

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155674	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/01/2016
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NAME OF PROVIDER OR SUPPLIER  ST CHARLES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3150 ST CHARLES ST JASPER, IN 47546
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00208041.</p> <p>Complaint IN00208041 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F309.</p> <p>Survey dates: August 31 and September 1, 2016</p> <p>Facility number: 002628 Provider number: 155674 AIM number: 200299110</p> <p>Census bed type: SNF: 13 SNF/NF: 38 Residential: 34 Total: 85</p> <p>Census payor type: Medicare: 9 Medicaid: 28 Other: 14 Total: 51</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The submission of this plan of correction does not indicate an admission by St Charles Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of St Charles Health Campus This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.</p> <p>The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).</p> <p>To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>	

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

TITLE

(X6) DATE

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.

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F 0157 SS=G Bldg. 00	<p>Quality review completed by #02748 on September 9, 2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form</p>			

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	<p>of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician and family of a resident's condition change, resulting in the resident being transferred to the hospital and hospitalized, for 1 of 3 residents reviewed for notification, in a sample of 3. Resident C</p> <p>Findings include:</p> <p>The closed clinical record of Resident C was reviewed on 8/31/16 at 11:00 A.M. Diagnoses included, but were not limited to, chronic venous insufficiency, heart</p>	F 0157	<p><b>F 157</b></p> <p>The campus respectfully requests an IDR due to additional documentation. F157 Resident C no longer resides at St Charles. <b>Completion Date 09-30-2016</b></p> <p>All other residents have the risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will ensure notification of the family and the physician of any change of condition. All changes of condition have been reviewed to assure MD notification is complete. <b>Completion Date 09-30-2016</b></p> <p>All nurses have been in-serviced</p>	09/30/2016

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	<p>failure, and paroxysmal atrial fibrillation.</p> <p>An admission assessment, dated 8/4/16 at 5:32 P.M., indicated Resident C required a 2 person staff assistance with transfer, was alert and oriented x 3, speech was clear, responded to commands, and had full weight bearing.</p> <p>Nurses Notes included the following notations:</p> <p>8/5/16 at 5:47 A.M.: "Resident was given PRN [as needed] pain meds for pain to LLE [left lower extremity]. Medication was effective. Resident very cooperative and in pleasant mood. Staff assisted resident into wheelchair to go to appointment...Resident is sitting at nurses station conversing with other residents."</p> <p>A Social Services Progress Note, dated 8/5/16 at 3:20 P.M., indicated, "...Resident is alert with some confusion and forgetfulness... Will continue to observe."</p> <p>Nurses Notes continued:</p> <p>8/8/16 at 5:45 A.M.: "Rsd [resident] restless this noc [night]. PRN pain medication given...effective for the pain. Rsd rang call light multiple times this noc and was not sure what he rang for. This</p>		<p>concerning campus procedure of physician and family notifications. <b>Completion Date 09-30-2016</b></p> <p>Systemic Change: Nurses will complete walking rounds at change of shift to identify any changes of condition and ensure notifications complete. <b>Completion Date 09-30-2016</b></p> <p>The Facility Activity Report will be reviewed by nurse leaders in Clinical Care Meeting (CCM) to ensure physician notification complete on 3 random residents as applicable 5x a week for a month then 3x week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. <b>Completion Date 09-30-2016</b></p>	

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	<p>nurse stayed and spoke with Rsd just general conversation. Snack offered and eaten, water offered throughout the noc, urinal used a few times...."</p> <p>8/13/16 at 8:30 A.M.: "Resident resting in bed quietly with eyes closed at this time. This nurse asked resident if he was having any pain. Resident responded, 'No, not right now.' This nurse asked resident if he would like to get out of bed et [and] go to breakfast. Resident stated 'No, I don't feel too good. I'll get up tomorrow.' Resident repositioned for comfort, et encouraged to get up for meals. Will continue to monitor."</p> <p>8/14/16 at 10:24 A.M.: "Resident resting quietly in bed at this time. Resident replies 'No' when asked if he is in pain....Resident refusing to get out of bed et eats meals in room. Will continue to monitor."</p> <p>8/14/16 at 1:11 P.M.: "Resident refusing to leave brief or blankets on. When asked if he is uncomfortable, resident does not respond. Resident requiring total dependance [sic] with all ADL [activities of daily living] tasks including use of urinal, eating, et drinking. Resident denies pain at this time...Will continue to monitor."</p>			

