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	12/03/2025

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 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a restorative program for a resident with limited mobility. This failure resulted in R22 experiencing a decline in mobility. This applies to 1 of 6 residents (R22) reviewed for range of motion/mobility in the sample of 17. The findings include: R22's admission Record dated 12/2/25, shows she was admitted to the facility on [DATE], with diagnoses including osteoarthritis, abnormalities of gait and mobility, morbid obesity, pain in right knee, localized edema, and anxiety disorder. An order for physical therapy was entered on June 25, 2025. On 12/1/25, at 10:57 AM, R22 was observed sitting in her wheelchair. R22 said she is not able to stand. R22 said she does exercises when the exercise room is opened, but it's not opened every day. R22 said when the exercise room is opened, she does exercise to her right leg which is her weaker leg. R22 said no one walks her in the facility. R22 said facility staff have to use the stand lift in order for her to use the bathroom. R22 said she wanted to do enough exercises to allow her to go back home.On 12/3/25, at 9:10 AM, V10 Certified Nursing Assistant (CNA) said when residents get restorative therapy, the minutes are documented in the facility's computer charting program. At 9:12 AM, V11 Restorative CNA said she is working the floor today as a certified nursing assistant. V11 said R22 goes to the exercise room and does exercises with her right leg. V11 said the exercise room is opened at various times. V11 said the exercise room is only opened if there is enough staff because staff has to stay in the exercise room when residents are in there. V11 said the last day the exercise room was opened was on 11/26/25. V11 said she mostly works Monday Friday and every third weekend. V11 said she is usually able to do restorative exercises with the residents 1-2 days per week and the rest of the time she is working on the floor as a CNA because there is not enough staff to allow her to do restorative therapy. At 9:40 AM, V3 Licensed Practical Nurse (LPN) said the facility has a restorative nurse. V3 said the restorative nurse works the floor at times so she is unable to do restorative exercises with the residents. V3 said there is an exercise room that residents can use, but it's not always opened because staff have to be in there, and there are not always staff available to be there. V3 said the purpose of restorative therapy is to keep residents stabilized in their movements, keep their health and weight stable. R22's Minimum Data Set, dated [DATE], shows that she was using a walker and a wheelchair. R22's Minimum Data Set, dated [DATE], shows she was only using the wheelchair. R22's Rehab Form dated 6/30/25, shows, Presents to outpatient physical therapy with generalized weakness and impaired functional mobility which is not impairing her ability to transfer from her reclining lift chair and also to mobilize with use of her four-wheeled walker and use of the wheelchair. It is patient's desire to return to home alone in her single-story home. R22's Outpatient Therapy discharge note dated 7/25/25, shows, R22 performed all of her exercises with physical therapy and was discharged from physical therapy. Education provided for home exercise program and continued work on transfers and mobility with restorative therapy. She will continue to work with restorative therapy on strengthening and sit to stand transfers from her wheelchair within the parallel bars or with use of her front wheel walker. She has progressed with transfers from transferring with maximum assistance of one to transferring with minimum to moderate assistance of (continued on next page)

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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F 0688 Level of Harm - Actual harm Residents Affected - Few	one with use of front wheel walker. She is able to stand approximately 60 seconds with standby assistance with use of the front wheel walker and is standing more upright without assistance. She is independent with her home exercise program and will continue with strengthening with restorative therapy. R22's Restorative documentation group exercises shows R22 has received 195 minutes of restorative therapy in the last 30 days. There was five days where R22 did not receive any restorative therapy. On 12/3/25, the facility said they did not have a policy in regard to Restorative Therapy.

