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	12/30/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interviews, the facility failed to implement a physician order given after a low lab result for 1 of 5 residents (Resident #1) in the sample. The facility reported a census of 104 residents. Findings include: Review of the Minimum Data Set (MDS) dated [DATE] identified Resident #1 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. The MDS list of diagnoses included malignant neoplasm of the colon (colon cancer), arthritis and aphasia (difficulty speaking). The MDS indicated Resident #1 required substantial/maximal staff assistance with toileting, partial/moderate assistance with showers, dressing, putting on and removing footwear and repositioning. Review of the electronic health record (EMR) revealed an admission Record which indicated Resident #1 admitted to the facility on [DATE] and discharged on 12/19/25.Review of a 12/8/25 Progress note -routine written by a Nurse Practitioner (NP) revealed a 12/5/25 lab result of K+ (potassium) result of 3.2 - L (low). The Assessment & Plan section included.Hypokalemia (low potassium) Will start potassium chloride 10-mEq (milliequivalents) daily. Repeat BMP (Basic Metabolic Panel - a lab order that includes potassium level) in 1 week. Review of the EMR revealed a Health Status Note entered on 12/8/25 at 10:33AM, [Name of NP redacted] noted labs with no new orders.Review of the December 2025 Medication Administration Record (MAR) revealed a lack of an order for /administration of Potassium Chloride 10 mEq daily. A review of the lab reports revealed no reports after 12/8/25 results.During an interview on 12/23/25 at 7:32 AM, Staff D, Registered Nurse (RN) reported if a Nurse Practitioner writes a new order, she will leave the order with the floor nurse. Staff D explained the floor nurse would document this on a progress note and send the order to the pharmacy. The new order should be recorded on the physician order summary. Staff D stated the NP does not dictate the notes the day of rounds and a nurse may not see then for a week. During an interview on 12/23/25 at 2:35 PM, the NP reported she recalled she had written an order for Resident #1 on 12/8/25 for the potassium chloride 10 mEq daily. She stated she expected orders to be carried out within 24 hours. During an interview on 12/30/25 at 11:28 AM, the Director of Nursing reported when a NP writes a new order, it is placed on physician order sheet and should give it to the floor nurse or Unit Manager, either one is responsible for processing new orders. The Unit Manager is responsible for running a report to review for new orders on a daily basis. The order written 12/8/25 for potassium chloride for Resident #1 should have been processed and transcribed to the MAR within 24 hours of 12/8/25. Review of the facility policy, titled Verbal Orders dated 4/17/24 revealed the Policy statement Physician orders may be received by telephone, by a licensed nurse or registered health care specialist who is legally authorized to do so. The Policy Explanation and Compliance Guidelines directed, in part:1. Repeat any prescribed orders back to the physician or health care provider.2. Use clarification questions to avoid misunderstandings.3. Enter the order into the electronic medical record.4. The T.O. (telephone order) or V.O. (verbal order) must include: date, time, name of the resident, the complete order with form, dosage, route, frequency and indication, the name of the physician or health care provider and nurse sign off of the electronic order as per the software system guidelines. 5. The physician or provider will authenticate the order within the time limit set by state regulations.6. Preferred method for provider signatures: Physician or provider should authenticate the order within Point Click Care's order portal.7. If necessary, the order may be printed out for the physician or provider to sign in wet ink within state identified time limit. If the order is signed in this manner, the actual signed order should be scanned into Point Click Care, and the order should be marked as ‘signed in wet ink' in the orders portal as soon as reasonably able to be completed.8. Follow through with orders by making appropriate contact or notification (e.g., lab or pharmacy).

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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** Based on observation, clinical record review and staff interviews, the facility failed to utilize isolation gowns when providing resident care that require the use of Enhanced Barrier Precautions (EBP) for 1 of 3 residents (Resident #3) in the sample. The facility reported a census of 104 residents.Findings include:Review of the Minimum Data Set (MDS), dated [DATE] identified Resident #3 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS list of diagnoses included pressure ulcer to the sacral region. The MDS indicated Resident #3 dependent on staff for assistance with toileting and transfers in and out of bed/chair, and required substantial/maximal assistance with showers.Review of Resident #3 Care Plan, dated 2/12/25, the Care Plan revealed a Problem to address The resident requires enhanced barrier precautions (EBP) to reduce the spread or potential spread of multi-drug resistant organisms R/T (related to) a pressure injury. Interventions included, in part:a. Nursing staff to wear gown and gloves during wound cares. Date Initiated: 2/12/25.b. Staff are to wear gown and gloves with ADL (activities of daily living) cares such as: dressing, bathing/showering, catheter or ostomy cares, and toileting tasks including changing briefs, and toileting hygiene. Date Initiated: 2/12/25.During an observation on 12/23/25 at 1:22 PM, an Enhanced Barrier Precautions sign posted on the room of Resident #3 door. During an observation on 12/29/25 at 11:25 AM, Staff G, Licensed Practical Nurse (LPN) and Staff H, Registered Nurse (RN) each wore isolation gown and gloves while they assisted Resident #3 with toileting. Staff F, CNA entered the bathroom wearing gloves but did not wear a gown. During an interview on 12/29/25 at 1:46 PM, Staff F, CNA reported when providing cares to Resident #3, staff should be wearing a gown and gloves. She admitted she gave Resident #3 a shower earlier and took the isolation gown off afterward and forgot to put another one when she dried her back.During an interview on 12/29/25 at 2:03 PM, Staff G, LPN reported before staff provide care for Resident #3, they should wear an isolation gown and gloves as she is on EBP. Staff G stated Staff F, CNA should have worn an isolation gown during cares today.During an interview on 12/30/25 at 11:28 AM, the Director of Nursing reported she would expect staff to wear an isolation gown and gloves prior to providing care to Resident #3 as she is in EBP. Review of the facility policy titled, Enhanced Barrier Precautions Policy dated 3/27/25 included, in part:a. Policy statement: It is the policy of this home to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. b. Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.c. Policy Explanation and Compliance Guidelines section: 3. Implementation of Enhanced Barrier Precautions b. PPE (Personal Protective Equipment, i.e gloves and gowns) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4. High-contact care activities include: Dressing, Bathing, Transferring Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters), Wound care: any skin opening requiring a dressing