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	<p>Documentation of further assessment of the resident, including a neurological assessment and vital signs, was not found after 8/14/16 at 1:11 P.M. until 8/15/16 at 12:27 P.M.</p> <p>Nurses Notes continued:</p> <p>8/15/16 at 12:27 P.M.: "N.O. [new order] to send resident to [name of hospital] for eval [evaluation] and treat. 1220 [12:20 P.M.] EMS [emergency medical services] was called."</p> <p>An Ambulance Service note, dated 8/15/16 at 12:35 P.M., indicated, "...Upon arrival the pt [patient] was found was....alert but would only respond with moan [sic] and groans. The nurse in the room stated that last night the nurse who was taking care reported that he was only moaning and groaning for them and they could not get a response out of him either. The current nurse that we were speaking too [sic] stated that the last time she seen him was this past Friday and his mental status was normal then. The Pt. was alert but would only respond with moans and groans...The Pt. could not open his eyes upon command. I then opened them and found that the pt's right pupil was constricted...and the pt's left pupil was dilated...."</p>			

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	<p>"Emergency Department [ED] Nurse Documentation," dated 8/15/16 at 1:05 P.M., indicated, "History, Arrived by EMS. Historian: EMS and nursing home nurse. This started yesterday. (Patient was known to be in state of altered mental status since yesterday. EMS was called from [name of facility] after brother of patient requested transportation to hospital for evaluation of condition, 'because his brother is not normally like this.' Patient arrives to ER, moaning with head turned to the left. Pupils are different in appearance and size...Patient will open his eyes in response to voice, does not give appropriate answers but only moans...After pt arrived, called [name of facility] for a report, Spoke with [LPN # 1] , she stated he was acting differently and could barely answer yes or no questions and was moaning continuously, was unsure what was wrong, but they got him into a wheelchair and took him to breakfast, then because he would not eat put him back to bed.' Pt brother states 'I called the dr office and told them that he needed to be seen, and he had them call the ambulance.' Upon arrival pt is moaning will answer no at times. Pt mouth and eyes are matted shut...."</p> <p>"ED Physician Documentation," dated 8/15/16 at 1:21 P.M., indicated, "Chief</p>			

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	<p>Complaint: Decreased Mental Status. The patient was found unresponsive. This started yesterday and is still present...Appearance: Lethargic. Patient in severe distress...Disoriented to place and time. Eyes open to pain...Clinical Impression, Acute mental status change with lethargy and confusion...."</p> <p>A hospital History and Physical, dated 8/15/16 at 5:59 P.M., indicated, "...Patient is poorly responsive...history of, for the past 2 days, having mental status changes where previously he spoke to this brother on the phone at least once a day, sometimes twice a day, was able to interact and have conversation. The last 2 days, the brother has been unable to get him on the phone at the nursing home. The brother went to the nursing home today to check on him, found that the patient could not speak, had some drooping on the right side of his face. They became concerned and then brought him into the emergency room at that time...Patient opens his eyes. Patient moans with any movement. Patient is unable to answer questions at this time...."</p> <p>A hospital Discharge Summary, dated 8/22/16, indicated, "Discharge Diagnoses: 1. Aortic infective endocarditis [infection around heart] with</p>			

