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 _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAHL HOME FOR THE AGED & INFIRMED	6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807

(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	INITIAL COMMENTS Correction Date 9/5/17 The following deficiencies relate to the annual recertification survey completed .8/14/17 through 8/17/17 (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000		9-5-17
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Duffey — TITLE: Administrator — (X6) DATE: 9-5-17

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.

9/6/17 Jann Capleder

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 _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAHL HOME FOR THE AGED & INFIRMED	6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807

(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 226	Continued From page 1 (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on personnel file review, policy review and staff interview, the facility failed to obtain timely criminal and abuse background checks prior to hire for 1 of 9 employee records selected for review (Staff B). The facility identified a census of 113 residents. Findings include: Staff B's, Certified Nurse Aide (CNA) human resource record had documentation of the following: a. Date of hire: 10/24/16. b. Single contact license and background check. (SING check) completed 2/2/17 (3 months later). c. Authorized Representative Review and Verification form with a first day of employment of 10/24/16. d. Facility hiring checklist with criminal back ground check for Iowa and out of state, none completed for this employee. A review of the facility procedure titled: Criminal Record Checks dated 11/15/03 had documentation of the following: a. All applicants are required to have a criminal history check done through the Division of Criminal Investigation. b. This information is then keyed into an internet website by the director of personnel for verification of any criminal history.	F 226		

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 _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAHL HOME FOR THE AGED & INFIRMED	6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807

(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 226	Continued From page 2 c. If the criminal history comes back clear it is attached to the application and no further action is taken. d. If the criminal history comes bac with a record, the facility must wait for a confirmation that there is a record that the applicant's file is actually clear. e. If the applicant's file is actually clear, the facility may proceed with the hiring process During an interview on 8/16/17 at 9:16 a.m., the Human Resources (HR) coordinator reported she had to complete the tasks for both the HR director and the HR coordinator for almost 4 months after the previous director left and the new director had started full time. She reported Staff A had quit after she had been hired 10/24/16 and admitted she could not find the SING check form until Staff A had been rehired in February of 2017. In an interview on 8/17/17 at 7:41 a.m., the administrator reported she was not aware of the situation until 8/16/17, that the HR coordinator should have had assistance with the extra duties acquired during the transition of HR directors. During an interview on 8/17/17 at 8:22 a.m., the HR director reported that SING checks should be completed on all new hires prior to orientation, she had a hire date of 9/16/16 and during the past year the facility hired 197 employees and terminated 197 employees, that the HR coordinator had to complete the tasks of both director and coordinator for several months and could have used assista	F 226		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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 _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAHL HOME FOR THE AGED & INFIRMED	6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807

(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 281	Continued From page 3 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy review, the facility failed to properly dispose of an expired insulin flex-pen 28 days after opening and continued to administer the insulin 16 days after the expiration date for one resident reviewed (Resident #24), also failed to properly administer medications for 1 of 20 residents reviewed. (Resident #9) The facility reported a census of 113 residents. Findings Include: 1. During the review of the 2 south medication cart on 8/14/15 at 3:17 p.m. with the Assistant Director of Nursing (ADON), noted a Novolog injection flex-pen for Resident #24 had a pharmacy label that directed the nursing staff to dispose of the flex-pen after 28 days once opened. On the label a hand written date of 7/1/17 noted on the date open line. Review of the physician orders for Resident #24 revealed an order on 5/3/17 for blood sugars to be checked before meals and to follow a sliding scale insulin schedule for the Novolog flex-pen. Review of the August 2017 electronic Medication Administration Record (MAR) for Resident #24	F 281		

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 _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAHL HOME FOR THE AGED & INFIRMED	6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807

