

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010904</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NATHAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205</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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Final Observations</p> <p>LICENSURE VIOLATIONS:</p> <p>300.1210b) 300.1210d)2) 300.1210d)3) 300.1220b)2) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the</p>	S9999		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>10/24/14</b>
---	-------	------------------------------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010904</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NATHAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205</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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 1</p> <p>nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review, the Facility failed to adequately assess/monitor and treat for fractures for 2 of 3 residents (R2, R3) reviewed for fractures in the sample of 3. This failure resulted in the delay of treatment for a femur fracture in both R2 and R3.</p> <p>Findings include:</p> <p>1. R2's Minimum Data Set (MDS) dated 09/17/2014 documents that R2 has a Brief Interview of Mental Status of 14 with 15 being the highest cognition. This MDS documents diagnoses, in part, of Anemia, Hypertension, Dementia, Right Hemiparesis, and Gastroesophageal Reflux Disease. This MDS also documents that R2 needs limited assistance from staff with bed mobility, extensive assistance of one staff member for transfers and that R2 uses a wheelchair for ambulation.</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010904</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NATHAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205</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) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>Review of the Nurses Note dated 09/10/2014 at 5:00 PM documents upon rounds nurse noted resident having difficulty ambulating and transferring to his wheelchair upon assessing this resident (R2a) nurse noted resident right knee warm and red resident complaining of pain vital signs 99.1, 120,20.143/86.</p> <p>The Nurses Note dated 09/10/2014 at 5:02 PM documents nurse spoke to Z1 (physician) about resident (R2) condition orders received to send out to local hospital for evaluation and treatment.</p> <p>The Nurses Note dated 09/10/2014 at 5:56 PM documents resident (R2) left facility via ambulance to a local hospital.</p> <p>The Nurses Note dated 09/11/2014 at 1:15 AM documents resident (R2) returned from local hospital with new orders for an antibiotic eye drop and a venous Doppler study of the right leg.</p> <p>The Nurses Note dated 09/11/2014 at 9:00 AM documents thigh redness and swelling remain.</p> <p>The Nurses Note dated 09/11/2014 at 5:00 PM documents remains up in wheelchair denies complaint of pain no attempts to transfer self to bed moderate assist of 2 needed to complete task. right sided weakness noted, noted with facial grimacing and moaning during range of motion of right leg .Continues to deny pain.</p> <p>The Nurses Note dated 09/11/2014 at 7:00 PM documents Received verbal report from local hospital negative for deep vein thrombus. Medical Doctor aware doctor also informed of increase assist with transfer from supervision to assist of 2 and more frequent complaint of pain. New order received for screen nursing therapy</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010904</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NATHAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205</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) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>communication completed.</p> <p>The Nurse Note dated 09/12/2014 at 9:00 AM documents Resident (R2) up to wheelchair with maximum assist of 2 this AM. Generalized right sided weakness remains. Facial grimacing remains when right leg range of motion performed swelling remains to right foot not leg. Rates pain a 7 on 0-10 scale. Call placed to Z1 (physician) for signed script for Hydro/APAP 5-500 mg.</p> <p>The Nurses Notes dated 09/13/2014, 09/14/2014 and 09/15/2014 7:00 AM thru 7:00 PM shift, 09/17/2014, do not assess right leg pain, the appearance of the right leg or residents need for assistance with transfers.</p> <p>The Nurses Note dated 09/15/2014 at 11:50 PM documents no complaint of pain to right leg, no swelling noted.</p> <p>The Nurse Note dated 09/16/2014 at 11:50 (does not document AM or PM) documents no swelling to extremities noted no complaint of pain or discomfort.</p> <p>The Nurse Note on "EPICS DAILY DOCUMENTATION" dated 09/18/2014 untimed documents "recent lack in coordination along with overall generalized weakness noted. Unsteady gait with transfers noncomplaint with assistance during transferr needs".</p> <p>The Nurses Note on "EPICS DAILY DOCUMENTATION" dated 09/19/2014 untimed documents (R2) requiring more assistance with self care with bathing toileting and grooming. Noted with incontinence episode of urine and bowel movement. Maximum assist of 1 with care.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010904</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NATHAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205</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) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>Swelling remains to right leg. Noted limited range of motion on the right. Maximum assistance of 1 needed for transfer to wheelchair.</p> <p>The Nurses Note dated 09/20/2014 at 10:45 AM documents staff continues to assist (R2) with activities of daily living of transfers zero distress noted will monitor. At 12:00 PM the Nurse Note documents resident (R2) noted dragging right foot will continue to monitor for changes.