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	05/30/2024

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 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on record review, resident and staff interview, and policy review, the facility failed to document the review of the bed hold policy prior to residents being transferred to the hospital for three of four residents reviewed (Residents #1, #4, and #5). The facility reported a census of 99 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #1 as cognitively intact with a BIMS score of 13 out of 15, and had the following diagnoses: Heart Failure, Peripheral Vascular Disease, and Renal Insufficiency (Kidney Failure). The MDS also identified Resident #1 was totally dependent on staff for assistance with toileting hygiene, upper and lower body dressing, help with footwear, and transfers. A review of the Progress Notes revealed the following: 3/29/24 at 11:33 AM This nurse was summoned to the Resident #1's room by the assigned aide. Resident #1 was laying on her back on the floor of the restroom with her head being held by the aide. The aide reported they were transferring her from the wheelchair to the toilet when she slid from the Hoyer sling and bumped her head. There was a moderate amount of blood from this wound where her head hit the toilet riser. The injury was a laceration which measured 2.5 cm (centimeters) long. Resident #1 was assisted off the floor using a full body sling by 2 to 3 staff. 3/29/24 11:53 AM several attempts made to contact the resident's daughters and son without any response. The physician was called and provided orders to transfer to the ER if family wishes. 3/29/24 12:38 PM Resident #1 had the nurse call her daughter from her personal cell phone. The nurse informed her daughter of the incident and gave permission to take her to the hospital. The Progress Notes did not have any documentation to show the Bed Hold Policy had been reviewed with the resident/family. In an interview on 5/28/24 at 1:57 PM, Resident #1's family member reported she did not receive any information on the Bed Hold Policy until 4/6/24 informing her she had 10 days to respond after she had been transferred to the hospital on 3/29/24. (continued on next page)

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

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	2. The MDS dated [DATE] identified Resident #4 as cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 9 and had the following diagnoses: Renal Insufficiency (Kidney Failure), Cerebrovascular Accident (Stroke), and Diabetes Mellitus. The MDS also identified Resident #4 required substantial/maximal staff assistance with toileting, showers, putting on and taking off footwear, and transfers. A review of the Progress Notes revealed the following: 5/10/24 at 9:56 AM Resident noted to have dark brown emesis. Resident #4 is currently on Eliquis (a blood thinner). Nurse Practitioner notified of possible GI bleed and orders received to send to the emergency room for evaluation and treatment. 5/10/24 at 10:05 AM Medics transported Resident #4 to the ER. 5/13/24 at 9:40 PM returned from the hospital via ambulance. The Progress Notes did not have any documentation to show the resident's family had been informed of the Bed Hold Policy. 3. The MDS dated [DATE] identified Resident #5 as cognitively intact with a BIMS score of 15. The MDS also identified Resident #5 required substantial/maximal staff assistance with showers. The MDS also identified Resident #5 to be dependent on staff for assistance with toileting hygiene, lower body dressing, putting on and taking off footwear, and transfers. A review of the Progress Notes revealed the following: 3/2/24 at 1:19 PM Medics arrived at about 1:05 PM to transport Resident #5 to the emergency room . 3/6/24 at 4:12 PM Resident returned from the hospital with a diagnosis of Pulmonary Embolism (blood clot) and cellulitis to the left thigh. The Progress Notes did not have any documentation to show the resident's family had been informed of the Bed Hold Policy. In an interview on 5/29/24 at 10:30 AM, Staff C, Unit Clerk/CNA/CMA reported the following: a. When asked who was responsible for reviewing the Bed Hold Policy with residents/family when they are transferred to the hospital, she stated the Social Worker has always done it. b. The review of the Bed Hold Policy with residents/families are usually documented in the electronic medical record. c. She did now know what the time frame was to complete the review and documentation of the Bed Hold Policy with residents/families after the resident had been transferred to the hospital. In an interview on 5/29/24 at 1:35 PM, the Director of Nursing reported the following: (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 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	a. When asked who is responsible for reviewing the Bed Hold Policy with residents/family when they are transferred to the hospital, she stated the Social Worker. b. In the case of Resident #1, the Administrator followed up with the family and told them the facility would hold her bed because she had lived here for so long. The Administrator had explained that the facility would waive the bed hold charge and we would keep her bed for her until she returned. c. She did not know where the review of the Bed Hold Policy is documented. d. The time frame is 14 days to complete and review and documentation of the Bed Hold Policy with residents/families after the resident had been transferred to the hospital. In an interview on 5/29/24 at 2:51 PM, the Administrator reported the following: a. When asked who is responsible for reviewing the Bed Hold Policy before residents are sent out to the hospital, she stated the Social Worker. b. The time frame to review and document the review of the Bed Hold Policy is within 10 days. c. The review of the Bed Hold Policy should be documented in the Progress Notes in the electronic medical record. d. Regarding Resident #1's transfer to the hospital on 3/29/24, she spoke to Resident #1's daughter about keeping her bed and that the facility would keep it open for her for as long as they needed to. She had documented in an e-mail that she would not give her bed up. In an interview on 5/30/24 at 8:30 AM, Staff G, LPN/Unit Manager reported she looked through the Social Worker's office (as the Social Worker was on medical leave) to locate any paperwork regarding the review of the Bed Hold Policy for Residents #1, #4, and #5. A review of the facility policy titled: Bed Hold Process Facility Policy with the effective date of 2/28/23 had documentation of the following procedure: a. The Nurse will obtain the Bed Hold Policy and Return to Facility Notice and provide the notice to the resident and their representative at the time of transfer or leave of absence. b. In cases of an emergency transfer, notice at the time of transfer means the facility will send the notice along with the necessary paperwork to the receiving setting and the resident representative will receive a notice sent within 24 hours of transfer. If the facility is unsuccessful in contacting the resident representative, all attempts must be documented. c. The nurse will ensure that a copy of the notice accompanies the resident as the resident leaves the facility. d. The nurse will inform the resident representative on the telephone, if necessary, about the Bed Hold and Return to Facility Policy and ask how best to provide a copy of the notice to the representative. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	aa. The nurse will inform the representative that the notice accompanied the resident at the time the resident left the facility. bb. The nurse will document the provision of the Bed Hold Policy and Return to Facility Policy to the resident, and information given to the representative in the resident's record.