(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 281	Continued From page 4 revealed the resident received a sliding scale insulin injection 11 of the 14 days with 5 of the 11 days receiving the sliding scale injection twice in a day. The staff administered Novolog from the Novolog insulin pen opened on 7/1/17. At the time of the last sliding scale injection at lunch time 8/14/17, the Novolog noted to be 16 days past when the pen should have been discarded per pharmacy instructions. The ADON noted the expired insulin and agreed the Insulin pen is expired and disposed of the pen properly. A new Novolog Insulin pen secured from the 2 south medication room and placed on the medication cart for Resident #24. During an interview on 8/16/17 at 7:48 a.m., the Director of Nursing stated the expectations of the nursing staff is to date insulin when first opened and discard the insulin per pharmacy or manufacturer's direction. The DON reported an inservice done prior to his/her hiring on insulin dating and when to discard. Review of the undated Insulin Storage Policy states the policy intended to ensure the storage of insulin is done correctly to provide for safety and effective results. The procedure directed the nursing staff that once insulin is opened, it expires 28 days after opened. Insulin must be dated when opened and the number of days insulin pens are good vary depending on the type. Review of the undated Insulin Administration information sheet for the nurses, noted at the end of the information a statement to date all insulin when opened and to discard after 28 days.	F 281		

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 _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAHL HOME FOR THE AGED & INFIRMED	6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807

(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 281	Continued From page 5 On 8/16/17 at 11:25 a.m., the Inservice Director presented documentation from a mandatory nurses meeting dated 9/14/16, at that meeting it was discussed the need to date insulin when opening and discard when outdated. 2. The MDS (Minimum Data Set) assessment tool dated 5/22/17, listed diagnoses for Resident #9 which included Heart Failure, Hypertension, Peripheral Vascular Disease, and Non-Alzheimer's Dementia During a medication pass observation on 8/16/17 at 7:30 a.m., Staff A, LPN (licensed Practical Nurse) prepared medication for administration to Resident # 9. The following medication in tablet form were crushed: Hydrocodone, Lasix, Lorazepam, Seroquel, and Sodium Chloride. Culturelle and Potassium Chloride (KCL) were in capsule form and electronic medication administration record stated to give in sprinkle form. Staff A dispensed the crushed medication in pudding and put the capsules whole into the pudding. Resident #9 chewed the pudding but with the first spoonful the resident spit out a white, hard substance and during second spoonful of pudding spit out a whole blue capsule (KCL), refusing the medications. Staff A discarded the medication and documented refusal in the electronic medication record Review of a physician order dated 8/2/17 listed an order for Culturelle capsule, in sprinkle form and potassium (KCL) in sprinkle form. The ordered informed staff they may crush medication or open capsules unless pharmaceutically unacceptable. Review of a statement provided on 8/16/17 from the facility pharmacy in regards to opening the	F 281		

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 _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAHL HOME FOR THE AGED & INFIRMED	6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807

(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 281	Continued From page 6 capsule and sprinkling the contents onto a soft food such as applesauce or pudding, both of the following medications would allow for this practice: Potassium Chloride Extended Release and Culturelle Probiotic Capsules. During an interview with Inservice Director, Registered Nurse (RN) on 8/16/17 at 1:30 p.m. she stated she would look at the order and follow what the electronic medication administration record directs the staff to do. Interview with Director of Nursing on 8/16/17 at 4:15 p.m. stated if staff are directed to use medication in a sprinkle form the nurse should open the capsule and sprinkle on soft foods instead of giving the medication whole. Review of a facility policy dated 6/11/08 revealed all medication shall be administered in a safe and timely manner, as prescribed.	F 281		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 371		

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 _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAHL HOME FOR THE AGED & INFIRMED	6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807

(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 371	Continued From page 7 from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the maintenance cleaning schedule, the facility failed to maintain proper storage of food products in the dry storage area and failed to keep 3 out of 4 ice machines clean within the 4 dietary areas. The facility reported a census of 113 residents. Findings Include: During the initial dietary tour on 8/14/17 at 10:00-10:54 a.m. with the Food Services Director (FSD) the following concerns noted: a. In the dry storage room of the main kitchen area a 5 pound Culinary Secrets white cake mix box opened with the plastic bag inside open not sealed exposing the cake mix. The Food Services Director stated didn't understand why the cake mix box to be opened like that as once opened, the cake mix is completely utilized for baking. The Food Services Director took the cake mix box to be disposed of. b. In Pantry #1 on first floor noted a Scotsman Prodigy ice machine to have a black substance to the back wall. When rubbed with a paper towel,	F 371		

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 _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAHL HOME FOR THE AGED & INFIRMED	6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807

