

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>41384</p> <p>Based on observation, interview, and record review, the facility failed to provide care with dignity to 3 of 3 residents (R21, R56, and R50) reviewed for resident rights in a sample of 23.</p> <p>The findings include:</p> <p>On 12/17/24 at 12:33 PM, during a dining observation, V4 CNA (Certified Nurse's Assistant) was observed standing over R21 while feeding R21 her lunch. Then V4 moved to a nearby table and stood over R56 and began feeding R56. Then after giving R56 a few spoons of food, V4 returned to the first table and stood between R21 and R50, feeding both. This was done for the entire lunch for R21, R56, and R50.</p> <p>On 12/19/24 at 01:30 PM, V2 DON (Director of Nursing) said that the staff should be sitting next to the residents while feeding them for dignity and home life environment.</p> <p>R50's 11/10/24 MDS (Minimum Data Set) showed his mental cognition is severely impaired and he needs partial/moderate assistance from staff for eating.</p> <p>R56's 10/25/24 MDS showed that her cognition is severely impaired and she needs partial/moderate assistance from staff for eating.</p> <p>R21's 9/30/24 MDS showed that her cognition is severely impaired and she needs partial/moderate assistance from staff for eating.</p> <p>The facility's Assistance with Meals policy dated March 2022 shows that residents shall receive assistance with meals in a manner that meets the individual's needs of each resident. Who cannot feed themselves will be fed with attention to safety comfort and dignity for example not standing over residents while assisting them with meals.</p> <p>The facility's Dignity policy dated February 2021 showed that each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. When assisting with care, residents are supported in exercising their rights for example, residents are provided with a dignified dining experience.</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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>41384</p> <p>Based on observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) care for residents who require assistance from staff for ADLs.</p> <p>This applies to 4 of 4 residents (R11, R46, R52, R60) reviewed for ADLs in a sample of 23.</p> <p>The findings include:</p> <p>1. On 12/17/24 at 12:02 PM, R52 was observed in her bed and a mat was on the floor next to her bed and her lunch plate and dessert cup was on her over the bedside table out of her reach. On the plate was mashed potatoes and a scoop of a brown substance. There was also a cup of a pureed brown substance in a dessert cup. None of the food had been touched. At 12:23 PM, R52 was observed in her bed, her food was still on her over the bedside table out of reach untouched, and R52 said she was hungry. At 01:03 PM, R52 was still in her bed, her lunch was still out of reach on her over the bedside table and R52 again said that she was hungry. The plate of food was still full and untouched. The surveyor then left R52's room and stood next to R52's door and at 01:04 PM V5 (Kitchen staff) went into R52's room and came back out of her room with R52's full plate and full dessert cup and disposed of the items on her cart. V5 said that she informs the nursing staff when the residents have not eaten their food.</p> <p>R52's 11/13/24 care plan shows that R52 is at risk of weight loss and requires extensive assistance for eating with interventions including requires adequate time to eat, provide cues and encouragement. R52's 11/13/24 MDS (Minimum Data Set) showed that her cognition is severely impaired and she needs substantial/maximal assistance for eating.</p> <p>On 12/19/24 at 02:04 PM, V2 (DON) said that R52 care has just changed from Palliative to Hospice and she has had a significant weight loss. V2 said that because of R52's current care needs, her expectations are for the staff to attempt to feed R52, give her time when she eats, re-approach and try to attempt to feed her again.</p> <p>2. On 12/18/24 at 11:26 AM, R11 was observed with long jagged fingernails. R11 said that he had not received nail care in a couple of weeks.</p> <p>R11's 10/6/24 care plan showed that R11 requires supervision for personal hygiene with interventions including setting up items, assistance as needed, and supervision and cueing. R11's 10/6/24 MDS showed that R11's cognition is severely impaired.</p> <p>12/19/24 01:57 PM, V2 DON (Director of Nursing) said that staff should provide nail care as needed.</p> <p>3. On 12/17/24 at 12:14 PM, R46 was observed in his bed with long toenails, about 1 inch over the top of the toes. R46 said that he could not recall the last time he had toenail care.</p> <p>R46's 10/3/24 MDS showed that his cognition is moderately impaired and that he needs partial/moderate assistance from staff with personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/19/24 at 02:01 PM, V2 said that R46 is not a diabetic so the nurse or the CNAs (Certified Nurse's Assistants) should have cut R46's toenail for his comfort, dignity, and safety.