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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 0689 Level of Harm - Minimal harm or potential for 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** 25855 Based on record review, family and staff interview, and policy review, the facility failed to safely transfer one of three residents reviewed with a mechanical lift (Resident #1). The facility reported a census of 99 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #1 as cognitively intact with a BIMS of 13 out of 15, and had the following diagnoses: Heart Failure, Peripheral Vascular Disease and Renal Insufficiency (Kidney Failure). The MDS also identified Resident #1 was totally dependent on staff for assistance with toileting hygiene, upper and lower body dressing, help with footwear, and transfers. On 4/6/18, the Care Plan identified Resident #1 with the problem of having an ADL (Activities of Daily Living) self-care performance deficit related to Parkinson's with dementia and directed staff to have two staff assist with toileting with the Hoyer Lift to the Shower Chair. A review of the incident report dated 3/29/24 at 11:12 AM had documentation of the following: Resident #1 fell during a transfer in the resident's bathroom. Resident #1 was laying on her back with the aide holding the back of her head. There was a small to moderate amount of bleeding from the back of her head. She is alert and verbally responsive. Her legs are on the base of the Hoyer lift with the lift sling still attached to the lift. Resident #1's only complaint is a headache. Three staff members utilized a full sized sling and Hoyer lift to transfer her from the floor to her bed. After notification of her physician and family she was transferred to the hospital. The resident reported she slid out of the Hoyer sling and struck the back of her head on the toilet riser. A review of the undated written witness statement by Staff B, CNA revealed the following: She entered Resident #1's room to assist her with going to the bathroom. Staff B brought in the Hoyer lift and put the Hoyer sling around Resident #1 and went to get assistance. When Staff B and Staff D, CNA returned, they connected the sling straps to the hooks on the Hoyer. After they transferred her to the bathroom, they began to lower Resident 1's pants. Resident #1 then slipped out back first hitting her head on the toilet. A review of the undated written witness statement by Staff D, CNA revealed the following: Staff B, CNA asked for help to transfer Resident #1 from her chair to the toilet. Resident #1 was already hooked up in the sling and ready to be lifted. Both aides hooked the leg straps into the machine. She operated the lift while the other aide held the back of the sling correctly. After they got her into the bathroom, they both started to pull Resident #1's pants down, then Resident #1 slid out of the sling before they could catch her. Her head slid out and hit part of the toilet while her legs were still in the air, All the straps were hooked on correctly. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/28/24 at 1:57 PM, Resident #1's power of attorney reported Staff C, Unit Clerk/CNA/CMA had informed her sister that the staff did not secure the sling to the lift properly. In an interview on 5/29/24 at 10:03 AM, Staff B, CNA reported the following: a. When using a mechanical lift to transfer a resident, there should be two staff to transfer. b. Before she transfers a resident she would make sure everything is hooked up correctly and in there comfortably. c. She was trained by another CNA on the use of mechanical lifts. When she transferred Resident #1 on 3/29/24, it was her first time to use the Hoyer lift after her 2 day training. d. Resident #1 was care planned to be transferred with use of the Hoyer lift. e. Both Staff B and Staff D, CNAs were in the room when Resident #1 fell . f. When asked how the sling was connected to the resident and to the lift, she reported she put the sling behind the resident and wrapped it around her. She would need to make sure the buckles to the middle and across the chest are buckled. The sling should be near the top of the head. Make sure the sling is underneath the legs and cannot be criss-crossed. Then we put the loops from the sling and hook it up to the Hoyer. I think there are 2 in the middle and 2 on top. g. When Staff B and Staff D transferred Resident #1 to the bathroom, she was first in her wheelchair and they moved her from wheelchair to toilet. They put the sling underneath her and connected it to the lift. Staff B operated the lift and Staff D connected the sling to the lift and guided her body during the transfer into the bathroom. h. As Staff B and Staff D pulled Resident 1's pants down, Staff D held on to the back of the sling holding on to the handle and Resident #1's shoulder. As they both lowered Resident #1's pants, she began to lean backwards and pushed her weight on the lift and she slipped out of the lift. Everything was secure. i. Staff D went to have the DON (Director of Nursing) assess Resident #1 as Staff B stayed with her. The DON looked at everything and said everything was connected the way it should have been. The DON felt Resident #1 kept leaning backwards and caused her to slip out of the sling. j. If they had helped her to stay upright and have one person stand behind her as the other one pulled her pants down, this might have prevented the fall. In an interview on 5/29/24 at 8:31 AM, Resident #1's other family member reported on 3/29/24 Resident #1 called