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	<p>methicillin-sensitive Staphylococcus aureus [MRSA]. 2. Septic emboli [blood clots] and acute embolic stroke...3. [MRSA] septicemia, secondary to bilateral extremity cellulitis and deep wounds. 4. Bilateral extremity cellulitis and venous stasis changes...Brain MRI showed septic emboli in multiple areas of brain...</p> <p>A facility Nurses Note indicated, "Recorded as Late Entry on 08/16/2016 02:01 PM) Around lunch on Monday, 8/15/16, resident's brother [name] came to see resident. He tried to talk to resident, but resident did not respond much to brother. Brother asked nurse about resident and nurse stated that resident seemed to be like this most of the day and when asked about pain or discomfort, resident denied any. Brother mentioned that he may contact [name of physician] and see what he thought. Nurse took resident down to restorative to feed him lunch. He took a few bites and then started to pocket and spit out the food....During lunch, nurse was called out of dining room for a phone call from [name of physician's] office...Nurse told [name of physician] office that resident was just moaning but said that he didn't need anything and wasn't in any pain. [Name of physician] office said that maybe it would be a good idea to send</p>			

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	<p>him to the ER for Eval and Treat. Nurse got paperwork together and called EMS for transport. EMS arrived and transported resident to [hospital] to eval and treat."</p> <p>On 9/1/16 at 9:45 A.M., during an interview with LPN # 2, she indicated she worked on the resident's hall on 8/13/16 and 8/14/16. She indicated she could not really remember details regarding Resident C, and then reviewed her notes. She indicated the resident denied pain when she asked him. She indicated the resident did not want to get out of bed, but that was not unusual for him. She indicated the resident was not really unresponsive, but "just didn't want to talk." She indicated she never thought to call the physician; she felt like the resident "was just giving up."</p> <p>On 9/1/16 at 10:05 A.M., LPN # 1 was interviewed. LPN # 1 indicated she was working on 8/15/16. She indicated Resident C "kept moaning, like he didn't feel well." She indicated he sounded like he was hurting, but that he denied pain. She indicated he did not want to get up, but the staff got him up for lunch. She indicated the resident's brother came to visit, and indicated, "Maybe I'll call the doctor." LPN # 1 indicated she told the brother to let her know what the doctor</p>			

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	<p>said. She indicated the resident started pocketing food, and "wasn't acting right." She indicated the physician's office called her back, and she informed them that the resident kept moaning, but denied everything, and his vital signs were good. She indicated the office nurse told her to send him to the emergency room. She indicated she could not remember if the night nurse told her that the resident had not been acting right, nor could remember if she told the ambulance driver or the hospital that the resident had not been acting right for a couple of days.</p> <p>On 9/1/16 at 11:30 A.M., during an interview with the Administrator and the Director of Nursing (DON), the DON indicated the resident frequently moaned out. She indicated she saw the resident the morning of 8/15/16, and did not feel that there was a condition change. The Administrator and DON indicated the resident did require total care at times, so that was not a condition change either. The DON indicated she did not know why the ambulance and hospital reports indicated LPN # 1 informed them that the resident had been like that for the day previous. The Administrator indicated perhaps LPN # 1 did not know the resident very well.</p> <p>On 9/1/16 at 3:45 P.M., RN # 1 was</p>			

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	<p>interviewed. RN # 1 indicated he was "helping out" on Sunday 8/14/16 until approximately 8:00 P.M. RN # 1 indicated he had not worked much with Resident C. He indicated when he came in, Resident C was asleep, and did not appear in any distress. He indicated he did start moaning at approximately 7:30 P.M., and so he gave him a pain pill. He indicated the resident did not get up for supper. He indicated he thought the resident did respond to him, but just acted more tired than usual.</p> <p>On 9/1/16 at 12:35 P.M., the DON provided the current facility policy on "Guidelines for Change in Resident Condition," undated. The policy included: "Policy, To identify resident changes in condition. The clinical team is committed to the resident's assessment and care planning eschar [sic] to address changes in needs of each resident served...Notification of the resident physician and responsible party will be documented in EHR [electronic health record] reflecting date and time of notification."</p> <p>This Federal tag relates to Complaint IN00208041.</p> <p>3.1-5(a)(2)</p>			