</p> <p>4. On 12/17/24 at 12:56 PM, R60 was observed with long jagged fingernails with nail polish on the upper half of some of the nails. R60 said that she wanted staff to provide nail care for her.</p> <p>R60's 11/20/24 MDS showed that she needs partial/moderate assistance from staff for personal hygiene.</p> <p>On 12/19/24 at 01:52 PM, V2 DON said that nails should be short and neat and not jagged, and staff should be providing nail care as needed for infection control, dignity, and safety.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46003</p> <p>Based on observation and interview the facility failed to ensure a resident's mattress fit the bedframe to prevent injury.</p> <p>This applies to 1 of 6 residents (R334) reviewed for accidents in a sample of 23.</p> <p>Findings include:</p> <p>R334 has diagnoses that include streptococcal sepsis, urinary tract infection, atrial fibrillation, pulmonary embolism, heart failure, spinal stenosis, history of transient ischemic attack, history of cerebral infarction, abnormalities of gait and mobility and unsteadiness on feet. R334's current care plan includes at risk for falls related to history of falls, impaired mobility, impaired balance / gait, psychotropic and cardiac meds, sensory impairment and cognitive impairment. R334's care plan also includes problem related to skin integrity.</p> <p>On 12/17/24 at 11:56 AM, R334 was observed lying in bed. Approximately eight inches of the metal bed frame was exposed on the right side of the bed.</p> <p>On 12/17/24 at 01:23 PM, V13 CNA (Certified Nursing Assistant) stated informed the nurse on 12/16/24 of R334's exposed bed frame.</p> <p>On 12/17/24 at 01:30 PM, V14 RN (Registered Nurse) stated she observed R334 in bed in the morning with the larger bed frame. V14 stated the frame appeared as though it should have a larger mattress and she would notify maintenance.</p> <p>On 12/18/24 at 11:13 AM, R334 was observed lying in bed with metal bed frame still exposed and not covered by the mattress.</p> <p>On 12/19/24 at 11:56 AM, R344 was not in the room. The bed was stripped of linens and the same exposed metal bed frame with the smaller mattress remained in place.</p> <p>On 12/19/24 at 01:00 PM, V15 (Facilities Management Director) and V16 (Associate Director) came to observe the bed. V15 stated nursing decides what kind of bed / mattress residents require. Nursing sends maintenance a request and they bring the bed frame requested. V15 stated the mattress did not fit the frame. V16 stated the frame is extra wide for a bariatric mattress and the mattress that was in place is a regular sized mattress. V16 stated a larger mattress should be placed on the frame.</p> <p>On 12/19/24 at 03:24 PM, V2 DON (Director of Nursing) stated for the resident's safety the mattress should fit the bed frame. It is everyone's responsibility to make sure the resident has the appropriate equipment. The nurses should have sent a work order.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy Hazardous Areas, Devices and Equipment dated July 2017 states all hazardous areas, devices and equipment in the facility will be identified and addresses appropriately to ensure resident safety and mitigate accident hazard to the extent possible. A hazard is defined as anything in the environment that has the potential to cause injury or illness and includes but not limited to devices and equipment that are improperly used or poorly maintained. The facility policy Bed Safety dated December 2007 states the facility will strive to provide a safe sleeping environment. To prevent deaths / injuries from beds and related equipment (including the frame and mattress) the facility shall promote the following approaches: Inspections by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>46003</p> <p>Based on interview and record review, the facility failed to ensure monthly pharmacy recommendations were addressed.</p> <p>This applies to 2 of 5 residents (R21 and R51) reviewed for medication review in a sample of 23.</p> <p>The findings include:</p> <p>On 12/19/24 at 10:44 AM, surveyor requested V2 (DON--Director of Nursing) to provide all the pharmacy monthly medication reviews for R21 and R51 as well as physician responses to pharmacy recommendations from March 2024 to the current date.</p> <p>On 12/19/24 at 03:24 PM, V2 stated he did not have any monthly pharmacy regimen reviews to provide. V2 stated it is his responsibility to submit the pharmacy reviews to the physician for review but he has been behind. V2 stated the process is for pharmacy to email him the recommendations. He is supposed to place the recommendations in a binder for the physician to sign off on, and the physician leaves the addressed recommendations in the binder for him to follow up on. V2 stated documentation for R21 and R51 was not available.