

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  12/20/2024
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40054</p> <p>Based on interview and record review, the facility failed to transcribe physician medication orders upon admission, which caused a resident to miss her significant medications for four days.</p> <p>This applies to 1 of 3 residents (R135) reviewed for significant medication errors in a sample of 23.</p> <p>Findings Include:</p> <p>On 12/17/2024 at 5:53 PM, V20 (R135's family member) said Eliquis (a blood thinner) and Atorvastatin medications were on R135's admission/transfer form and didn't know why it was not prescribed. V20 said R135 missed a total of eight doses, and the doctor should have been notified. V20 said R135 is [AGE] years old and has atrial fibrillation, mitral valve prolapse, and heart conditions with a pacemaker, and the missing Eliquis could have caused severe conditions.</p> <p>On 12/19/24 11:40 AM, R135 said the facility failed to give her the Eliquis and cholesterol medication. R135 said something happened when they were transferring the information. She said because she didn't receive the Eliquis, she felt very tired.</p> <p>R135 was a [AGE] year-old female admitted to the facility on [DATE] during the evening shift with diagnoses including atrial fibrillation, hypertensive heart diseases with heart failure, presence of the cardiac heart monitor, mitral valve presence, deep vein thrombosis, diabetes mellites type 2, and hyperlipidemia. Based on multidisciplinary admission progress notes from 12/12/2024- 12/15/ 2024, R135 was cognitively moderately intact and required one person to assist with activities of daily living (ADL), transfers, and bed mobility.</p> <p>A review of the hospital discharge instructions dated 12/11/2024 showed R135 had multiple medications, including Eliquis 2.5 milligrams at 9:00 AM and 5:00 PM daily, and Atorvastatin 10 milligrams every Monday, Wednesday, and Friday at 9:00 PM. The V12's (Registered Nurse-RN) nursing admission progress notes showed that V12 reviewed the medication list with the physician and was okay with continuing all medications.</p> <p>A review of the admission physician orders entered by V18 showed Eliquis and Atorvastatin had been omitted during transcription. R135's December 2024 Medication Administration Record showed R135 received her first dose of Eliquis 2.5 milligrams on 12/15/2024 at 9:00 PM, and Atorvastatin 10 milligrams on 12/18/2024. R135 missed eight doses of Eliquis and three doses of Atorvastatin.</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145409
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/20/2024 at 9:06 AM, V12 (RN) said she called R135's physician and received an order to continue all medications. V12 said since she was busy with nighttime medication administration, V18 (RN-unit Manager) entered the medication orders. On 12/12 /2024 at 10:15 AM, V18 said she helped to enter R135's medication order, and both V12 and V18 said they forgot to review the entered medication orders. On 12/20/2024 at 11:35 AM, V19 (R135's Physician) said that an oversight had occurred, which could have caused a stroke, and fortunately nothing happened.</p> <p>On 12/18/2024 at 3:37 PM, V2 (Director of Nursing) said on the evening of 12/15/2024, R135's family requested the nurse to go over R135's medications list with them and the facility found out R135 had missed her Eliquis and Atorvastatin. R135 received her first doses on 12/15/2024 at 9:00 PM (four days after admission). V2 said it was an oversight from the nursing staff to transcribe the prescribed order, and the staff should have reviewed the orders.</p>