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F 0309 SS=G Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to completely assess a</p>	F 0309	<p><b>F 309</b> The campus respectfully requests an IDR due to additional documentation. <b>F309</b> Resident C no longer resides at St Charles.</p>	09/30/2016

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	<p>resident with a mental status change, and failed to recognize and document areas of skin impairment, resulting in the hospitalization for a CVA and a wound infection which spread to the heart, for 1 of 3 residents reviewed with skin impairments and assessments, in a finding of 3. Resident C</p> <p>Findings include:</p> <p>The closed clinical record of Resident C was reviewed on 8/31/16 at 11:00 A.M. Diagnoses included, but were not limited to, chronic venous insufficiency, heart failure, and paroxysmal atrial fibrillation.</p> <p>An admission assessment, dated 8/4/16 at 5:32 P.M., indicated Resident C required a 2 person staff assistance with transfer, was alert and oriented x 3, speech was clear, responded to commands, and had full weight bearing.</p> <p>Nurses Notes included the following notations:</p> <p>8/5/16 at 5:47 A.M.: "Resident was given PRN [as needed] pain meds for pain to LLE [left lower extremity]. Medication was effective. Resident very cooperative and in pleasant mood. Staff assisted resident into wheelchair to go to appointment...Resident is sitting at nurses</p>		<p><b>Completion Date 09-30-2016</b> Other residents have the risk to be affected by the alleged deficiency and through alterations in processes and in- servicing the campus will ensure the facility provides the necessary care and services to attain or maintain the highest level of being in accordance with the comprehensive assessment of care.</p> <p><b>Completion Date 09-30-2016</b> All nurses have been in-serviced concerning documentation and change of condition</p> <p><b>Completion Date 09-30-2016</b> Systemic Change: Nurses will complete walking rounds at change of shift to identify any changes of condition and ensure notifications complete.</p> <p><b>Completion Date 09-30-2016</b> DHS/designee will perform audit's to assure nurses completing timely documentation of assessments when a change of condition occurs on 3 random residents 5x week x one month, 3x a week x one month, then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.</p> <p><b>Completion Date 09-30-2016</b></p>	

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	<p>station conversing with other residents."</p> <p>A Social Services Progress Note, dated 8/5/16 at 3:20 P.M., indicated, "...Resident is alert with some confusion and forgetfulness... Will continue to observe."</p> <p>Nurses Notes continued:</p> <p>8/8/16 at 5:45 A.M.: "Rsd [resident] restless this noc [night]. PRN pain medication given...effective for the pain. Rsd rang call light multiple times this noc and was not sure what he rang for. This nurse stayed and spoke with Rsd just general conversation. Snack offered and eaten, water offered throughout the noc, urinal used a few times...."</p> <p>A Skin Integrity Event, dated 8/10/16 at 1:29 P.M., indicated: "Stasis to Left Inner Foot. Stasis wound present on admission? Yes...Length: 3.5 [centimeters] Width: 1.6, Depth: &lt;0.1, Partial thickness, Granulation Tissue - beefy deep red and irregular surface...No Exudate [drainage]...No pain...Treatment Orders: Optifoam AG every 3 days and PRN [as needed] soiling."</p> <p>A Skin Integrity Event, dated 8/10/16 at 3:33 P.M., indicated: "Deep Tissue Injury to Right Great Toe Tip. Length: 1.5,</p>			