</p> <p>The facility policy Medication Utilization and Prescribing- Clinical Protocol dated April 2018 states the consultant pharmacist should use the monthly and interim drug regimen review to help identify potentially problematic medications, including medication regimens that are not supported based on clinical signs or symptoms. Based on input from the staff and resident, the physician will adjust mediations based on their efficacy, indications and the continued presences of clinically significant risks. The physician will provide and / or document a rationale when the indication dose, duration or frequency of a prescribed medication is greater than the commonly accepted practice or the manufacturer's recommendations or the medication is considered high risk compared to other available, relevant alternatives. The physician will document a clinically pertinent rationale for not modifying a medication in a situation where an adverse drug reaction is likely.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were safely and securely stored.</p> <p>This applies to 4 of 4 residents (R61, R68, R137, R139) reviewed for medications in a sample size of 23.</p> <p>The findings include:</p> <p>1. On 12/17/24 at 12:05 PM, R61 was not in her room. On two of her end tables in her room, the following medications were noted: Baush and [NAME] soothe lubricant eye drops, Equate Ultra Strength pain relieving cream which contained (camphor, menthol, methyl salicylate), Refresh plus lubricant eye drops, Gas-x simethicone 125 MG (Milligrams) anti-gas soft gels, extra strength gas relief simethicone 125 MG chewable tablets, and Lidotral 3.88% cream (Lidocaine HCL).</p> <p>On 12/19/24 at 1:50 PM, surveyor went back to her room. The medications were still in her room. R61 stated the medications are always kept in her room. V3 (R61's sister) stated that she brought all those medications for R61 from home and the pharmacy. She stated that R61 has pain and spasms in her legs that wake her up at night. She said that was the reason for the pain creams.</p> <p>R61's face sheet shows diagnoses of other abnormalities of gait and mobility, unsteadiness on feet, restless legs syndrome, GERD (Gastro-esophageal reflux disease) without esophagitis, and multi-system degeneration of the autonomic nervous system. R61's MDS (Minimum Data Set) dated 10/20/24 showed she is cognitively intact. Review of R61's POS (Physician Order Sheet) shows no order for these medications and no order for it to be unlocked and at the bedside.</p> <p>2. On 12/17/24 at 12:21 PM, R137 had a pill organizer which contained unknown pills in each compartment. R137 stated she brought the medications from home, and she didn't know the names of the medications. R137 stated she was under the impression that the nurses were taking the medications from the pill organizer and giving them to her.</p> <p>On 12/18/24 at 1:48 PM, surveyor went with V2 (DON-Director of Nursing) to R137's room. R137 was not in her room. The same pill organizer with medications was still on her table. R137's assigned nurse was V17 (RN-Registered Nurse). V17 stated, I didn't see this was here. I don't get any medications from here (pill organizer). I get all of (R137)'s medications from the medication cart. V2 stated the medications should be locked up and she was not aware of R137's pill organizer.</p> <p>R137's face sheet shows an admitted [DATE]. R137's face sheet shows diagnoses of unspecified systolic (congestive) heart failure, other pulmonary embolism without acute cor pulmonale, and hypertensive heart disease with heart failure.</p> <p>3. On 12/17/24 at 12:28 PM, R139 had Fleet glycerin laxative suppository and Cortisone cream on her end table. R139 stated she brought them from home and the medications are always kept in her room.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R139's face sheet shows diagnoses of anxiety disorder, unspecified, unsteadiness on feet, other abnormalities of gait and mobility, aftercare following explanation of shoulder joint prosthesis. R139's MDS showed she is cognitively intact. R139's POS does show orders for these medications.</p> <p>On 12/18/24 at 11:35 AM, V2 (DON) stated the facility collects residents' home medications at the time of admission. V2 stated if we were to use them, we must get an order from physician. V2 stated we lock unused meds from home in the medication cart until the family can pick them up.</p> <p>Facility's policy titled Medication Labeling and Storage (February 2023) shows: Policy statement: The facility stores all medication and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Medication storage: 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.</p> <p>41384</p> <p>4. On 12/17/24 at 11:46 AM, R68 was in his room and there was 1 bottle of Systane (lubricant eye drop) 10ml 1/3 oz. (milliliters/ounces) at the table next to the bed and 1 bottle of Systane on the over the bedside table. R68 said that the nurse puts the medication in his eyes for him. On 12/19/24 at 11:31 AM, a record review of R68's electronic health record did not show an order for Systane.