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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146140 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/04/2024 |
| NAME OF PROVIDER OR SUPPLIER Galena Stauss Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543</p> <p>Based on interview and record review the facility failed to notify R1's physician of new-onset neck pain following a fall from a hoist mechanical lift. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3.</p> <p>The findings include:</p> <p>R1's Admission Record (Face Sheet) showed an original admitted [DATE] with diagnoses to include partial left and right leg amputation; type 2 diabetes; and mild cognitive impairment.</p> <p>R1's 8/6/24 Quarterly Minimum Data Set (MDS) showed she was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15.</p> <p>On 9/3/24 at 9:05 AM, R1 stated she had a fall a few weeks prior; however, R1 was unable to recall the details of the fall. R1 stated soon after the fall she began experiencing neck pain. R1 stated it took at least a week before she was sent out for X-rays following her fall. R1 stated she believed the facility should have notified her provider of the neck pain sooner than they did.</p> <p>R1's Serious Injury Incident Report submitted on 8/21/24 showed, CNA (Certified Nursing Assistant) report (V3) 8/12/24 - When transferring resident to the chair from bed with mechanical lift, resident leaned too far to the left and started to slip out. This CNA tried to brace the fall, but she still fell down .physician (V6 R1's physician) here to assess resident, 8/21/24, ordered x-ray at [local area hospital] hospital confirmed fx (fracture) of neck .</p> <p>R1's 8/13/22 Incident Note from 3:22 AM showed, .Resident states her neck was stiff. PRN (As needed) pain medication administered with HS (evening) pills. (Pills administered the evening of 8/12/24) .</p> <p>On 9/3/24 at 1:06 PM, V3 CNA stated herself and V9 CNA were transferring R1 from the bed to her geri-chair (a high back reclining chair) on 8/12/24. V3 stated she was monitoring/handling R1 during the transfer and V9 was operating the hoist mechanical lift. V3 said R1 was partially suspended over the seat of her geri-chair and as she (V3) pulled R1 towards the back of the chair R1 fell out the left side sling and hit her head, neck, and shoulder on the floor. V3 said R1 began complaining of neck pain the following day (8/13/24).</p> <p>(continued on next page)</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 9/3/24 at 11:30 AM, V9 CNA stated she was controlling the hoist mechanical lift for R1 on 8/12/24. V9 said she did not work with R1 for a couple of days after the fall. V9 said the next time she worked with R1, R1 was complaining of neck pain with movement.</p> <p>R1's 8/13/24 Incident Note from 11:08 AM showed R1 was reporting neck pain.</p> <p>R1's 8/14/24 Incident note from 12:41 PM, showed R1 was reporting a sore neck.</p> <p>R1's 8/18/24 Health Status Note showed R1 continued to experience neck pain with her hoist mechanical lift.</p> <p>R1's 8/21/24 Leave of Absence note from 9:30 AM showed R1 left the facility for a neck X-ray.</p> <p>R1's CT scan of the cervical spine from 8/21/24 showed, Impression: Acute (recent onset) nondisplaced (a fracture where the bone did not move) fracture of the odontoid process (a specific appendage of the cervical spine) .</p> <p>On 9/3/24 at 2:20 PM, V6 R1's Physician stated, Cervical fractures present as pain. I was concerned about a fracture, which is why I shot over there right away. They said the pain was moderate in nature .My concern with the neck pain, was that she had a cervical fracture as a result of her fall, which was the reason I had her sent out. She did have a cervical fracture . V3 said the facility should have notified him of R1's neck pain on 8/13/24, when it first presented. V3 stated, if he was notified of R1's neck pain on 8/13/24, he would have sent R1 out for imaging at that time. V3 stated, in R1's case, the delay in imaging and treatment did not negatively impact R1's prognosis and the delay did not change the type of treatment that was provided.</p> <p>The facility's 72 Hour Fall Protocol showed, .Notify physician of any change in assessment .</p> <p>The facility's Symptom Pursuit Charting policy (not dated) showed, 1. At the time a change is noted in a resident's condition, the nurse in charge shall utilize the Symptom Assessment Charting with [electronic health charting] to accurately assess and document the resident's change/s. 2. The nurse shall complete the Symptom Assessment that correlates with the resident's symptoms. 3. The attending physician and significant other shall be notified of the change. If the physician and significant other are not notified, the nurse assessing the resident is to indicate why no notification was made within the record .</p> | | |

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| <p>F 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543</p> <p>Based on observation, interview, and record review the facility failed to safely transfer a resident with a hoist mechanical lift, which resulted in the resident falling from the hoist and sustaining a cervical spine (neck) fracture. This applies to 1 of 3 (R1) residents reviewed for falls in the sample of the 3.</p> <p>The findings include:</p> <p>R1's Admission Record (Face Sheet) showed an original admitted [DATE] with diagnoses to include partial left and right leg amputation; 2 diabetes; and mild cognitive impairment.</p> <p>R1's 8/6/24 Quarterly Minimum Data Set (MDS) showed she was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The MDS showed R1 was dependent upon staff for transfers from the bed to chair.