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	02/13/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, clinical record review, facility policy review, staff, family and resident interviews, the facility failed to answer call lights within 15 minutes to meet resident needs for 1 of 3 residents reviewed (Residents #5). The facility reported a census of 104 residents. Findings include: Resident #5's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated moderate cognitive impairment. The MDS documented the resident admitted [DATE] and needed substantial to maximal assistance with toileting hygiene, toilet transfers, and lower body dressing. The Care Plan, initiated 1/8/25 documented the resident required 1:1 staff for toileting. During an interview on 02/10/25 at 12:56 PM Resident #5 shared that some call lights took a longer time to answer, maybe 15-20 minutes. He stated he knew staff were busy but he needed help to go to the bathroom. On 2/11/25 at 8:58 AM during a hallway observation the resident's call light was noted to be on. At 9:14 AM two therapy staff and a CNA walked by the resident's room and did not ask what Resident #5 needed. At 9:19 AM, 21 minutes after activated, staff entered his room with the vitals cart and asked why his light was on. The resident stated he was waiting to go to the bathroom. During an interview on 02/11/25 at 09:27 AM Staff R, Certified Nursing Aide (CNA) reported call lights could be seen at the resident's door and on a screen by the nurses station. Staff were able to tell if the light was from the bathroom or their regular room light. Staff R stated they could also hear the sound the system made in the spa room and in linen and laundry, and that included lights for the whole floor. When asked about the time frame for answering lights, she confirmed staff are trained they should answer them in 15 minutes or less. While in the resident's room for a follow up interview on 02/11/25 at 02:50 PM Resident #5 indicated that he had long call lights that morning and the evening before. A family visitor stated the long lights did not happen every day, but at least every other day since he arrived. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/12/25 at 09:11 AM, Staff E, Licensed Practical Nurse (LPN) stated they tried to answer call lights promptly and stated any staff could answer them to see what a resident needed. They tried to get to everyone in 15 minutes but acknowledged it sometimes took longer, especially in the skilled area. During an interview with the Director of Nursing on 2/13/25 at 8:26 AM she stated call lights were always a factor. She expected everyone to stop and ask what the resident needed, and reported call light expectations were an ongoing topic of staff education. At 8:54 AM on 2/13/25 the Administrator sent an email documenting that the facility did not have a report that printed out call light response, and they had not completed any call light audits. She further reported the unit managers, nurses, and DON were responsible for monitoring call light answering. She wrote the 'box' that made the sound for a call light was at the nurses station to get the call light handled as soon as possible. A policy titled Call Lights: Accessibility and Timely Response implemented 10/21/24 noted call lights would directly relay to a staff member or centralized location to ensure appropriate response. Compliance guidelines included staff education on the proper use of the call system and ensuring resident access to the call light, resident education, and resident evaluation for unique needs and preferences. It further documented all staff members who see or hear an activated call light were responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observations, facility policy review, and staff interviews, the facility failed to ensure the disposal of expired food items, and food items in a resident refrigerator were labeled with the name of the food item, date placed in refrigerator and the date item needed to be disposed in an effort to prevent the potential for foodborne illness. The facility reported a census of 104 residents. Findings include: 1. During the initial tour of the kitchen and dry storage room on [DATE] at 9:58 AM, the following food times were found to be expired: a. 1- Chocolate Cake Mix expired [DATE]. b. 12- Apricot Nectar cans expired [DATE]. c. 1 - Baking Powder container expired [DATE] and 2 additional cans expired [DATE]. d. 1 - Poultry Seasoning canister expired [DATE]. e. 2 - Ground Mustard canisters - 1 expired [DATE], the other expired [DATE]. f. 11 - Cornbread Mix boxes - 4 expired [DATE], 7 expired [DATE]. g. 1 - Whole Sesame Seeds canister expired [DATE]. h. 1 - Nutmeg canister expired [DATE]. i. 8 - Lemon Juice bottle- 1 expired [DATE] and 7 expired [DATE]. j. 1 - Ground Sage canister expired [DATE]. k. 1- Red Hot Seasoning canister expired [DATE]. l. 2- Thyme canisters - 1 expired [DATE] and 1 expired [DATE]. m. 3 - Lasagna noodles boxes expired [DATE]. n. 1 - Balsamic Vinegar bottle did not have an expiration date or open date, the top was crushed, and the liquid inside appeared separated and lumpy. During an interview after the initial tour, Staff A, Certified Dietary Manager (CDM) stated she expected the cooks of disposal of expired items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 2:31 PM, the 1st floor north unit