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to obtain and monitor weights for a resident (R6) with recent significant weight loss. The facility failed to inform the dietician of a decreased oral intake for a resident (R6) with recent significant weight loss. The facility also failed to notify the dietician that a resident's (R7) nutritional supplement was discontinued. These failures contributed to R6 and R7's continued weight loss. This applies to 2 of 3 residents (R6, R7) reviewed for weight loss in the sample of 17.The findings include: 1.R6's care plan revised on 7/21/24 showed R6 was at risk for weight loss related to her diagnosis of Multiple Sclerosis. The plan showed R6 required staff assistance to complete all activities of daily living. R6 was cognitively intact. R6's Weight Summary report showed R6 weighed 237.5 lbs (pounds) on 8/12/25, 218.9 lbs on 9/24/25 and 206 lbs on 11/5/25. The report showed no documented weight in October 2025 for R6. The report showed R6 sustained a significant weight loss of 13.3% from August 2025 to November 2025. The report showed no documented weights for R6 after 11/5/25. A Dietary Progress Note dated 11/12/25 showed R6 was seen and assessed by V7 Dietician. The note showed R6 had a 13% weight loss in 3 months related to her diagnosis of MS (Multiple Sclerosis) and consuming less than 50% of meals and skipping meals. R6 also had slow healing wounds to both buttocks. The note showed, Nutrition interventions. Recommend start 2 Cal (liquid protein supplement) three times a day, weights to be monitored weekly. monitor oral intake. On 12/1/25 at 9:52 AM, R6 was in bed. R6 stated she had been losing weight. R6 stated, No my weight loss wasn't something I was trying to do. I haven't been hungry. When V6 was asked when she was last weighed, V6 stated, It's been a little awhile. R6's Nutrition/Meal Intake report dated 11/12/25-12/2/25 showed R6 primarily consumed only 0-25% of her meals during that time. The report showed R6 refused to eat 12 meals during that time. On 12/2/25 at 10:37 AM, R6 was weighed by V6 Certified Nursing Assistant (CNA) with this surveyor present. The scale showed R6's weight was 199 lbs. This showed R6 had sustained an additional 3.4% weight loss from 11/5/25-12/2/25. On 12/2/25 at 9:55 AM, V4 Registered Nurse (RN) stated staff monitor residents for weight loss by weighing residents and monitoring how much residents eat. V4 stated staff are to notify the dietician as soon as possible, via note or phone call, if a resident is losing weight and/or not eating. On 12/2/25 at 11:35 AM, V7 Dietician stated she monitors residents for weight loss by monitoring residents' weights and their oral intake. V7 stated, I expect staff would notify me if a resident, with a history of weight loss, continued to lose weight and/or if that resident wasn't eating. V7 stated she assessed R6 on 11/12/25 after she had sustained a significant weight loss. V7 stated, I recommended starting her on a protein supplement for the weight loss. I also requested (R6) be weighed weekly and staff were to monitor her oral intake. V7 stated she was not aware R6 had not been weighed since 11/5/25. V7 stated, She was to be weighed once a week starting November 12, 2025. R6's meal intake record dated 11/2/25-12/2/25 was reviewed with V7. V7 stated she had not been notified by facility staff that R6's oral intake had continued to be poor from 11/2/25-12/2/25. V7 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	stated, The expectation was that (R6) was weighed as I had recommended. If she had continued to not eat or continued to have a poor appetite, I should have been notified. 2. R7's admission Record shows she was admitted to the facility on [DATE], with diagnoses including paraplegia, dementia, and dysphagia. R7's Weights and Vitals Summary dated 12/2/25, shows R7 weighed 166.1 on 3/2/25. R7 weighed 145.5 on 9/3/25. This was a 12.4% weight loss over six months. V7's Dietitian Note dated 9/12/25, shows, Resident with fair to good oral intakes; has been noted to be eating less at meals by staff. Significant weight loss per minimum data set. Recommend starting 60ml Two Cal (liquid nutritional supplement) three times per day and monitoring weekly weights. Recommendations to be faxed to primary care provider. Goal for weight to remain within 5 pounds of 145 pounds. R7's Medication Administration Record (MAR) dated 9/1/25-9/30/25, shows an order for nutritional supplement 60 ml three times per day. R7's MAR shows she received the supplement 15 out of 18 times. R7's MAR dated 10/1/25-10/31/25, shows she received the supplement 13 out of 16 times. R7's MAR shows the nutritional supplement was discontinued on 10/6/25. R7's Progress Note dated 10/6/25, entered by V3 Licensed Practical Nurse (LPN) shows that R7 disliked the nutritional supplement, refused to drink it, and the order was discontinued. R7's Weights and Vitals Summary dated 12/2/25, shows R7 weighed 161.4 pounds on 6/3/25. On 12/1/25, R7 weighed 135 pounds with is a 16% weight loss in six months. R7 weighed 145 pounds on 11/4/25, and on 12/1/25, R7 weighed 135 pounds which is a 6.9% weight loss in one month. On 12/2/25, at 11:34 AM, V7 Dietitian said she started the nutritional supplement in September 2025 due to her weight loss. On 12/3/25, at 9:40 AM, V3 LPN said when residents refuse nutritional supplements, it is documented in the residents' MAR. V3 said the dietitian should be notified if residents are refusing nutritional supplements so the dietitian can try something else. V3 said if residents do not take their nutritional supplements, then the resident can continue to lose weight and not get the nutritional value that they need. V3 said that V7 Dietitian was aware that R7 was not taking her supplement and did not know if V7 tried any other dietary