</p> <p>On 12/19/24 at 01:59 PM, V2 (Director of Nursing) said that the 2 bottles of Systane should not have been in R68's room because they need to be secured safely.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene and handled and transported soiled linen in a sanitary manner, and ensure visitors were educated on isolation practices.</p> <p>This applies to 6 of 6 residents (R50, R21, R56, R52, R58, R188) reviewed for infection control in a sample of 23.</p> <p>Findings include:</p> <p>1. On 12/17/24 at 12:33 PM, during a dining observation, V4 CNA (Certified Nurse's Assistant) was observed feeding R21, touching her peanut butter and jelly sandwich and giving R21 a spoonful of strawberry ice-cream. Then V4 went to R56's table and began feeding R56. V4 did not clean her hands after feeding R21 her food. Then V4 went back to R21's table and was feeding R21 and feeding R50. V4 was using her same hand she used to feed R56, and she never cleaned her hands after she finished feeding R56. V4 continued feeding R21, R56, and R50 their entire lunches and never stopped to clean her hands in between assisting each resident.</p> <p>On 12/19/24 at 01:30 PM, V2 DON (Director of Nursing) said that V4 should be cleaning her hands between each resident.</p> <p>The facility's Handwashing/Hand Hygiene policy dated August 2019 showed that all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The policy shows that hand hygiene should be done before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with the residents' intact skin, after contact with blood or bodily fluids, after contact with objects in immediate vicinity of the resident, before and after eating or handling food, before and after assisting a resident with meals.</p> <p>2. On 12/17/24 at 01:23 PM, V8 (CNA) provided incontinence care for R52 when had urinated and had a bowel movement. V8 cleaned R52's perineal area and rectal area with gloved hands, and then removed the soiled brief and disposable linen protector from under R52. Without changing her gloves or performing hand hygiene, V8 placed a clean brief, readjusted R52 linen and blanket, handled the bed control, and closed R52's drawer.</p> <p>On 12/17/24 at 01:53 PM, V8 said that she did not change her gloves or cleaned her hands after going from a dirty area to a clean area.</p> <p>On 12/19/24 at 02:09 PM, V2 (DON) said that V8 should have cleaned her hands after she went from a dirty area before she went to a clean area for infection control.</p> <p>3. On 12/17/24 at 01:16 PM, V7 (CNA) carried soiled linen in her arms with the linen touching her clothes. V7 carried the soiled linen from R58's room to the soiled linen container, which was 15 rooms away. V7 said that is how her and the staff do it because there is only one soiled linen container for the hall.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/19/24 at 01:39 PM, V2 (DON) said that all soiled linen should be bagged, and it should not touch the staff's clothing while it is being carried for infection control.</p> <p>The facility policy Laundry and bedding, Soiled, dated October 2018 states soiled laundry / bedding shall be handled, transported and processed according to best practices for infection prevention and control. All laundry is handled as potentially contaminated until it is properly bagged and labeled for appropriate processing. Soiled laundry and bedding contaminated with blood or other potentially infectious materials is handled as little as possible and with minimum agitation. Contaminated laundry is placed in a bag or container at the location where it is used.</p> <p>46003</p> <p>4. On 12/17/24 at 01:03 PM, R58's bed was stripped and soiled lines were balled up on the floor next to her bed.</p> <p>On 12/19/24 at 03:24 PM, V2 (DON) stated soiled lines should not be left on the floor because of infection control issues.</p> <p>40054</p> <p>5. R188 is an [AGE] year-old male with multiple comorbid diagnoses, including viral infection, urinary tract infection, acute respiratory failure, and unproductive cough and wheezing.</p> <p>On 12/18/2024 at 10:05 AM, V10 (Registered Nurse) said R188 had isolation precautions in place for rhinovirus. V22 (R188's family) and V23 (Care Giver) were in the room. V10 was asked whether V22 or V23 were using PPE (Personal Protective Equipment), and V10 said she told them to wear it. Observed R188 in the room and V22 and V23 were sitting closely and not wearing any PPE. V22 and V23 said no one told them to wear the PPE.</p> <p>On 10/17/24 at 11:30 PM, V9 (ADON/Assitant Director of Nursing and Infection Control Nurse) said Nurses should educate, encourage, and emphasize PPE to visitors, and if there is a refusal from the visitors, that needs to be documented.</p> <p>The facility's isolation-transmission-based precautions initiation policy dated 09/2022 showed that the facility should educate visitors about why PPE, ensure staff and visitors enter the room wearing PPE, and dispose before leaving the room.</p>		