

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/22/2018
NAME OF PROVIDER OR SUPPLIER KAHL HOME FOR THE AGED & INFIRMED			STREET ADDRESS, CITY, STATE, ZIP CODE 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 ✓ 3/6/18	INITIAL COMMENTS Correction date <u>3/5/18</u> The following deficiency relates to the investigation of complaint #72557 & #73587. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C).	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/06/2018

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.

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IA0920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/22/2018
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NAME OF PROVIDER OR SUPPLIER KAHL HOME FOR THE AGED & INFIRMED	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807
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C 139	<p>50.7(1)a(2) Additional notification</p> <p>481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:</p> <p>50.7(1) Of any accident causing major injury.</p> <p>a. "Major injury" shall be defined as any injury which:</p> <p>(2) Requires admission to a higher level of care for treatment, other than for observation;</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to report a fall causing injury that required an admission to a higher level of care for one of six residents reviewed (Resident #6). The facility census was 96 residents.</p> <p>Findings include:</p> <p>1. An Incident/Accident report dated 1/3/18 at 5:45 p.m., revealed Resident #6 stood up from the wheelchair and walked behind the dining room table and fell. The resident was transferred to the hospital.</p> <p>The History and Physical revealed the resident was admitted to the hospital on 1/3/18 status post fall with neck pain.</p> <p>The Hospital Discharge Summary dated 1/5/18, revealed the resident had discharge diagnoses of cervical C2 and thoracic T3 fractures secondary</p>	C 139		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Amberly Dufsey

TITLE
Administrator

(X8) DATE
3-5-18

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IA0920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/22/2018
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C 139	<p>Continued From page 1</p> <p>to fall with closed head injury, left clavicle fracture, left scapular fracture, pneumonia and urinary tract infection. The resident was discharged to hospice.</p> <p>During interview on 2/22/18 at 11:24 a.m., the Director of Nursing, (DON) reported they report incidents to the department. The DON reported they thought if the physician determined the injury was not a major injury that it did not need to be reported. The DON reported they knew about the shoulder fractures right away and later learned of the cervical and thoracic fractures.</p>	C 139		

Kahl Home For The Aged and Infirm
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 by provisions 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.

C139-50.7 (1)a(2) Additional notification

1. The facility has taken the following action concerning the deficiency identified on the CMS-2567.
 - The facility incorporated a flow sheet to assist with determining the Need to report.
2. The facility has identified other residents similar to those identified on the CMS-2567 and are taking the following action:
 - There were no other similar residents noted.
3. To ensure the proper practices continue and that the problem does not recur:
 - All residents with a Non-Major Injury Form filled out and residents requiring a higher level of care for treatment will be reported to the Department of Inspections and Appeals.
 - The Administrator and DON will monitor for continued compliance.
4. The results of the monitoring completed under this Plan of Correction will be submitted to the QA Committee for review and follow up to ensure that solutions are permanent.

Completion Date: 3/5/2018