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	<p>Width: 1.0, Depth: &lt;0.1, Present on Admission? No, Unable to Stage, Eschar - firm dry desiccated (no moisture) black to brown appearance...Skin Prep as Ordered."</p> <p>A Skin Integrity Event, dated 8/11/16 at 1:58 P.M., indicated: "Unstageable Left Heel. Length: 2.5 [centimeters] Width: 3.0, Depth: &lt;0.1, Present on admission? Yes. Unable to stage - Unable to visualize wound bed, suspected deep tissue injury. Epithelial tissue - new skin growing in superficial wound deep pink, pearly pink, Granulation Tissue - beefy deep red and irregular surface. Eschar..No Exudate...No pain...Treatment Orders: Skin Prep and Apply Optifoam every 3 days and PRN."</p> <p>Nurses Notes continued:</p> <p>8/13/16 at 8:30 A.M.: "Resident resting in bed quietly with eyes closed at this time. This nurse asked resident if he was having any pain. Resident responded, 'No, not right now.' This nurse asked resident if he would like to get out of bed et [and] go to breakfast. Resident stated 'No, I don't feel too good. I'll get up tomorrow.' Resident repositioned for comfort, et encouraged to get up for meals. Will continue to monitor."</p>			

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	<p>8/14/16 at 10:24 A.M.: "Resident resting quietly in bed at this time. Resident replies 'No' when asked if he is in pain....Resident refusing to get out of bed et eats meals in room. Will continue to monitor."</p> <p>8/14/16 at 1:11 P.M.: "Resident refusing to leave brief or blankets on. When asked if he is uncomfortable, resident does not respond. Resident requiring total dependance [sic] with all ADL [activities of daily living] tasks including use of urinal, eating, et drinking. Resident denies pain at this time...Will continue to monitor."</p> <p>Documentation of further assessment of the resident, including a neurological assessment and vital signs, was not found after 8/14/16 at 1:11 P.M. until 8/15/16 at 12:27 P.M.</p> <p>Nurses Notes continued:</p> <p>8/15/16 at 12:27 P.M.: "N.O. [new order] to send resident to [name of hospital] for eval [evaluation] and treat. 1220 [12:20 P.M.] EMS [emergency medical services] was called."</p> <p>An Ambulance Service note, dated 8/15/16 at 12:35 P.M., indicated, "...Upon arrival the pt [patient] was found</p>			

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	<p>was....alert but would only respond with moan [sic] and groans. The nurse in the room stated that last night the nurse who was taking care reported that he was only moaning and groaning for them and they could not get a response out of him either. The current nurse that we were speaking too [sic] stated that the last time she seen him was this past Friday and his mental status was normal then. The Pt. was alert but would only respond with moans and groans...The Pt. could not open his eyes upon command. I then opened them and found that the pt's right pupil was constricted...and the pt's left pupil was dilated...."</p> <p>"Emergency Department [ED] Nurse Documentation," dated 8/15/16 at 1:05 P.M., indicated, "History, Arrived by EMS. Historian: EMS and nursing home nurse. This started yesterday. (Patient was known to be in state of altered mental status since yesterday. EMS was called from [name of facility] after brother of patient requested transportation to hospital for evaluation of condition, 'because his brother is not normally like this.' Patient arrives to ER, moaning with head turned to the left. Pupils are different in appearance and size. T-shirt that patient is wearing is spotted with emesis. Patient will open his eyes in response to voice, does not give</p>			

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	<p>appropriate answers but only moans. Multiple decubitus are found on bilateral feet in various sizes. Lower extremities are dark in colour [sic] and dry.....After pt arrived, called [name of facility] for a report, Spoke with [LPN # 1] , she stated he was acting differently and could barely answer yes or no questions and was moaning continuously, was unsure what was wrong, but they got him into a wheelchair and took him to breakfast, then because he would not eat put him back to bed.' Pt brother states 'I called the dr office and told them that he needed to be seen, and he had them call the ambulance.' Upon arrival pt is moaning will answer no at times. Pt mouth and eyes are matted shut. Pt noted to have 3 decub [decubitus ulcers] on the rt [right] foot and 2 on the left foot...Oral care provided, scrambled eggs and green leafy roughage removed from mouth, pt had copious amounts secretions, lips were crusted over. Pt face washed and the crusts removed from bilateral eyes..."</p> <p>"ED Physician Documentation," dated 8/15/16 at 1:21 P.M., indicated, "Chief Complaint: Decreased Mental Status. The patient was found unresponsive. This started yesterday and is still present...Appearance: Lethargic. Patient in severe distress...lower extremity edema with multiple decubitus</p>			

