

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 _____  The following information relates to the investigation of #80810, #80867 and #81060 conducted 2/6/19 to 3/7/19. All three investigations were substantiated. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)  §483.21(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 record review, observations and interviews the facility failed to follow physician's orders for 3 of 5 sampled. The facility reported a census of 55 residents.  Findings include:  1. According to the Admission Record dated 2/15/19 Resident #2 had diagnoses of respiratory failure, diabetes and morbid obesity.  The Minimum Data Set (MDS) assessment dated 1/18/19 revealed Resident #2 required total staff assistance with bed mobility and toilet use.  The Plan of Care revealed Resident #2 had skin integrity impairments and directed the staff to follow facility protocols for treatments.	F 658			

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

TITLE

(X6) DATE

04/26/2019

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 HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 658	<p>Continued From page 1</p> <p>According to the Admission Orders dated 1/11/19 Resident #2 had an order for Interdry to abdominal fold and thighs and change every three days. Resident #2 had an order for Mepilex to right knee and change three times a week.</p> <p>The Treatment Administration Record TAR revealed the orders entered on 1/16/19. The TAR revealed omissions in the Interdry and Mepilex dressing changes from 1/11/19 to 1/16/19.</p> <p>An interview on 2/15/19 at 11:22 a.m. Resident #2 reported the dressings to his/her abdominal fold and knee did not get changed for several days after admission to the facility.</p> <p>In an interview on 2/12/19 at 2:41 p.m. the Director of Nursing (DON) reported he/she completed the admission orders. The DON reported the treatments were due to be changed on 1/14/19. The DON reported the facility had no documentation to reflect the staff completed the treatments.</p> <p>2. According to the Admission Record dated 2/14/19 Resident #3 had diagnosis of stroke.</p> <p>The Minimum Data Set (MDS) assessment dated 1/28/19 revealed Resident #3 had short and long term memory impairments.</p> <p>The MDS dated 1/28/19 revealed Resident #3 required total staff assistance with bed mobility, dressing, toilet use and personal hygiene.</p> <p>The Order Summary Report dated 2/14/19 revealed an order dated 1/29/19 for Jevity 1.2 feeding per peg tube 80 milliliters (mL) per hour with 65 mL per hour water flush.</p>	F 658			

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 658	<p>Continued From page 2</p> <p>Observation on 2/12/19 at 8:59 a.m. revealed Resident #3 sitting up in the bed with the tube feeding running. The pump had the feeding running at 80 mL an hour and the flush at 50 mL an hour.</p> <p>An observation and interview on 2/12/19 at 9:10 a.m. revealed Staff C reported the pump beeped at the start of the shift (6:00 a.m.) and Staff C added more nutritional formula. Staff C did not know how the pump flush rate changed. Staff C verified the order for the feeding and flush and reset the pump flush to 65 mL an hour.</p> <p>Review of the December 2018 Medication Administration Record sheet revealed an order dated 7/14/18 for Jevity 1.2 237 mL via enteral feeding tube every four hours. The sheet revealed omissions in the treatment on 12/9/18 at 2:00 p.m., 12/16/18 at 6:00 p.m., 12/31/18 at 10:00 a.m. and 2:00 p.m.</p> <p>3. According to the Admission Record dated 2/15/19 Resident #5 had a diagnosis of femur fracture.</p> <p>The Plan of Care directed the staff to provide tube feedings as ordered and follow the facility protocol for administration.</p> <p>Review of Resident #5's February 2019 Medication Administration Record sheet revealed an order for Jevity (enteral feeding) 1.2 one and a half cans at 6:00 a.m. and 2:00 p.m. The sheet revealed omissions in the feedings on 2/5/19, 2/8/19, 2/11/19, 2/12/18 and 2/13/19 at 6:00 a.m.</p> <p>Review of Resident #5's December 2018</p>	F 658			

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>800 EAST RUSHOLME STREET DAVENPORT, IA 52803</b>		
(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 658	Continued From page 3  Medication Administration Record revealed an order for Jevity 1.2 1 can (237 mL) twice a day at 10:00 a.m. and 10:00 p.m. The sheet revealed an order for Jevity 1.5 cans (356 mL) twice a day at 6:00 a.m. and 2:00 p.m. The sheet revealed omissions in the feedings on 12/21/18 at 10:00 a.m. and 2:00 p.m., on 12/26/18 at 2:00 p.m., 12/28/18 at 10:00 a.m. and 10:00 p.m., and 12/31/18 at 10:00 p.m.  On 2/15/19 at 12:31 p.m. the Director of Nursing reported the facility audits the Medication Administration Records on a weekly basis. This process was initiated in September of 2018. The DON reported the facility plans to implement an electronic medication record and it will help resolve the issue.  The Administering Medications Policy revised December 2012 revealed medications shall be administered in a safe and timely manner as prescribed. The Director of Nursing Services will supervise and direct all nursing personnel who administer medications. Medications must be administered in accordance with orders, including any required time frame.	F 658			
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)  §483.60(d) Food and drink Each resident receives and the facility provides-  §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;  §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing	F 804			

