferred her by himself. Staff O stated she first heard of the incident during supper, when Staff J whispered that Resident #2 had a cut toe that occurred while he was attempting to adjust her feet during a transfer. Staff O stated Staff J was upset. Staff O stated Resident #2 often had lower extremity swelling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/2/25 at 12:22 PM, Staff P, Licensed Practical Nurse (LPN), queried about Resident #2's right foot injury on 5/13/25. Staff P recalled it was supper time and she was in the nurse's station charting when Staff J, CNA approached her and said Resident #2's toe was bleeding. Staff J stated she went to look at her toe and she was in her Broad chair. Her right 5th toe was bleeding slightly and there was a slit on the bottom joint of her toe. Staff IP stated she cleaned it and wrapped it gauze. After supper it seemed to start bleeding more. Staff IP, LP stated she cleaned it, added an antibiotic ointment and wrapped it more firmly in Kerlix (an umbrella brand name used to for a gauze like bandage roll). Staff P stated Staff J told her he had hit her foot on the Broda chair foot rest. Staff P stated she notified family, physician and supervisors of the incident. Staff P stated she was not aware that Staff J had transferred Resident #2 using the full body mechanical lift by himself. During an interview on 7/2/25 at 7:57 AM, the Hospice Case Manager (HCM) queried regarding Resident #2's foot injury on 5/13/25, stated the facility notified them (hospice) of an incident resulting in a laceration of Resident #2 ' s right toe. The facility stated they were trying to move her and dropped her foot. Hospice sent out a nurse who assessed the wound noting a small, but deep laceration on her right small toe. The whole foot was swollen. The HCM stated the following day she assessed the right foot and stated it was black and blue, the big toe swollen and black. During an interview on 7/2/25 at 9:30 AM, the Director of Nursing (DON) queried what she knew of Resident #2's right foot injury on 5/13/25, stated Staff J, CNA had Resident #2 sitting in her Broda chair and her foot rest was not flipped open. According to Staff J, he lifted her foot to open up the foot rest and dropped her right foot striking the foot rest and resulting in the lacerated right 5th toe. In a follow up interview on 7/3/25 at 11:40 AM, the DON queried regarding the injury of Resident #2. The DON stated she was aware that Staff J, CNA had transferred Resident #2 using a mechanical lift from her bed into her Broda chair by himself. The DON stated the transfer was successful and it was the positioning the resident after the transfer when the injury occurred. Review of the policy titled, Resident Care-Safe Resident Handling/Transfer, dated 9/12/2024 revealed a Policy statement which declared, It is the policy of this home to ensure residents are handled and transferred safely to prevent or minimize the risk for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. The Compliance Guidelines section, directed staff, in part: #10 Two staff members must be utilized when transferring residents with a mechanical lift. Review of facility staff training documentation revealed: a. An In Service Sign In sheet, dated 5/14/25, Topic: All Staff Mechanical Lift Requires assist x 2. The Sign In sheets had a total of 54 facility staff signatures. b. An In Service Sign In sheet, dated 5/15/25, Topic: Proper Placement of feet in W/C (wheelchair) and Broda. The Sign In sheets had a total of 55 facility staff signatures.