(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 371	Continued From page 8 the substance came off on the paper towel. c. In Pantry #2 on second floor noted a Scotsman Prodigy ice machine to have a black substance to the back wall and a rust colored area in the right hand corner of the back wall. When rubbed with a paper towel, the substances came off on the paper towel. d. In Pantry #3 on third floor noted a Scotsman Prodigy ice machine to have a black substance to the back wall. When rubbed with a paper towel, the substance came off on the paper towel. The FSD indicated the cleaning of the ice machines is a task done by the maintenance department. During an interview on 8/15/17 at 11:15 a.m., the FSD reported they thought the maintenance staff cleaned the ice machines on a monthly basis. During an interview on 8/15/17 at 11:18 a.m., the Maintenance Supervisor reported the maintenance staff clean one ice machine a month but not all the ice machines every month. The supervisor presented a yearly calendar book and showed each month since January 2017 an ice machine a month was cleaned and logged in that book. The supervisor stated there was not a formal policy in regards to the cleaning of the ice machines.	F 371		

Kahl Home for The Aged And Infirmed
6701 Jersey Ridge Road
Davenport, IA 52807

Preparation and/or execution of this document and Plan of Correction does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth in the Statement of Deficiencies. These documents and Plan of Correction are prepared and/or executed solely because they are required of Federal and State law. Let these documents and Plan of Corrections serve as this facility's credible allegation of compliance.

The following Plan of Correction is being submitted because it is required under federal law and is not an admission of any wrong doing or the existence of any deficiency under the Medicare or Medicaid Programs. This Plan of correction is not an admission that there are measures or steps that the facility could have or should have taken to address the alleged deficiency in the past.

F226- Develop/Implement Abuse/Neglect, Etc. Policies

1. The facility has taken the following action concerning the deficiency Identified on the CMS-2567:
    - In-service training 8/17/17 on Background Check Importance, timeliness, and new checklist excel form to ensure Background Checks are completed before hire.
2. The facility has identified other employees similar to those identified on the CMS-2567 and has taken the following actions:
    - A full audit of all employee files was completed ensuring all background checks were completed and timely.
    - Facility will follow the facility background check policy with the background check initiated and checked prior to orientation.
3. To ensure that proper practices continue and that the problem does not Recur:
    - The Administrator will monitor the checklist excel form to ensure all new employee Background checks were completed prior to orientation.
    - The results of the monitoring completed will be submitted to the QA Committee for review and follow up to ensure compliance.

F 281- Services Provided Meet Professional Standards

1. The facility has taken the following action concerning the deficiency Identified On the CMS-2567:

    - In-service training provided to nurses 8/16/17 on expired insulin flex-pens and medication administration.
    - On 8/14/17, all medication carts and med rooms were audited for outdated products.
    - The facility identified residents on Culturelle Capsules and potassium (KCL) and changed the E-Mar to open and sprinkle the medication.

2. The facility has identified all residents on insulin flex-pens, Culturelle capsules, and potassium (KCL) on the E-Mar similar to those on the CMS-2567 and has taken the following action:

    - The facility has developed a weekly Insulin Pen and Insulin Vial Audit Form to be completed by the Unit Managers.
    - The E-Mar has been updated to state to open and sprinkle the medication for Culturelle Capsules and Potassium (KCL) The facility developed an audit tool to be completed by the Unit Managers to ensure medication is opened and sprinkled.

3. To ensure that proper practices continue and that the problem does not Recur:

    * Pharmacy has been notified to do periodic checks to ensure compliance.
    - The Director of Nursing will review the audits completed by the Unit Managers to ensure compliance.
    - The results of the monitoring completed will be submitted to the QA committee for review and follow up to ensure compliance.

F371-Food Procure, Store/Prepare/Serve-Sanitary

1. The facility has taken the following action concerning the deficiency identified On the CMS-2567:

    - The dietary manager audited other boxes of cake mix to ensure they were closed and marked.
    - The dietary manager audited and cleaned the facility ice machines.
    - The dietary department was in-serviced on 8/17 the importance of closed/marked items, and cleaned ice machines.

2. The facility has identified other items that are not closed/marked plus all ice Machines to be cleaned appropriately similar to those on the CMS 2567 and Has taken the following action:

    - The dietary manager initiated daily audits to ensure closed/marked items and cleanliness of the ice machines.

3. To ensure that proper practices continue and that the problem does not Recur:

    - The Administrator/designee will review the daily audits to ensure compliance.
    - The results of the monitoring completed will be submitted to the QA Committee for review and follow-up to ensure compliance.