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 804	<p>Continued From page 4</p> <p>temperature. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews the facility failed to serve food at adequate temperatures for 6 of 6 residents reviewed. The facility reported a census of 55 residents.</p> <p>Findings include:</p> <p>During the group interview on 2/6/19 at 3:15 p.m., 6 of 6 residents reported the food is served lukewarm, the soup is served cold, the butter is hard and will not melt on toast or baked potatoes, vegetables are undercooked and the scalloped potatoes are hard. The residents reported the food tastes good it's just not hot or it's undercooked.</p> <p>Observation on 2/7/19 at 11:30 a.m. revealed Staff F obtained a temperature of 80 degrees Fahrenheit on the pureed pork chop. Staff F placed the pan of pureed pork chop back in the oven. Staff F obtained a temperature of 130 degrees Fahrenheit on the mechanical soft pork chop. Staff F placed the mechanical soft pork chop back in the oven at 450 degrees Fahrenheit. Staff F reported one side of the double oven does not function and the staff bake everything on the one side of the oven. Staff F reported the staff submitted a work order on the oven last week.</p> <p>Observation on 2/7/19 at 12:05 p.m. revealed the dietary staff initiated the room tray service for L and R Hall. The staff placed the plates on plate warmers. The staff prepared a test tray. At 12:17 p.m., the room trays left the kitchen. At 12:25 p.m., the test tray revealed the following temps:</p>	F 804			

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 804	Continued From page 5  a.)Pork 113 degrees Fahrenheit with good flavor. However, tough when chewed. b.) Cream Corn 128 degrees Fahrenheit and lukewarm when tasted. c.) Baked Potato 125 degrees Fahrenheit and easily mashed with fork and warm when tasted . d.) Milk 46 degrees Fahrenheit. e.) Lemonade 41 degrees Fahrenheit and watered down to taste.  The Food Temperature table posted on the cooler in the kitchen directed to serve fresh pork at 145 degrees Fahrenheit.	F 804			
F 806 SS=J	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5)  §483.60(d) Food and drink Each resident receives and the facility provides-  §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;  §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to offer an alternate for residents with food allergies for 2 of 2 residents reviewed. Resident #1 had a shellfish allergy. On 1/18/19, the facility served her shrimp for dinner. As a result, Resident #1 displayed signs of an allergic reaction (swelling and respiratory problems) that required her to be transferred to the ER (emergency room) and intubated (tube	F 806			

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 806	<p>Continued From page 6</p> <p>inserted in the mouth and down the throat to maintain an airway). The resident then had to be sent to another hospital and admitted to the Intensive Care Unit for airway protection and sedation. This situation constituted an Immediate Jeopardy (IJ) to resident health and safety. The facility reported a census of 55 residents.</p> <p>Findings include:</p> <p>The Admission Record dated 1/25/19 revealed Resident #1 had diagnoses of chronic obstructive pulmonary disease and dementia.</p> <p>The Minimum Data Set (MDS) assessment dated 10/28/18 revealed Resident #1 experienced severe cognitive impairments.</p> <p>The MDS dated 1/18/19 revealed Resident #1 required consistent carbohydrate diet with ground or chopped meat, regular bread, and desserts.</p> <p>The Plan of Care revealed Resident #1 had an allergy to shellfish, no teeth, and a history of dysphagia (difficulty swallowing. The Care Plan directed staff to monitor for chewing ability and oral intake at meals.</p> <p>The Dietary Progress Note dated 10/30/18 revealed Resident #1 on consistent carbohydrate diet with ground meat and 1500 milliliter fluid restriction, feeds self with good/excellent oral intake at meals and no chewing or swallowing problems.</p> <p>The Active Orders revealed Resident #1 had an order for consistent carbohydrate diet, regular texture and a 1.5 Liter fluid restriction.</p>	F 806			

