STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002208	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAELSEN HEALTH CENTER	831 NORTH BATAVIA AVENUE BATAVIA, IL 60510

(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
S 000	Initial Comments Facility Reported Incident of 3/13/25/IL1888920.	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.1210b)1) 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. Restorative measures shall include, at a minimum, the following procedures: 1) The licensed nurse in charge of the restorative/rehabilitative nursing program shall have successfully completed a course or other training program that includes at least 60 hours of classroom/lab training in restorative/rehabilitative nursing as evidenced by a transcript, certificate, diploma, or other written documentation from an accredited school or recognized accrediting agency such as a State or National organization of nurses or a State licensing authority. Such training shall address each of the measures outlined in subsections (b)(2) through (5) of this Section. This person may be the Director of Nursing, Assistant Director of Nursing or another nurse designated by the Director of Nursing to be	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002208	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAELSEN HEALTH CENTER	831 NORTH BATAVIA AVENUE BATAVIA, IL 60510

(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	Continued From page 1	S9999		

in charge of the restorative/rehabilitative nursing program.

This REQUIREMENT was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a restorative program is provided for the residents of the facility and failed to employ a licensed nurse who successfully completed 60 hours of training/education in restorative nursing.

This failure has the potential to affect all 63 residents currently residing in the facility.

The findings include:

The Facility Data Sheet dated 4/2/25 shows the resident census of the facility is 63.

On 4/2/25 at 12:21 PM, V3, Assistant Director of Nursing (ADON), said the facility does not have a restorative nurse currently and she is not sure who is doing the restorative evaluations.

On 4/2/25 at 12:41 PM, V2, DON, said the facility does not have a restorative program right now. V2 said they don't have a restorative nurse, the previous restorative nurse resigned in May of 2024 and has not been replaced.

The facility's Restorative Nursing Services Policy (revised July 2017) shows residents will receive restorative nursing care as needed to help promote optimal safety and independence.

(B)

Statement of Licensure Violations: (2 of 2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002208	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAELSEN HEALTH CENTER	831 NORTH BATAVIA AVENUE BATAVIA, IL 60510

(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	Continued From page 2 300.1210b) 300.1210d)6) 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. Restorative measures shall include, at a minimum, the following procedures: 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was rolled in a safe manner by two staff persons during incontinence care for 1 of 3 residents (R1) in the sample of 3 reviewed for safety and supervision. This failure resulted in R1 falling out of bed and sustaining	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002208	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAELSEN HEALTH CENTER	831 NORTH BATAVIA AVENUE BATAVIA, IL 60510

(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	Continued From page 3	S9999		

fractures of her right and left femurs.

The findings include:

R1's Face Sheet dated 4/2/25 shows R1 was admitted to the facility on 7/19/2021 with a diagnosis of osteitis deformans of other bones (chronic condition affecting bone structure). R1's MDS dated 1/28/25 shows R1 requires substantial/maximal assistance to roll left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed) and with toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). This same MDS also shows R1 is always incontinent of bowel and bladder.

R1's Clinical Notes dated 3/13/25 at 6:58 AM show the following excerpt, "While providing incontinence care, CNA stated she turned resident on her side when her legs then dangled off the bed and caused her to slide off the bed. CNA then did her best to lower resident to the floor."

On 4/2/25 at 9:10 AM, R1 was lying in bed on an air mattress. R1 said she broke both of her legs a couple weeks ago after she fell out of her bed. R1 said all she knows is that a lady was on one side, and she was on the other side and, "I got dropped." R1 said only one person was with her.

On 4/2/25 at 2:45 PM, V7, Certified Nursing Assistant (CNA) said she had been changing R1 by herself (on 3/13/25) and as she was rolling R1 in bed, she moved a little too hard, and R1's feet started to slide off the bed. V7 said R1's "legs are dead weight" and the weight of her body was pulling her off the bed. V7 said R1's legs are so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002208	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAELSEN HEALTH CENTER	831 NORTH BATAVIA AVENUE BATAVIA, IL 60510

(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	Continued From page 4	S9999		

heavy, the (air) mattress is slippery and R1 has no control over her legs, so R1 started to slide out of the bed. V7 said she was unable to get R1's legs back into the bed so she guided her head and shoulders as R1 fell out of her bed. V7 said it all happened so fast she is not sure if R1's knees hit the floor when she fell out of her bed.

On 4/2/25 at 9:29 AM, V10, CNA, said before R1 fell, she required two people to change her, one on each side of the bed.

On 4/2/25 at 9:39 AM, V9, CNA, said R1 required two people to change her. V9 said for bed baths, one person could wash R1's front side, but then they would need to get a second person to come help turn R1 and wash her back side.

On 4/2/25 at 1:20 PM, V5, MDS (Minimum Data Set) Nurse, said she gathers information from the CNAs and the nurses, does observations of residents, and looks at therapy and doctor's notes to determine a resident's mobility and care needs for their MDS. V5 said a resident who needs substantial/maximal assist needs two staff persons to help complete the given activity.

On 4/2/25 at 12:41 PM, V2, Director of Nursing (DON), said a person requiring maximal assist would require two persons to assist with the given activity.

On 4/2/25 at 2:22 PM, V6, Registered Nurse (RN), said she was R1's nurse on 3/13/25. V6 said V7 told her she was turning R1 and R1's legs started dangling off the bed and the weight of her legs caused R1 to fall forward, and she slid off the bed. V6 said R1 is heavier and difficult to turn.

On 4/2/25 at 2:08 PM, V8, Orthopedic Surgeon,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002208	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAELSEN HEALTH CENTER	831 NORTH BATAVIA AVENUE BATAVIA, IL 60510

(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	Continued From page 5 said R1 sustained bilateral femur fractures. V8 said a low energy impact could have caused R1's fractures. V8 said R1 has not been ambulatory for six years and she had poor, weak bone quality. R1's hospital Discharge Summary dated 3/21/25 shows R1 was admitted to the hospital on 3/13/25. in part due to bilateral distal femoral fractures due to a fall. R1's H&P dated 3/13/25 shows R1 presented to the hospital after a fall out of bed, she is bedbound at baseline, but apparently rolled out and fell onto both knees. R1's left femur x-ray resulted 3/13/25 shows a transverse fracture of the distal femoral diametaphyseal junction with impaction of three centimeters (cm) and posterior angulation. R1's right femur x-ray resulted 3/13/25 shows a mildly comminuted fracture of the distal diaphysis of the femur with posterior displacement 18 millimeters. (A)	S9999		