

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Michaelsen Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 831 North Batavia Avenue Batavia, IL 60510	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44387</p> <p>Based on observation, interview and record review, the facility failed to obtain a resident's blood glucose level for sliding scale insulin administration prior to that resident eating a meal.</p> <p>This applies to 1 of 2 residents (R20) reviewed for glucose monitoring.</p> <p>The findings include:</p> <p>R20's Electronic Medical Record (EMR) shows that R20 was admitted to the facility on [DATE] with diagnoses of sepsis due to methicillin susceptible staphylococcus aureus (MRSA), paroxysmal atrial fibrillation, type 2 diabetes mellitus without complication, non-pressure chronic ulcer right foot, and chronic kidney failure. R20's Physician Order Sheet (POS) shows an order to monitor blood sugar, insulin aspart subcutaneous per sliding scale at 8am and 5 pm.</p> <p>On 3/29/24 at 9:11 AM, V7 (RN/Registered Nurse) went in to R20's room to administer his morning medications. R20 had empty plates on his bedside table as he had finished his breakfast. V7 asked how his breakfast was, and R20 said he enjoyed his breakfast. After administering his medication at 9:20 AM, V7 proceeded to check R20's blood glucose levels. R20's blood glucose level was 222. V7 then administered 2 units of insulin aspart per sliding scale.</p> <p>On 4/2/28 at 3:28 PM V2 (DON/Director of Nursing) said resident blood glucose levels should be checked prior to eating and not after eating because it can give a false high glucose level. V2 said the facility does not have a policy regarding checking blood glucose levels.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44387</p> <p>Based on interview and record review, the facility failed to administer intravenous (IV) antibiotics according to physician orders. This applies to 1 of 8 residents (R2) reviewed for medication administration.</p> <p>The findings include:</p> <p>R2's Electronic Medical Record (EMR) shows that R2 was admitted to the facility on [DATE] and was discharged on [DATE]. R2's census sheet shows that he was at the facility from 2/28/24, was sent to the hospital on 3/1/24, returned to the facility on [DATE], and discharged to the hospital again on 3/18/24. R2 had the following diagnoses of hypertensive heart disease, rhabdomyolysis, localized swelling mass and lump in head, acute kidney failure and benign neoplasm of skin, scalp and neck. R2's Physician Order Sheet (POS) showed an order for IV Zosyn (antibiotic) 4.5 gram/100ml (milliliters) in dextrose piggyback solution every 8 hours for 17 days starting 3/14/24.</p> <p>On 4/2/24 at 1:47 PM, V2 (Director of Nursing/DON) said R2 was sent to the hospital on 3/1/24 because he was not eating, was only alert and oriented to self, was sweaty and clammy. V2 said the nurse assigned to R2 consulted with the NP (Nurse Practitioner) who also assessed R2, and he was sent to the hospital for further evaluation and was admitted to the hospital for pneumonia. V2 said that R2 returned to the facility on [DATE] and was sent back out to the hospital on 3/18/24. V2 said when R2 returned from the hospital on 3/14/24, he had an order for IV Zosyn antibiotic which was what he had been receiving, but on 3/15/24, he received one dose Ampicillin antibiotics instead of Zosyn. V2 said the doctor was informed, orders were given to continue with Zosyn. V2 said the nurse pulled the IV ampicillin from facility's convenience box because his medications had not arrived from the pharmacy.</p> <p>On 4/2/24 at 2:45 PM, V3 (Registered Nurse/RN) said she administered IV Ampicillin instead of Zosyn to R2 and the physician was made aware of the incident.</p> <p>On 4/2/24 at 3:52 PM, V12 (R2's Physician/Medical Director) said R2 did receive one dose of Ampicillin instead of Zosyn and they continued the IV Zosyn after.</p> <p>The facility's Administering Medications policy (revised April 2019) states that medications are administered in accordance with prescriber orders. The individual administering the medication checks the label three times to verify right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p>		