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 806	<p>Continued From page 7</p> <p>Resident #1's tray card revealed Resident #1 had a mechanical soft diet and shellfish allergy on the breakfast lunch and dinner card.</p> <p>The Allergies List revealed Resident #1 and Resident #8 had shellfish allergies.</p> <p>The Daily Spreadsheet revealed the Week One Friday Dinner Menu of popcorn shrimp, cocktail sauce, crispy French fries, creamy coleslaw, lemon cheesecake bar, homemade hushpuppy, 2% milk, coffee/hot tea and condiments. The ground diet instructions directed to grind the popcorn shrimp with mayonnaise, serve mashed potatoes instead of French fries and serve a soft biscuit instead of the hushpuppies.</p> <p>The Production Sheet Week One Friday Dinner sheet dated 1/18/19 revealed the start temperatures on popcorn shrimp regular, ground shrimp and puree shrimp. The sheet revealed omissions in temperatures for the oven fried fish fillet, puree coleslaw, unfrosted yellow cake, puree lemon cheese bar, hushpuppies and soft biscuit.</p> <p>The Progress Notes dated 1/18/19 at 9:48 p.m. revealed the nurse entered Resident #1's room to administer medications. Resident #1 complained of a sore throat, speech within normal limits lung sounds diminished throughout, continues on oxygen at 3 Liters and no signs of distress.</p> <p>The Progress Notes dated 1/18/19 at 10:45 p.m. revealed the nurse received a call from Resident #1's family member asking the staff to check on Resident #1. The nurse entered Resident #1's room. Resident #1 had the phone in his/her hand</p>	F 806			



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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>800 EAST RUSHOLME STREET DAVENPORT, IA 52803</b>		
(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 806	<p>Continued From page 8</p> <p>attempting to call family member. Resident #1's family member called and talked to Resident #1.</p> <p>The Progress Notes dated 1/18/19 at 11:15 p.m. revealed Resident #1's family member arrived at the facility and went to Resident #1's room. A few minutes later Resident #1's family member asked the staff why they didn't call him/her. The family member asked the staff for a copy of Resident #1's medication list and the address and phone number of the facility. The family member then wheeled Resident #1 in the wheelchair by the nurse's station with no indication of where Resident #1 was going or why Resident #1 was leaving the facility.</p> <p>The Progress Note dated 1/19/18 at 1:47 a.m. revealed the staff called the emergency room and the emergency room staff reported Resident #1 intubated due to edema and transferred to another hospital to an intensive care unit.</p> <p>An interview on 2/12/19 at 2:49 p.m. the family member reported he/she and another family member visited Resident #1 after supper and then left the facility. The family member reported Resident #1 was fine during the visit. Around 8:00 p.m., the family member received a call from Resident #1. The family member reported Resident #1's words were slurred and he/she could only understand Resident #1 saying "hospital". The family member called the facility and asked the nurse to check on Resident #1. The family member then called Resident #1's room and could hear the nurse and then the phone disconnected. The family member drove to the facility to check on Resident #1. The family member reported Resident #1 was struggling to breathe. The family member called 911.</p>	F 806			

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 806	<p>Continued From page 9</p> <p>The Medic Emergency Medical Services final report dated 1/18/19 revealed the medics arrived to the facility at 11:27 p.m. for a report of difficulty breathing. Resident #1 sitting in the wheelchair with swelling in the face and tongue only. Resident #1 unable to speak due to swelling. No visible rash noted. The family reported Resident #1 began swelling 10 minutes prior to calling 911. The family reported Resident #1 allergic to shellfish, but not any medications.</p> <p>The Emergency Department Physician Notes dated 1/18/19 at 11:40 p.m. revealed Resident #1 had mild respiratory distress, moderate tongue swelling, drooling and speech obstructed by tongue. Resident #1 received Benadryl 25 milligrams, Pepcid 20 milligrams and Solu-Medrol 125 milligrams intravenously. Resident #1 received endotracheal intubation. The notes revealed a differential diagnoses of upper respiratory infection, allergies, angioedema and allergic reaction. Resident #1 transported to another hospital to an intensive care unit.</p> <p>The Hospitalist History and Physical dated 1/19/19 at 3:10 a.m. revealed Resident #1 admitted Intensive Care Unit intubated for airway protection and sedated.</p> <p>In an interview on 3/5/19 at 11:36 a.m. the Hospitalist reported an allergy to Losartan is very rare. The Hospitalist reported it's even more unlikely as Resident #1 was on Losartin for several months. The Hospitalist reported he/she would look for other causes and when asked, stated was not aware Resident #1 possibly ate shrimp. The Hospitalist reported a shellfish allergy can cause angioedema, the same as any</p>	F 806			