her and said they wanted to send her to the ER. She said she fell out of the Hoyer lift and hit her head. The family member then spoke to Staff C, Unit Clerk who informed her that Resident #1 was in the Hoyer lift which was not fastened correctly, she fell out and hit her head on the toilet riser and it bled. Then they sent Resident #1 to the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/29/24 at 10:30 AM, Staff C, Unit Clerk/CNA/CMA reported she was not in the room when Resident #1 fell on [DATE] was told that there was an incident where the girls transferred her with the Hoyer lift and she hit her head. In an interview on 5/29/24 at 12:59 PM, Staff D, CNA reported the following: a. When using a mechanical lift to transfer a resident, there should be 2 staff to transfer. b. When transferring a resident using a mechanical lift, she would first check the care plan. Get another worker in the room with her. We would make sure to put the sling underneath the resident. There are two long straps that go under the legs and go up. There are clips under each side of the resident's ears and by the ribs that need to be clipped together. Then attach the straps to the lift. One person would operate the lift and the 2nd person should be behind the resident. She would hold on to the strap behind the sling. c. Resident #1 had Staff B as her primary aide for her aide that day. She was brand new and only had 2 days of training. d. Resident #1 was care planned to be transferred with use of the Hoyer before she fell on [DATE]. e. Before she entered Resident #1's room, Staff B had already put the sling on her and said all she needed help with was transferring. She could not recall if the sling was placed properly or not. f. When Staff B and Staff D transferred her to the bathroom, Staff D operated the lift. Staff B stood behind Resident #1. Staff B was not holding on to the strap attached to back of the sling. When Resident #1 was up in the air, she started to complain her arm was hurting. Staff B and D tried to pull her pants down before sitting her on the toilet. Then Resident #1 started to slip out of the bottom of the sling and hit her head on the front of the toilet seat. After that she fell down to the floor and hit her head on the floor. Her legs were still up in the sling but then they eventually slid out. Staff B held Resident #1's head up and held pressure to the back of her head where it was bleeding. Staff B stayed with Resident #1 while Staff D went to get Staff D, LPN. After Staff D assessed her, they transferred her back to bed. Staff D could not see where anything had snapped, broke, tore or ripped. g. When asked if the fall could have been prevented, she said she couldn't say. She reported she did not know Staff B had transferred anyone using a Hoyer before that. She only had two days of training before this fall. There is no checklist that is to be completed before new aides are allowed to start working on the floor. In an interview on 5/29/24 at 1:35 PM, the Director of Nursing (DON) reported the following: a. When using a mechanical lift to transfer a resident, she would expect two staff members to transfer the resident. b. The procedure she would expect staff to to follow when transferring with a mechanical lift: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tell the resident what they're doing. Make sure all the straps are under the armpits and they are clipped under the arm and then clipped to the Hoyer. The straps used for the transfer on 3/29/24 was the toilet sling so the straps underneath the legs went straight up and hooked up to the lower part of the Hoyer. The toilet sling does not cover the resident below the thighs. The one aide should stand in front of the lift and would be operating the lift. The 2nd person should be standing behind the resident holding on to a handle which is on the back of the sling to keep the resident from swinging. c. When new CNAs are hired, they receive a 3 day orientation which should include the use of mechanical lifts with a return demonstration. d. The staff contacted the DON immediately after Resident #1 fell on [DATE]. When she arrived to her room, Resident #1 was on the floor with her head on the floor beside the toilet. She had a shower chair riser over the toilet and she bumped her head on that when she slid out of the Hoyer and fell approximately 2 feet from the lift to the floor. She had the blue sling. Everything looked like everything was hooked correctly. They said they had her clipped right. e. When Resident #1 fell out of the sling, the aides were trying to pull her pants off and she leaned too far back. f. When asked how the fall could have been prevented, she reported the aides should have used a full body sling. g. Resident #1 was later transferred to the hospital where she had multiple scans and everything was negative. While at the hospital, she had an anaphylactic reaction to the Lidocaine which she thought they used before they treated the laceration. She was later intubated and sent to a critical illness recovery hospital. A review of the undated facility form titled: Mechanical Lifts Competency had documentation of the following: When transferring a resident with a lift, it must always be from surface to surface. The surfaces should be directly next to each other. Never transfer a resident from a bed or recliner to the restroom using the lift. The residents should not be wheeled while in the lift throughout the room. The resident is to be transferred to a wheelchair or toilet chair and then taken into the bathroom.