STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146140	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Galena Stauss Nursing Home	215 Summit Street Galena, IL 61036

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on interview and record review the facility failed to ensure residents were treated with dignity and respect for 2 of 5 residents (R2 and R3) reviewed for resident rights in the sample of 5. The findings include: 1. On 4/30/24 at 11:20 AM, R2 said that she had an issue with V3 (Registered Nurse) two Sundays ago. R2 said that the new person in the room next to her was having her family bring in a rug and she didn't feel that that was appropriate due to being a trip hazard. R2 said that V3 came to give her with evening medications and she questioned her about the rug and V3 turned bright red, put her hand up in my face to gesture stop and said very loudly, I don't know who gave them permission, it's not your concern. She was not speaking to me in a very dignified manner and I didn't appreciate it. All she had to say is I'm not sure but I will look into it and move on. R2's Minimum Data Set assessment dated [DATE] shows that her cognition is intact. 2. On 4/30/24 at 12:15 PM, R3 said that she has had issue with V3 in the past but she has gotten better. R3 said that V3 had came into her room and asked her a question and she responded, No. V3 then said to her in a very loud voice, Don't talk to me that way. R3 said that V3 was just not very nice and did not treat her with respect. R3 said, She (V3) turns really quickly and I don't know why. R3's Minimum Data Set assessment dated [DATE] shows that her cognition is intact. On 4/30/24 at 2:44 PM, V1 (Administrator) said that all residents should be treated with dignity and respect at all times. The Facility's Resident's Rights for People in Long-Term Care Brochure that is provided to the upon admission shows, You have the right to safety and good care .The facility must provide services to keep your physical and mental health and sense of satisfaction.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 34490 Based on interview and record review the facility failed to implement their abuse policy by not immediately protecting a resident from the alleged perpetrator after an alleged abuse for 1 of 6 residents (R1) reviewed for abuse in the sample of 6. The findings include: On 4/30/24 at 10:01 AM, V4 (Registered Nurse-RN) said that on Thursday 4/25/24 around 7 or 8 PM, she was doing a narcotic count with V3 (RN) and V5 (Licensed Practical Nurse-LPN). V4 said that R1 was sitting near the nurse's station as she usually does. V4 said that she had her back to R1 when she heard a commotion so she turned around and she saw V3 grab an ice cream out of R1's hand and throw it away. V3 then took a tissue and angrily gave it to R1 and said, Clean yourself up and then said, We are not doing this sh** tonight. V4 said that she is not sure what provoked the response because R1 was having a good day. V4 said that she didn't want to make it worse for anyone so she did not say or do anything and continued with narcotic count with V3 and V5 and left. V4 said that she thought about the incident over the weekend and decided to email V1 (Administrator) because she didn't want anything to happen to R1 or any other resident again. On 4/30/24 at 11:26 AM, V3 said that she worked from 7 PM to 7 AM on 4/25/24 and received a call on Monday morning that she was suspend while an abuse investigation was performed. On 4/30/24 at 2:44 PM, V1 (Administrator) said that all allegation of abuse should be reported to her immediately. V1 said that if the allegation was reported to her when it happened, she would have sent V3 home and immediately started an abuse investigation. V1 said that since it was not reported, V3 worked her shift and was notified on Monday that she was suspended due to an allegation of abuse. The Facility's undated Abuse Prevention Policy and Procedure shows, It is our policy to immediately remove the perpetrator from the facility. It is the responsibility of the Abuse Prevention team and/or shift supervisor to escort and/or ensure that the perpetrator has left the facility within minutes of the alleged incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34490 Based on interview and record review the facility failed to ensure a staff member immediately reported an alleged abuse the the administrator for 1 of 1 resident (R1) reviewed for abuse reporting in the sample of 6. The findings include: On 4/30/24 at 10:01 AM, V4 (Registered Nurse-RN) said that on Thursday 4/25/24 around 7 or 8 PM, she was doing a narcotic count with V3 (RN) and V5 (Licensed Practical Nurse-LPN). V4 said that R1 was sitting near the nurse's station as she usually does. V4 said that she had her back to R1 when she heard a commotion so she turned around and she saw V3 grab an ice cream out of R1's hand and throw it away. V3 then took a tissue and angrily gave it to R1 and said, Clean yourself up and then said, We are not doing this sh** tonight. V4 said that she is not sure what provoked the response because R1 was having a good day. V4 said that she didn't want to make it worse for anyone so she did not say or do anything and continued with narcotic count with V3 and V5 and left. V4 said that she thought about the incident over the weekend and decided to email V1 (Administrator) because she didn't want anything to happen to R1 or any other resident again. V4 said that she knows that she should have reported it immediately after it happened but she did not. On 4/30/24 at 2:00 PM, V2 (Interim DON) said that V4 came up to her on Monday morning around 7:30 AM and said that she witnessed V3 yell at R1 and take her ice cream away and throw it in the garbage. V2 said that she immediately went to V1 and notified her and they immediately started an investigation. On 4/30/24 at 2:44 PM, V1 (Administrator) said that all allegations should be reported to her immediately so an investigation can be started and an initial report sent to the state survey agency. V1 said that V4 should have called her and let her know what had happened immediately after it happened. The facility's Alleged Abuse Report shows that the alleged incident happened on 4/25/24 and the report was dated 4/29/24. There was an email attached to the report that shows that V4 emailed V1 on 4/28/24 at 9:30 AM about the incident that happened on 4/25/24. The email from V4 documents, I printed the abuse policy and there are things that I did wrong such as waiting too long to report. I did not work on Friday and chose not to call any of you over the weekend. The facility's undated Abuse Prevention Policy and Procedure shows, It is our policy to report all incidents of abuse. If the reporter is unsure an incident meets the definition of abuse, our policy is to report. All abuse incidents shall be reported to the state no later than 24 hours of the incident or sooner.