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	<p>ulcers...Disoriented to place and time. Eyes open to pain...Clinical Impression, Acute mental status change with lethargy and confusion...."</p> <p>A hospital History and Physical, dated 8/15/16 at 5:59 P.M., indicated, "...Patient is poorly responsive...history of, for the past 2 days, having mental status changes where previously he spoke to this brother on the phone at least once a day, sometimes twice a day, was able to interact and have conversation. The last 2 days, the brother has been unable to get him on the phone at the nursing home. The brother went to the nursing home today to check on him, found that the patient could not speak, had some drooping on the right side of his face. They became concerned and then brought him into the emergency room at that time...Patient opens his eyes. Patient moans with any movement. Patient is unable to answer questions at this time...He has noticeable swelling of the left lower extremity...does seem to have tenderness with palpation of the leg...He has some open pressure ulcer-type areas and arterial ulcerations of his lower extremities..We will obtain wound cultures. We will also get a wound consult...."</p> <p>A hospital Skin Care Assessment, dated</p>			

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	8/16/16, included the following: 1. Upper Right Coccyx Pressure Ulcer, Stage 1, 2. Right Lower Coccyx Pressure Ulcer, Stage 1, 3. Right Heel Pressure Ulcer, Suspected Deep Tissue Injury, Length 2.5 cm, Width 2.2 cm. 4. Right great toe, Suspected deep tissue injury, Length 1.0, Width 1.0. 5. Lower Middle Back Pressure Ulcer, Unstageable, Drainage amount Scant, Drainage Amount Serosanguineous, General Appearance Red, Black (Eschar), Brown (Eschar), Draining, Length 0.9 cm, Width, 1.0 cm, Depth Obscure...SDTI [suspected deep tissue injury]...opening as measured above surrounding purple/red SDTI measures total 2.8 cm x 1.6 cm. 6. Left Upper Lateral Calf Suspected Venous/Arterial, Red/Purple Intact, Length 4.5 cm, Width 2.5 cm. 7. Left middle back pressure ulcer, Stage 1. 8. Left medial foot suspected venous/arterial Wound, Drainage amount scant, Drainage Description Serosanguineous, Red, White Slough, Black (Eschar), Length, 2.5 cm, Width 2.9 cm, 10% Red, 10% Yellow, 80% Black. 9. Left Lower Calf Suspected Venous/Arterial, Red/Purple Intact, Length 1.0 cm, Width 2.6 cm. 9. Left Lower Back Pressure Ulcer, Stage 1. 10. Left lateral foot Suspected Venous/Arterial, Fluid Filled Blister, Length 1.1 cm, Width 0.5 cm. 11. Left			

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	<p>heel Pressure Ulcer, Unstageable, Black, Length 1.6 cm, Width 1.2 cm, 100% Black. 12. Left great toe, Skin split between toes.</p> <p>A hospital Discharge Summary, dated 8/22/16, indicated, "Discharge Diagnoses: 1. Aortic infective endocarditis [infection around heart] with methicillin-sensitive Staphylococcus aureus [MRSA]. 2. Septic emboli [blood clots] and acute embolic stroke...3. [MRSA] septicemia, secondary to bilateral extremity cellulitis and deep wounds. 4. Bilateral extremity cellulitis and venous stasis changes...Brain MRI showed septic emboli in multiple areas of brain...</p> <p>A facility Nurses Note indicated, "Recorded as Late Entry on 08/16/2016 02:01 PM) Around lunch on Monday, 8/15/16, resident's brother [name] came to see resident. He tried to talk to resident, but resident did not respond much to brother. Brother asked nurse about resident and nurse stated that resident seemed to be like this most of the day and when asked about pain or discomfort, resident denied any. Brother mentioned that he may contact [name of physician] and see what he thought. Nurse took resident down to restorative to feed him lunch. He took a few bites</p>			

