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 02/16/2023

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 Investigation of January 13, 2023 / IL156397	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. 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 These requirements are not meet as evidenced by: Based on interview and record review, the facility failed to safely position a resident during a bed bath. This failure resulted in R1 falling out of the bed and sustaining a subarachnoid hemorrhage. This applies to 1 of 4 (R1) residents reviewed for falls and accidents. Findings include: On 2/14/23 at 11:40 AM, R1 said on the day of the fall (1/13/2023), V4 (CNA/Certified Nurse Aide) was giving her a bed bath. R1 said that V4 rolled her onto her left side, away from V4. R1 said her right leg went over her left leg and over the bed and she slipped and fell off the bed. R1 said she hit her head when she fell off the bed and she had a "big bump" on the back of her head. R1 said the staff called the ambulance and she was taken to the hospital. R1 said a CT (Computerized Tomography) scan was done and they informed her that had a brain bleed. R1's face sheet shows R1 was admitted to the	S9999		

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S9999	Continued From page 2 facility on 12/1/22 and was discharged on 2/10/23. R1 has the following diagnoses, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, hemiplegia affecting right dominant side, history of falling, nondisplaced posterior arch fracture of first cervical vertebra, subsequent encounter for fracture with delayed healing, abnormalities of gait and mobility and lack of coordination. R1's MDS (Minimum Data Set) dated 12/20/22 shows R1's cognition is intact and R1 needs extensive assistance with one person staff assist with bed mobility. R1's care plan initiated 12/2/22 and updated on 1/13/23 (day of the fall) shows that R1 requires two staff assist while providing care in bed. The facility's incident report dated 1/13/23 documents, "On 1/13/23 at 10:30 resident had witnessed fall from bed. Staff were assisting resident with care and bed bath, resident lying on her left side moved her legs and slid from bed to floor. Resident sent to ER (Emergency Room) via 911. Resident admitted with small sub-arachnoid bleed." On 2/14/23 at 12:04 PM, V4 CNA said while she was giving R1 a bed bath on a low air loss mattress, she asked R1 to turn on her left side so she could wash R1's back. V4 said she turned R1 away from her and R1 was positioned on her left side. V4 stated R1 was holding on the quarter side rail on the other side of the bed. V4 said when R1 turned, she moved her right leg over and R1 fell off the bed; V4 said she was unable to prevent R1's fall. V4 said she saw that R1 hit her head on the bedside table. V4 said R1 did not have any bleeding, only small bump at the back of her head. V4 said that R1 had a cervical collar on (for her existing neck fracture) during the bed	S9999		

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S9999	Continued From page 3 bath. V4 said she called out for help and R1's nurse came in to assess R1. V4 said R1 was sent to the hospital via ambulance. V4 said she did not receive any special training for residents that have a cervical collar, she was only informed that R1's cervical collar has to be in place at all times. On 2/14/23 at 12:18 PM, V5 (Agency Nurse) said V4 CNA informed her that R1 fell off the bed during a bed bath. V5 said R1 was on the floor when she got to R1's room. V5 said she assessed R1, there was no bleeding; V5 said they did not move R1 off the floor, she called 911 and R1 was sent to the hospital. V5 said R1's cervical collar was on at the time of the fall. On 2/14/23 at 1:16 PM, V2 (DON/Director of Nursing) said V4 CNA informed her that R1 fell off the bed during a bed bath. V2 said when V4 was attempting to wash R1's back, V4 turned R1 to her left side, and when R1 moved her right leg, the momentum caused R1 to slip off the bed causing R1 to fall. V2 said R1 was admitted to the facility with a cervical fracture, and R1 had to have on cervical collar at times. V2 said R1 needed extensive assistance with one person assist for bed mobility. On 2/15/23 at 10:13 AM, V2 said staff was aware of R1's right sided weakness, and there were no specialized staff training for R1's cervical collar or right sided weakness. V2 said V4 should have had R1 turn towards her instead of away from her to wash her back, or there should have been another staff on the other side to assist, for safety reasons. On 2/15/23 at 10:36 AM, V13 (NP/Nurse Practitioner for Physiatrist) said the low air loss mattress could be slippery, the CNA should have had R1 roll towards her and not away from her since there was no other staff on the other side of	S9999		

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S9999	Continued From page 4 the bed to guard and protect the resident and prevent a fall. According to R1's hospital record dated 1/13/23 shows, "small region of left posterior superior temporal lobe subarachnoid hemorrhage likely from contrecoup injury as there is a large scalp swelling and hematoma along the right sided parietal and occipital scalp." Review of the facility's Support Surfaces Guidelines (September 2013), Turning a Resident on His/Her Side Away from You (October 2010), and Bath, Bed (March 2021) policies did not specify how many staff members are needed while giving a resident on low air loss mattress a bed bath or how to safely turn a resident in bed. (A)	S9999		