</p> <p>The Nurses Note dated 09/21/2014 at 11:35 AM documents staff transfer of 2 assist gait weak and unsteady continues to drag right foot therapy notified will monitor for changes.</p> <p>The Nurses Note on "EPICS DAILY DOCUMENTATION" dated 09/22/2014 untimed documents right side weakness remains, noted holding right leg with facial grimacing swelling remains. Initially denies complaint of pain encouraged resident (R2) to allow staff to help with pain management eventually resident (R2) rates pain a 10 on 0-10 scale. Call placed to physician to obtain signed script for hydroco-acetaminophen.</p> <p>The Nurses Note dated 09/22/2014 at 12:40 PM documents this nurse informed speech of difficulty swallowing medications this AM. Return call to Medical Doctor informed of change in condition, multiple incontinent episodes of bowel and bladder, no relief from as need pain medication, pain increase in right leg when touched facial grimacing continues. Order given to send resident (R2) out for evaluation and treatment.</p> <p>The Note Nurses dated 09/22/2014 at 1:05 PM documents: Emergency Medical Services arrived</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010904</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NATHAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205</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) COMPLETE DATE
S9999	<p>Continued From page 5</p> <p>resident (R2) in route to local hospital.</p> <p>The Occupational Therapy Note date 09/18/2014 documents: Complains of right knee pain Physical Therapy and Nursing aware.</p> <p>The Emergency Department progress note date 09/22/2014 documents right comminuted femoral neck fracture patient will be transferred to another local hospital for treatment.</p> <p>R2's Medication Administration Record (MAR) documents that R2 was given 650 milligrams of Acetaminophen on 09/11/2014 and 09/22/2014 and R2 was given Hydrocod-APAP 5-500 mg on 09/12/2014.</p> <p>On 09/25/2014 at 11:10 AM, E3 Licensed Practical Nurse (LPN), stated tht she was the nurse that sent R2 out the first time on 09/10/2014. E3 stated R2 was complaining of pain in his leg and when he tried to get up he had tears and when she assessed his leg it was red and swollen. E3 stated she notified the doctor and got R2 sent out to the local hospital for evaluation. E3 stated then over the weekend R3 was dragging his right leg so she called therapy at home to make sure therapy evaluated him on Monday because something was just not right. On 10/1/2014 at 12:47 PM, E3 stated before R2's right leg pain R2 would transfer himself and propel himself in wheelchair.</p> <p>On 10/1/2014 at 12:44 PM, E4 Certified Nurses Aide (CNA), stated before R2 started having leg pain he would transfer himself and would get his own gown and undress. E4 stated when R2 came back from hospital after the first time he was noticeably in pain with grimacing and guarding but he would deny that he was in pain.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010904</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NATHAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205</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) COMPLETE DATE
S9999	<p>Continued From page 6</p> <p>On 10/1/2014 at 1:07 PM, E6 CNA, stated that before R2 had leg pain R2 would do everything for himself. After he (R2) came back from emergency department the first time he needed help with transfers, he became incontinent, he had facial grimacing and he needed help propelling his wheelchair at times.</p> <p>On 10/1/2014 at 1:02 PM, E7 CNA, stated that a sit to stand machine was needed for a transfer to the wheelchair.</p> <p>On 10/1/2014 at 10/1/2014, E2 Director of Nurses (DON) states that R2 has had very similar problems before and therapy would get involved and he would recover. E2 states that now knowing that R2 has a fracture nursing should have seen the red flags. E2 admits that R2 was having increased pain and a decrease in activities of daily living between hospital Emergency Room visit and hospital admission. On 09/29/2014, E2 stated that she did not realize that R2 had not had a X-ray of the leg on his visit to the emergency room on 09/10/2014 until she started to do the investigation into his fracture.</p> <p>2. R3's MDS dated 09/18/2014 documents R3 is nonverbal and R3's cognitive skills are severely impaired. This MDS also documents that R3 is totally dependent on staff for all care. R3's Medication Administration Record (MAR) dated 10/1/2014 thru 10/31/2014 documents diagnoses of Osteopenia, Seizure, Cerebral Vascular Accident, Hypertension, and Multiple Sclerosis.</p> <p>The Nurses Notes dated 09/20/2014 documents nurse called to resident room right knee slightly swollen range of motion within normal limits for resident no complaint or signs and symptoms of</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010904</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NATHAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205</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) COMPLETE DATE
S9999	<p>Continued From page 7</p> <p>pain no facial grimace noted call placed to medical doctor, medical doctor notified of right knee slightly swollen new order received for X-ray of right leg.</p> <p>The Physician Order Sheet (POS) dated 09/20/2014 documents an order for x-ray of right leg.</p> <p>The Nurses Note dated 09/20/2014 at 5:00 PM documents X-ray results arrived results negative of fractures medical doctor aware no new orders. Right knee remains slightly swollen.</p> <p>The X-ray results dated 09/20/2014 documented the exam as a Tibulia/Fibula AP and Lat. Right.</p> <p>The Nurses Notes dated 09/21/2014 at 2:00 AM does not assess the right knee. The Nurses Note dated 09/22/2014 at 2100 does not assess the right knee or pain.</p> <p>The Nurses Note date 09/22/2014 at 11:30 PM documents obtained result of X-ray of right leg. X-ray shows no abnormalities assessment of right leg completed upper leg appears swollen and disfigured. Knee and hip joint unremarkable. Area distal to right hip approximately 7 inches above right knee appears abnormal. No redness or warmth. Resident grimaces when extremities are moved. Called Z1(Physician) awaiting return call. Director of Nurses called. The Nurses Note at 11:41 PM document orders received to send (R3) to hospital for evaluation. On 09/23/2014 at 1:00 AM the Nurses Note documents sent (R3) to hospital via ambulance.</p> <p>The hospital X-ray taken 09/23/2014 documents," Angulated, displaced fracture of the distal diaphysis of the femur. A small non displaced</p>	S9999		



Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010904</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NATHAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205</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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 8</p> <p>fracture line extends to the more distal diaphysis as well. Previous injury of the proximal femur which is healed, there is associated osteoarthritis and persistent slight displacement of the lesser trochanter medially".</p> <p>Review of hospital documents dated 09/23/2014 documents resident (R3) was transferred to another hospital for surgical repair of femur fracture.</p> <p>On 09/29/2014 at 10:37 AM, E17 Licensed Practical Nurse, stated that on 09/20/2014 on the day shift, E9 CNA, called her into R3's room to look at R3's leg. E17 stated it was slightly swollen around the knee area and she notified the doctor and got an order for an X-ray of the right leg. E17 stated when the X-ray technician came she told him she needed a X-ray of just the knee because that was what was swollen she didn't feel it necessary to do the whole leg. E17 stated she took care of R3 again on 09/21/2014 and 09/22/2014 and the leg looked the same just slightly swollen no bruising noted to the leg.</p> <p>On 10/1/2014 at 10:20 AM, E10 CNA stated that she worked the nightshift on 09/20/2014 and R3's below the knee looked broke to her and the thigh was swollen. E10 stated she went and told the nurse and she told her R3's leg was fine and that an X-ray had been done.</p> <p>On 10/1/2014 at 11:00 AM, E11 Registered Nurse (RN), stated that on the evening shift of 09/22/2014 he noticed that an X-ray had been done on R3's Tibulia/fibula and he had no idea why. E11 stated that when E12 RN came they both went to look at R3's leg. E11 stated R3's right leg clearly looked like a femur fracture, there was 1-2 plus edema with a marked deformity.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010904</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NATHAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205</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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 9</p> <p>E11 stated that when he touch R3's knee she grimaced.</p> <p>On 09/29/2014 at 3:30 PM, E13 CNA, stated that on 09/20/2014 she noted a greenish bruise on thigh with no swelling.</p> <p>On 09/29/2014 at 3:35 PM, E14 CNA, stated R3's knee area looked out of place when she took care of R3 on 09/20/2014.</p> <p>On 09/29/2014 at 3:10 PM, E15 RN, stated that she took care of R3 on 09/20/2014 and 09/21/2014. She stated she noted right thigh swelling but she went and checked the X-ray and it was negative so she let the CNAs get R3 up.</p> <p>On 09/29/2014 at 11:40 AM, E16 CNA, stated that she took care of R3 on 09/21/2014 and the knee was turned to the middle. E16 stated she did tell E15 RN and she said we know.</p> <p>On 09/29/2014 at 12:10 PM, E9 CNA, stated she took care of R3 on 09/20/2014 and noted an indent in the skin above the knee one could easily tell there was a problem. E9 stated she refused to get R3 up and went and got E17 LPN then E17 got an x-ray.</p> <p>On 09/29/2014 at 9:20 AM, E12 RN, stated that she took care of R3 on 09/19/2014 on the 11:00 PM until 7:00 AM. E12 stated during rounds early Saturday morning she noted that R3's right leg did not look right 6 to 7 inches above the knee and that it did not move right but R3 has foot drop and is contracted to she really did not think that much about it because there was no bruising, swelling or warmth. E12 stated when R3 was moved she had facial grimacing which E12 stated is normal for R3. E12 stated that she did not</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010904</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NATHAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205</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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 10</p> <p>report it to the oncoming nurse. E12 stated she assumed that the CNAs reported to the oncoming shift because an X-ray was obtained during the day shift. E12 stated that she worked again on the 9/22/2014 and when she saw R3's right leg with E11 RN R3's leg had plus 3 edema and deformity. E12 stated she called for an ambulance to get R3 to a hospital for treatment.</p> <p>On 09/29/2014 at 12:30, E18 CNA, stated that she took care of R3 on 09/22/2014 and R3's leg looked twisted and the leg was swollen.</p> <p>On 09/29/2014 at 2:20 PM, Z1 (Physician) stated that on 09/20/2014 he ordered a right leg X-ray for R3 and that he was unaware that the entire leg was not X-rayed.</p> <p>On 09/29/2014 at 9:23 AM, Z2 (X-ray service call center supervisor), stated that for an entire leg the nurse would need to enter a hip, femur, knee and tibia/fibula, also that it is their policy that the technician speaks with the nurse to make sure the right body part is being X-rayed.</p> <p>On 09/29/2014 at 10:30 AM, E2 DON, stated that she agrees the whole right leg should have been X-rayed on 09/20/2014 not just the tibia/fibula. On 10/06/2014 at 3:40 PM, E2 stated that she expects the nurse that finds a problem or change in condition to be the one to report it to the doctor and then the next shift will follow up on it.</p> <p style="text-align: center;">(B)</p>	S9999		
-------	---	-------	--	--