STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145409	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Michaelsen Health Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845 Based on interview and record review, the facility failed to notify a resident's emergency contact representative regarding a fall incident. The failure to notify placed the resident at risk for compromised advocacy and potentially delayed medical decision making. This applies to 1 of 3 (R1) residents reviewed for notification of significant medical change. The findings include: The EMR (Electronic Medical Record) showed that R1, an [AGE] year-old with extensive diagnoses that included B cell lymphoma with metastasis to lymph nodes, lung cancer, intracerebral hemorrhage, atrial fibrillation, heart disease, hypertension, chronic obstructive pulmonary disease, peripheral vascular disease, venous insufficiency, left below knee amputee, chronic kidney disease, anemia, frontal temporal neuro cognitive disorder, urinary reflux, phantom limb syndrome with pain, anxiety, hyperlipidemia, osteoarthritis, Barrette's esophagus, benign prostate hypertrophy, carotid artery disease, hypomagnesemia, cholecystitis, acute kidney failure, mood disorder, malignant neoplasm of bone, non-Hodgkin's lymphoma, obesity, hyponatremia, psychophysical visual disturbances, falls, impaired gait, generalized weakness, and foot drop (right). R1 was admitted to the facility on [DATE] at 1:00 P.M. The EMR also revealed that R1 was hospitalized from March 29,2025 to April 4,2025 due to acute medical conditions that included UTI, urinary retention, toxic metabolic encephalopathy, and altered mental status. The hospital record dated March 29, 2025 showed that R1 was hallucinating, secondary to UTI and TME (toxic metabolic encephalopathy, which was a condition with cerebral dysfunction manifested by altered consciousness, behavior changes and or seizures). R1 was treated with intravenous antibiotics and was admitted to the facility with continued oral antibiotics for UTI. The Physician notes entered by V3 (Physician) dated April 4,2025 at 11:08 A.M., showed that R1 was seen and examined by V3. The notes showed that R1 was alert and oriented x2. The notes also document that R1 could not answer what brought him to the facility. The Nurse Practitioner Notes (V4) dated April 4,2025 at 5:16 P.M., showed that R1 was alert and oriented x1-2. The notes showed that Assessment and Plan were muscle weakness, gait disorder, assist with ADL's (Activities of daily Living), PT/OT (Physical and Occupational therapy), and fall precautions. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's notes dated April 6,2025 at 2:33 A.M. showed that V5 (Registered Nurse) had documented that R1 was found sitting on the floor next to the reclining chair in his room on April 5,2025 at 9:45 P.M. The notes also showed that R1 had hit his head, left side of the upper body and left hip. The notes further showed that R1 had complained of pain to the left hip area. R1 had voiced pain rating of 6/10. The facility's pain rating showed that 6 /10 was moderate pain with 0 as no pain and 10 as worst possible pain. The notes also showed that V5 notified V3. The notes had no documentation that R1's emergency contacts were notified of R1's fall incident. The facility's incident report dated April 5,2025 showed that R1 fell on [DATE] at 9:45 P.M. The facility's incident report validated no family notification was made regarding the fall. On April 16, 2025 at 11:00 A.M., V5 said she did not notify R1's emergency contact when R1 had a fall incident on April 5,2025. The nurse's notes dated April 6,2025 showed that V7 (Registered Nurse) had documented that R1's left hip pain had worsened to 10/10 in the morning at 9:30 A.M. The notes showed that R1's pain was not relieved with Tylenol medication and x-ray imaging was not available in a timely manner, and therefore a decision was made for R1 to be send out to the hospital. The nurse's notes also showed V8 (R1's wife) arrived at the facility around noon time, found out about R1's fall and was in pain. V8 then requested to V7 that V9 (R1's daughter) be notified. The notes showed also that V9 is R1's POA (Power of Attorney). The face sheet showed that R1's Emergency Contact #1 was V8 (R1's spouse) and V9 was Emergency Contact #2. On April 16,2025 at 11:45 A.M., V7 said she left a message on V8's phone number on April 6,2025. V7 also said that she did not call V9 when she was not able to reach V8. V7 also said that V8 found out R1's change of medical condition related to the fall when V8 came to the facility on [DATE] around noon time. On April 14,2025 at 3:10 P.M., V8 said she was not informed of R1's fall incident. V8 said she found out of R1's change in medical condition when she arrived at the facility on April 6,2025 around 12:30 P.M. V9 was listening to the interview with V8. V9 said that she was not notified of R1's fall incident and R1 was in pain. V9 said that she is R1's POA. V9 expressed concern during the interview that had she been notified sooner; she could have facilitated timely medical intervention. V9 said that R1 left facility to the hospital on April 6, 2025 at around 2:00 P.M. The hospital record dated April 6,2025 showed that R1 was admitted with an acute fracture of the left hip. Surgical repair of the fracture was performed on April 7, 2025. On April 16,2025 at 1:15 P.M., V1 (Administrator) and V2 (Director of Nursing) both stated that R1's family were not notified of R1's fall incident on April 5,2025. The facility policy regarding Resident Rights dated October 2010 showed it is the resident's right that services and medical conditions be made aware to the resident and or legal representative.