</p> <p>On 9/3/24 at 9:05 AM, R1 stated she had a fall a few weeks prior; however, R1 was unable to recall the details of the fall. R1 stated soon after the fall she began experiencing neck pain.</p> <p>On 9/3/24 at 9:05 AM, R1 was in her geri-chair with a cervical (neck) brace in place. R1's left temple had a faint blue/purple color similar to a nearly faded bruise.</p> <p>R1's Serious Injury Incident Report submitted on 8/21/24 showed, CNA (Certified Nursing Assistant) report (V3) 8/12/24 - When transferring resident to the chair from bed with mechanical lift, resident leaned too far to the left and started to slip out. This CNA tried to brace the fall, but she still fell down .physician (V6 R1's physician) here to assess resident, 8/21/24, ordered x-ray at [local area hospital] hospital confirmed fx (fracture) of neck .</p> <p>R1's 8/12/24 Fall During Staff Assist form (Authored by V7 Registered Nurse) from 11:22 AM showed, CNA [V3] came out of [R1's] room to have me come in. I found [R1] laying on her back on the floor. The floor was dry, her geri-chair (high-back reclining chair) was upright with the cushion in it.</p> <p>R1's 8/13/22 Incident Note from 3:22 AM showed, .Resident states her neck was stiff. PRN (As needed) pain medication administered with HS (evening) pills. (Pills administered the evening of 8/12/24) .</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 9/3/24 at 1:06 PM, V3 CNA stated herself and V9 CNA were transferring R1 from the bed to her geri-chair on 8/12/24. V3 stated she was monitoring/handling R1 during the transfer and V9 was operating the hoist mechanical lift. V3 said R1 was partially suspended over the seat of her geri-chair and as she pulled R1 towards the back of the chair R1 fell out the left side sling and hit her head, neck, and shoulder on the floor. V3 said the mechanical lift sling has a strap at each of the four corners of the sling; two at the head and two at the legs, which are the attachment points for the sling to the hoist. V3 said R1 fell out the left side of the sling between the head and leg straps. V3 said, Nothing like this has happened before .I don't know if the sling was not positioned correctly. I don't know if she was leaning to the left because the sling was not positioned well. I don't think she was trying to lean and grab something . V3 said R1 began complaining of pain the next day after the fall.</p> <p>On 9/3/24 at 11:30 AM, V9 CNA stated she was controlling the hoist mechanical lift for R1 on 8/12/24. She fell over the left arm rest and on to the floor. She went through the gap between the head strap and the leg strap, through that hole, over the left arm rest and onto the floor. She hit her head, shoulder, and neck area first . V9 said she did not work with R1 for a couple of days after the fall. V9 said the next time she worked with R1 she was complaining of neck pain with movement.</p> <p>R1's 8/13/24 Incident Note from 11:08 AM showed R1 was reporting neck pain.</p> <p>R1's 8/14/24 Incident note from 12:41 PM, showed R1 was reporting a sore neck.</p> <p>R1's 8/18/24 Health Status Note showed R1 continued to experience neck pain with her hoist mechanical lift.</p> <p>R1's 8/21/24 Leave of Absence note from 9:30 AM showed R1 left the facility for a neck X-ray.</p> <p>R1's CT cervical spine scan from 8/21/24 showed, Impression: Acute (recent onset) nondisplaced fracture of the odontoid process (a specific appendage of the cervical spine) .</p> <p>On 9/3/24 at 2:20 PM, V6 R1's Physician stated, Cervical fractures present as pain. I was concerned about a fracture, which is why I shot over there right away. They said the pain was moderate in nature .My concern with the neck pain, was that she had a cervical fracture as a result of her fall, which was the reason I had her sent out. She did have a cervical fracture . V3 said his expectation is the facility should be able to perform safe mechanical transfers. V3 said R1 has no diagnoses that would prevent her from being safely transferred with a hoist mechanical lift.</p> <p>On 9/3/24 at 2:00 PM, V8 CNA stated R1 is a stable and safe transfer resident. V8 stated she could not think of any reason, other than improper sling placement, which would cause R1 to fall out of the sling.</p> <p>On 9/3/24 at 3:05 PM, V5 Registered Nurse (RN)/MDS/Falls Program stated, regarding R1's fall on 8/12/24, . My understanding is she (V3) was assisting with a transfer, and she (R1) was not properly placed in the sling If the [hoist mechanical lift] is used correctly it is our safest way to transfer her. If all the policies and procedures were followed correctly and she was positioned correctly, she (R1) should be able to be transferred without falling out of the [hoist mechanical lift]. The fall from the [hoist mechanical lift] caused the cervical fracture .</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 9/3/24 at 2:45 PM, V2 Director of Nursing stated, .If the CNAs are doing are everything correctly, there is no reason that [R1] should have fallen out of the sling. The only thing I can think of is that she was not positioned correctly. They way she fell out of the sling, as you describe it, is she was not positioned correctly in the sling. I have assisted with her transfers before, and she is generally very good during transfers and will follow our commands. Some days she may be more a little more confused. The sling and lift should be able to accommodate any movements she might make during the transfer</p> <p>The facility's undated Safe Resident Handling and Transfer policy showed, .Use mechanical lifting devices and other approved patient handling aids in accordance with instructions and training .The sling is placed under the patient appropriately and the straps are hooked upon the spreader bar</p> | | |