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 806	<p>Continued From page 10 other food allergy.</p> <p>An interview on 2/12/19 at 11:17 a.m. Staff I (Cook) reported he/she followed the planned menu. Staff I could not remember what he/she served Resident #1. Staff I reported Resident #1's diet card had the shellfish allergy listed. Staff I could not recall what alternate he/she prepared that evening. Staff I reported he/she did not obtain a temperature on an alternate meat dish that evening.</p> <p>During an interview on 2/7/19 at 2:08 p.m. Staff G (Nurse Aide) reported he/she thinks Resident #1 received shrimp for supper. Staff G reported there was not an alternate that night. Staff G asked Staff I (Cook) what the alternate was and Staff I reported there was not one. Staff G reported he/she saw Resident #1's family arrive. Staff G went over to Resident #1 and observed Resident #1 ate 100%. Staff G reported Resident #1 had breaded popcorn shrimp.</p> <p>During an interview on 2/7/19 at 2:32 p.m. Staff H (Nurse Aide) reported an alternate was not served. Staff H reported everyone received shrimp.</p> <p>During an interview on 2/27/19 at 9:22 a.m. Resident #8 reported if he/she gets a headache from eating raw shrimp. Resident #8 reported he/she can eat a few cooked shrimp and it doesn't bother him/her. Resident #8 reported several weeks ago the staff served him/her small breaded shrimp for supper. Resident #8 ate the shrimp and it didn't bother him/her. Resident #8 did not know if there was an alternate that night. Resident #8 reported he/she just eats what the staff serve.</p>	F 806			

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 806	Continued From page 11	F 806			
F 809 SS=D	<p>The facility abated the Immediate Jeopardy on 1/20/19 by educating the facility staff. The In-Service Education sheet dated 1/20/19 revealed all facility staff received training on residents with food allergies, inspecting trays prior to serving, preparing food for residents with allergies and the location of resident allergies on the tray card.</p> <p>Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3)</p> <p>§483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.</p> <p>§483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.</p> <p>§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to offer a bedtime snack for 4 of 5 residents reviewed. The facility reported a census of 55 residents.</p>	F 809			

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 809	<p>Continued From page 12</p> <p>Findings include:</p> <p>During the group interview on 2/6/19 at 3:15 p.m. 4 of 5 residents reported the facility does not offer a bedtime snack. The residents reported they have to ask for a snack at night. The residents reported the staff do not go room to room and ask the residents if they want a snack. The residents were not aware if the dietary department provided a snack cart/tray at night. Four of the residents in attendance reported they had diabetes.</p> <p>In an observation on 2/7/19 at 8:07 p.m., Staff A placed two small plastic containers at the back nurse's station. The containers contained 2 yogurt cups, 1 banana, 2 peanut butter and jelly sandwiches, 5 packages of graham crackers, 2 packages of animal crackers and 5 sugar free cookies.</p> <p>An interview on 8:17 p.m. revealed Staff B (licensed nurse) reported the residents can have a snack if they desire. After an hour the staff put the refrigerated items back in the refrigerator.</p> <p>Observation on 2/7/19 at 8:18 p.m. revealed a small plastic container at the front Nurse's Station. The container contained 6 fruit cups, 2 yogurt cups, 3 peanut butter and jelly sandwiches, 6 packages of graham crackers, 6 sugar free cookies and 1 package of animal crackers.</p> <p>Observation and interviews on 2/7/19 from 8:26 p.m. to 8:42 p.m. revealed a Staff E (nurse aide) offering snacks room to room on R hall. During an interview Resident #6 reported that was the first time the staff offered him/her a bedtime</p>	F 809			

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

PRINTED: 04/26/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT ST MARY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>800 EAST RUSHOLME STREET</b> <b>DAVENPORT, IA 52803</b>		
(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 809	<p>Continued From page 13</p> <p>snack since he/she admitted to the facility. During an interview Resident #7 reported that was the first bedtime snack the staff offered in some time and stated it was because "the state" was in the facility. Resident #2 reported tonight was the first time the staff offered a bedtime snack since he/she admitted to the facility.</p> <p>Observation of the containers on the back nurse's station revealed the container contained 2 yogurt cups, 4 fruit cups, 4 packages of graham crackers, and 4 sugar free cookies.</p> <p>An interview on 2/15/19 at 8:59 a.m. the Food Service Supervisor reported the facility does not keep a log of bedtime snacks. The FSS reported the kitchen sends out a small amount of bedtime snacks. The cook prepares peanut butter and jelly sandwiches for 5 residents and sends it with the supper tray so the residents can take it back to their room.</p>	F 809			