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845 Based on interview and record review, the facility failed to provide timely and comprehensive pain and physical assessment after a fall. This delay resulted in R1 experiencing untreated prolonged pain for five hours from a fracture after a fall and a delay in treatment. This applies to 1 of 3 residents (R1) reviewed for fall-related incidents. The findings include: The Electronic Medical Record (EMR) showed that R1, an [AGE] year-old resident, had an extensive medical history, including but not limited to: B-cell lymphoma with lymph node metastasis, lung cancer, intracerebral hemorrhage, atrial fibrillation, heart disease, hypertension, chronic obstructive pulmonary disease, peripheral vascular disease, venous insufficiency, left below-knee amputation, chronic kidney disease, anemia, frontal temporal neurocognitive disorder, urinary reflux, phantom limb pain, anxiety, hyperlipidemia, osteoarthritis, Barrette's esophagus, benign prostatic hypertrophy, carotid artery disease, hypomagnesemia, cholecystitis, acute kidney failure, mood disorder, malignant neoplasm of bone, non-Hodgkin's lymphoma, obesity, hyponatremia, psychophysical visual disturbances, fall history, impaired gait, generalized weakness, and right foot drop. R1 was admitted to the facility on [DATE], at 1:00 P.M., following a hospitalization from [DATE] to April 4, 2025, for acute conditions including urinary tract infection (UTI), urinary retention, toxic metabolic encephalopathy (TME), and altered mental status. Hospital records dated March 29, 2025, documented hallucinations secondary to UTI and TME, which were managed with intravenous antibiotics. R1 was admitted to the facility on continued oral antibiotic treatment. Physician notes by V3 (Attending Physician), dated April 4, 2025, at 11:08 A.M., documented R1 as alert and oriented to person and place but unable to state the reason for his admission. Nurse Practitioner notes by V4 from April 4, 2025, at 5:16 P.M., document R1 as alert and oriented to 1-2, with identified risks of muscle weakness, gait disorder, dependency in ADLs (Activities of Daily Living). The medical plan physical/occupational therapy and fall precautions. Nursing documentation on April 6, 2025, at 2:33 A.M. by V5 (RN/Registered Nurse) showed that R1 was found by V6 (CNA/Certified Nurse Assistant) at approximately 9:45 P.M. on April 5, 2025, sitting on the floor next to his reclining chair. R1 reported striking his head, left side, and left hip during the fall and rated his left hip pain as 6/10 (moderate pain). The facility was unable to provide documentation of a comprehensive assessment, including evaluation for range of motion limitations, extremity alignment, or a detailed pain assessment to identify potential injury severity. During an interview on April 16, 2025, at 11:00 A.M., V5 said she did not assess R1 for signs of musculoskeletal injury such as range of motion restriction or limb deformity. V5 also confirmed that a complete pain assessment was not conducted. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On April 6, 2025, at 9:30 A.M., V7 (RN) documented that R1's left hip pain had escalated to 10/10 and was unrelieved by Tylenol pain medication. V7 said that due to the absence of timely x-ray imaging, R1 was subsequently transferred to the hospital at 2:00 P.M. for further evaluation and treatment. This was a duration of approximately 5 hours for R1 experiencing pain. V7 stated on April 16, 2025 at 11:45AM, that after R1's pain intensified, she contacted V3 for an x-ray order. When the x-ray was delayed and R1's pain remained uncontrolled, V7 arranged for hospital transfer. In a separate interview on April 16, 2025, at 1:00 P.M., V3(Attending Physician) stated she had seen R1 on April 5, 2025, prior to the fall, and noted R1's confusion and poor safety awareness. V3 said that following R1's fall, V5 reported the incident to her, initially stating there were no injuries. V3 further explained that few minutes later after the first call, V5 had called again and informed her that based on standard facility policy for residents on anticoagulants, R1 should be send out to the hospital secondary to R1 being on anticoagulant and suffering an unwitnessed fall. V3 said she gave order to V5 for R1 to be sent to the hospital on the night of April 5, 2025. V3 expressed concern upon learning that R1 had remained at the facility overnight and only later was found to have sustained a left hip fracture requiring surgical repair. V3 stated: If I had been informed that R1 was still in the facility and experiencing increasing pain, I would have ordered immediate hospital transfer. This extent of injury could have been identified through a thorough post-fall assessment, including checking for extremity misalignment, rotation, swelling, discoloration, and a complete pain evaluation. Earlier identification would likely have reduced R1's prolonged and unnecessary pain. Hospital records dated April 6,2025 showed that R1 was admitted on [DATE], with an acute left hip fracture, which was surgically repaired on April 7, 2025.