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	<p>and then started to pocket and spit out the food....During lunch, nurse was called out of dining room for a phone call from [name of physician's] office...Nurse told [name of physician] office that resident was just moaning but said that he didn't need anything and wasn't in any pain. [Name of physician] office said that maybe it would be a good idea to send him to the ER for Eval and Treat. Nurse got paperwork together and called EMS for transport. EMS arrived and transported resident to [hospital] to eval and treat."</p> <p>On 9/1/16 at 9:45 A.M., during an interview with LPN # 2, she indicated she worked on the resident's hall on 8/13/16 and 8/14/16. She indicated she could not really remember details regarding Resident C, and then reviewed her notes. She indicated the resident denied pain when she asked him. She indicated the resident did not want to get out of bed, but that was not unusual for him. She indicated the resident was not really unresponsive, but "just didn't want to talk." She indicated she never thought to call the physician; she felt like the resident "was just giving up."</p> <p>On 9/1/16 at 10:05 A.M., LPN # 1 was interviewed. LPN # 1 indicated she was working on 8/15/16. She indicated</p>			

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	<p>Resident C "kept moaning, like he didn't feel well." She indicated he sounded like he was hurting, but that he denied pain. She indicated he did not want to get up, but the staff got him up for lunch. She indicated the resident's brother came to visit, and indicated, "Maybe I'll call the doctor." LPN # 1 indicated she told the brother to let her know what the doctor said. She indicated the resident started pocketing food, and "wasn't acting right." She indicated the physician's office called her back, and she informed them that the resident kept moaning, but denied everything, and his vital signs were good. She indicated the office nurse told her to send him to the emergency room. She indicated she could not remember if the night nurse told her that the resident had not been acting right, nor could remember if she told the ambulance driver or the hospital that the resident had not been acting right for a couple of days. She indicated she did not remember if she performed wound care that morning.</p> <p>On 9/1/16 at 11:30 A.M., during an interview with the Administrator and the Director of Nursing (DON), the DON indicated the resident frequently moaned out. She indicated she saw the resident the morning of 8/15/16, and did not feel that there was a condition change. The Administrator and DON indicated the</p>			

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	<p>resident did require total care at times, so that was not a condition change either. The DON indicated she did not know why the ambulance and hospital reports indicated LPN # 1 informed them that the resident had been like that for the day previous. The Administrator indicated perhaps LPN # 1 did not know the resident very well. The DON indicated the resident did not have skin impairments on the right side. The Administrator indicated perhaps the resident laid on a cot in the ER for an extended time, and obtained the areas there.</p> <p>On 9/1/16 at 3:30 P.M., the DON indicated she had spoken to RN # 1, who worked 8/14/16, and had performed the resident's dressing changes. She indicated RN # 1 did not observe any new skin areas on the resident. The DON indicated the CNAs who were working with the resident did not notice new skin areas.</p> <p>On 9/1/16 at 3:45 P.M., RN # 1 was interviewed. RN # 1 indicated he was "helping out" on Sunday 8/14/16 until approximately 8:00 P.M. RN # 1 indicated he had not worked much with Resident C. He indicated when he came in, Resident C was asleep, and did not appear in any distress. He indicated he did start moaning at approximately 7:30</p>			

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	<p>P.M., and so he gave him a pain pill. He indicated the resident did not get up for supper. He indicated he thought the resident did respond to him, but just acted more tired than usual. RN # 1 indicated he did not notice any new skin areas other than those on his back and his left foot.</p> <p>On 9/1/16 at 3:10 P.M., the Assistant Director of Nursing (ADON) provided the current facility policy on "Weekly Skin Assessment," revised 5/10/16. The policy included: "Purpose: To monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the early development state and implement other preventative and/or treatment measures as indicated...Initiate applicable Wound Event if a new area of impairment is identified (Pressure/Stasis/Arterial/Diabetic/Surgical or Other). Please initiate an event for each area identified...."</p> <p>This Federal tag relates to Complaint IN00208041.</p> <p>3.1-37(a)</p>			

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