refrigerator contained an individual cup of open, undated applesauce; an open, undated container of apple juice; an undated sandwich in plastic wrap; and a plastic grocery bag with a staff member's meal inside. Staff B, Dietician, and Staff A, CDM stated everything in the refrigerator must have a label with the name of the product, the date item placed in the refrigerator, and the date item needs to be disposed of (three days from in date), and the refrigerator was for resident food only. A sign which indicated these expectations observed on the refrigerator door. Staff A stated she expected dietary staff to check the unit refrigerators when they delivered food and drinks for dates and expired items daily. During an interview on [DATE] at 9:47 AM Staff C, Dietician, confirmed she was aware of the expired food items. She stated they had to work on a better schedule to check those things. A policy titled Dietary Storage Guidelines revised [DATE] documented all non-perishable and perishable items would be stored in the proper areas at proper temperatures and in a safe manner. All items were put away in the first in first out method and rotated to assure the use of older products first and avoid the use of outdated products. All opened items (such as refrigerated leftovers) would be dated and labeled with a specific label which contained the date of preparation or opening and the product name if needed.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review and staff interview, the facility failed to utilize Enhanced Barrier Precautions for 4 of 6 residents observed (Residents #12, #41, #68 and #89) and failed to keep the tubing of indwelling catheter tubing off the floor for one of two residents observed (Resident #68). The facility reported a census of 104 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #12 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: fractures/multiple trauma, pneumonia and a urinary tract infection. The MDS indicated the resident dependent on staff for toileting and showers, repositioning and required substantial/maximal staff assist with transfers, lower body dressing and putting on footwear. The MDS also identified Resident #12 had an unhealed Stage IV pressure ulcer, A review of the Physician Orders revealed the following orders: a. 10/29/24 Enhanced Barrier Precautions b. 11/12/24 for Sacral Stage 4 (wound): Apply wet-to-dry using dakins. Cover with super-absorbent. Then apply dry protective dressing twice daily and prn (as needed). every day and evening shift and every 1 hours as needed for soiled or displaced dressing. c. 12/3/24 Foley Catheter Diagnosis: Stage 4 sacral wound Catheter Size: 16 Fr (French)/10 mL (milliliter) balloon. Original Insertion Date: 12/1/24, Place Foley catheter drainage bag in privacy bag On 12/6/24, the Care Plan identified the resident with the problem of Stage 4 pressure injury to sacrum. Interventions did not direct the use of Enhanced Barrier Precautions (EBP) during wound care. On 2/11/25, the Care Plan identified the resident with the problem of an indwelling Foley catheter. Interventions did direct the use of EBP during catheter care. During an observation on 2/11/25 at 7:44 AM, Staff I, Registered Nurse (RN), and Staff L, Certified Nursing Assistant (CNA) entered Resident #12's room. Both Staff I and Staff L washed their hands and donned gloves. Neither one had donned isolation gown for EBP prior to wound care. The door and/or room did not have an indication of the need to use EBP for wound or catheter care, and isolation gowns were not immediately available to the staff. 2. The MDS dated [DATE] identified Resident #41 as cognitively impaired with a BIMS of 05 and had the following diagnoses: atherosclerotic heart disease, peripheral vascular disease and arthritis. It also identified Resident #41 was totally dependent on staff for assistance with toileting, showers, lower body dressing and putting on footwear and required substantial/maximal assist with the remainder of activities of daily living. The MDS also identified Resident #41 with a Stage III pressure ulcer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/5/24, the Care Plan identified Resident #41 with the problem of a Stage III pressure injury to the coccyx. Interventions did direct the use of EBP during wound care. A review of the Physician Orders revealed an order dated 1/22/25 to cleanse the coccyx with Wound Wash, apply Triad paste and cover with a dry protective dressing three times daily and as needed. The orders did not include placing the resident in Enhanced Barrier Precautions. During an observation of cares on 2/11/25 at 11:26 AM, Staff J, Licensed Practical Nurse (LPN) and Staff S, RN PN entered Resident #41's room. Staff J, and Staff S, washed their hands and donned gloves. Neither nurse donned gowns. Staff J proceeded to provide wound care. After wound care, both nurses removed their gloves and washed their hands. The door and/or room did not have an indication of the need to use EBP for wound or catheter care, and isolation gowns were not immediately available to the staff. During an interview on 2/12/25 at 8:51 AM, Staff G, LPN stated EBP should be in place for any resident with COVID or infectious disease. And when providing cares to a resident in Enhanced Barrier Precautions, staff should wear an isolation gown, gloves and a mask. During an interview on 2/12/25 at 9:17 AM, Staff H, CNA stated residents that should be placed in EBP if they have with catheters, COVID, flu, C-diff (a bacterium that can cause inflammation of the colon). When providing cares to a resident in EBP staff should wear a gown, gloves, mask and goggles if she would anticipate splashing. 3. The MDS dated [DATE] identified Resident #68 as cognitively intact with a BIMS of 14 and had the following diagnoses: cancer, atrial fibrillation (an abnormal heart rhythm) and peripheral vascular disease. The MDS also identified Resident #68 as totally dependent on staff for assistance with toileting and lower body dressing and putting on footwear. The MDS also identified Resident #68 had an indwelling urinary catheter. A review of the Physician Orders revealed the following: a. 12/3/24 Foley catheter 16 Fr 10ml balloon b. 2/12/25 Enhanced Barrier Precautions On 12/4/24, the Care Plan identified Resident #68 with the problem of an indwelling urinary catheter. Interventions did direct the use of EBP during catheter care. During an observation on 2/10/25 that started at 11:06 AM, Resident #368 noted to be in sitting in a wheelchair, with the tubing to his indewelling catheter on the floor The tubing drug on the floor while the resident self propelled down a hallway. At 2/10/25 at 11:09 AM, Resident #368 self propelled to the end of the hallway as Staff L, CNA walked beside him. Staff L did not reposition the catheter tubing off the floor. At 2/10/25 at 12:24 PM, the resident in his wheelchair while in the main dining room. The catheter tubing remained on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2/10/25 at 2:26 PM, Resident #368 self propelled himself from the main dining room to the hallway as the DON (Director of Nursing) beside him. The DON did not reposition the catheter tubing. During on obsevation on 2/11/25 at 8:13 AM Staff O, CNA and Staff L, CNA both entered Resident #68's room wearing masks. Both aides washed their hands and donned gloves, however, neither one donned an isolation gown. Staff L completed catheter care. The door and/or room did not have an indication of the need to use EBP for catheter care, and isolation gowns were not immediately available to the staff. During an interiveiw on 2/12/25 at 10:13 AM, Staff L, CNA reported when a resident has an indwelling catheter, the tubing should never be on the floor. During an interview on 2/12/25 at 10:09 AM, the DON stated she would expect the nursing staff to pick up the Foley tubing off the floor if they would see it on the floor. A review of the undated facility policy titled: Catheter Care did not direct staff to maintain the indwelling catheter tubing off the floor. 4. The MDS dated [DATE] identified Resident #89 as cognitively intact with a BIMS of 14 and had the following diagnoses: stroke, cancer and coronary artery disease. It also identified Resident #89 required partial/moderate assistance with most activities of daily living and had a feeding tube. A review of the Physician Orders revealed an order, dated 11/20/24 Aspiration precautions: keep head of bed elevated above 30 degrees at all times. Check tube for correct placement and patency before administration medication, administration of feeding and tube flushes. Enhanced Barrier Precautions. On 11/21/24, the Care Plan identified Resident #89 with the problem of requiring a tube feeding. Interventions did direct the use of EBP during catheter care. During an observation of gastric tube cares on 2/11/25 at 10:26 AM Staff J, LPN entered Resident #89's room Staff J washed her hands and donned gloves, but did not don isolation gown. Staff J used the proper technique to for gastric tube care. The door and/or room did not have an indication of the need to use EBP for gastric tube care, and isolation gowns were not immediately available to the staff. During an interview on 2/12/25 at 9:36 AM, Staff J, LPN reported she had never been informed that Resident #89 was supposed to be placed in Enhanced Barrier Precautions. She also reported that residents that required Enhanced Barrier Precautions were residents who had catheters, colostomy, any kind of wounds that have drainage. During an interview on 2/12/25 at 10:09 AM, the DON stated Resident #89 should be on EBP as he has the feeding tube. She stated she did believe the EBP precaution sign was posted, or PPE available outside of the room. A review of the facility policy dated as last revised March 2024 and titled: Enhanced Barrier Precautions had documentation of the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	INITIATION OF ENHANCED BARRIER PRECAUTIONS a. Residents will be reviewed upon admission and/or change of condition for the need of EBP by the Director of Nursing/Designee. b. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with MDRO (Multi-Drug Resistant Organisms) that is not currently targeted by the CDC (Center for Disease Control). c. An order for Enhanced Barrier Precautions will be obtained for residents for any of the following: aa. Wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with an MDRO bb. Infection or colonization with a CDC targeted MDRO when contact precautions do not otherwise apply. IMPLEMENTATION OF ENHANCED BARRIER PRECAUTIONS a. Make gown and gloves available immediately near our outside the resident's room. b. Enhanced Barrier Precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.