supplement. On 12/3/25, at 10:20 AM, V7 Dietitian said she was not aware that R7's nutritional supplement was discontinued in October. V7 said if she had known that R7's nutritional supplement was discontinued, then V7 would have implemented other interventions to prevent further weight loss. V7 said R7 likes chocolate, so chocolate could have been added to the nutritional supplement. V7 said there are other options for nutritional supplements. V7 said she would want to know if a resident if refusing their nutritional supplement. The facility's Dietary Policy: Obtaining Accurate Height/Weight revised 1/6/11, shows, All weekly weight will be completed on Monday of each week. Registered Dietitian and Physician will be notified of any significant weight change. The facility's Significant Weight Loss policy implemented 10/1/07, shows, The goal of medical (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	nutrition therapy is to stabilize the weight, identify underlying causes or factors contributing to the significant unplanned weight loss, and intervene as appropriate to resolve the problem.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review the facility failed to provide a facility assessment. This applies to all 34 residents residing in the facility. The findings include:The long-term care facility application for Medicare and Medicaid dated 12/1/25 shows, there are 34 residents residing in the facility. On 12/3/25 at 11:40 AM, V1 Administrator stated she could not find her completed facility assessment. V1 did provide a facility assessment tool kit that did not have any facility information in it. The facility provided paper on 12/3/25 shows, Facility Assessment: Completed: 11/28/2024 however, there was no completed assessment. On 12/3/25 at 2:25 PM, V1 Administrator stated, she did not have a facility assessment policy. The facility did not provide a policy on the facility assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a dressing was in place to an open wound. This applies to 1 of 17 residents (R22) reviewed for quality of care in the sample of 17.The findings include: R22's admission Record shows she was admitted to the facility on [DATE], with diagnoses including osteoarthritis, diabetes mellitus, morbid obesity, localized edema, and venous insufficiency. R22's Order Summary Report dated 12/3/25 shows an order was entered 6/25/25 for, Sodium chloride external solution. Apply to bilateral lower extremities two times a day. Cleanse bilateral lower extremities venous stasis ulcers with 50/50 vinegar and normal saline. Apply nonadherent gauze, abdominal dressing (as needed for drainage), and kerlix wrap. On 12/1/25 at 10:57 AM, R22 was observed sitting in her wheelchair. There was a large open wound to R22's left knee area that was about two inches by two inches. The wound had a yellowish wound bed. There was no dressing in place to this wound. R22 said facility staff do not put a dressing to the wound to her left knee area. On 12/3/25 at 10:26 AM, V12 Infection Preventionist/Registered Nurse said R22's left knee wound is cleaned with a cleanser, but no dressing is placed. V12 was unsure how they were preventing infection from getting into R22's knee wound. V12 said she was going to clarify R22's dressing orders with R22's doctor. (No clarification was provided to the team by the end of this survey). On 12/3/25 at 9:12 AM, V11 Certified Nursing Assistant (CNA) said sometimes R22 has a dressing to her left knee and sometimes she does not.

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	146140	A. Building B. Wing	12/03/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to supervise residents during medication administration to prevent a medication administration error. The facility failed to ensure a resident was transferred in a safe manner. This applies to 2 of 17 residents (R3, R28) reviewed for safety and supervision in the sample of 17.The findings include:1.R3's current care plan showed R3 was severely cognitively impaired related to her diagnosis of dementia.R3's Incident Notes dated 10/31/25 showed, While giving medication to tablemate (R17), resident (R3) grabbed the pills and water and started taking the other residents pills. The notes showed R3 ingested R17's medications which included Bumex (diuretic medication) 1 mg (milligram), Entresto 24/25 mg (blood pressure medication), Rexulti 0.5mg (antipsychotic), Rosuvastatin 10 mg (cholesterol medication), and Spironolactone 25 mg (diuretic). The notes showed R3's physician was notified of the incident. R3 was monitored by facility staff. R3 had no adverse outcome from the medication ingestion. On 12/1/25 at 11:29 AM, V3 Licensed Practical Nurse (LPN) stated on 10/31/25, I was passing medications in the dining room. I set (R17's) pills in a cup on the table by her. (R3) was also seated at the table. When I turned away to give (R17) her insulin shot, (R3) reached over and swallowed (R17's) pills. I tried to get her to spit them out. V3 stated, I should have watched (R17) take her pills first. I should have given (R17's) insulin shot to her in her room.The facility's Medication Administration/Control of Medications policy (undated) showed the facility will establish safe and accurate nursing procedures for dispensing medications to residents.2.R28's admission Record dated 11/14/25 showed she was admitted to the facility with diagnoses of repeated falls and unsteadiness related to leg weakness.R28's Baseline Care Plan dated 11/14/25 showed R28 required assistance from one staff member for toileting and transfers. On 12/1/25 at 9:12 AM, R28 was seated on the toilet in her room with her call light on and flashing. A wheelchair was positioned in front of R28, with the handles of the wheelchair facing R28. At 9:14 AM, V8 Certified Nursing Assistant (CNA) entered R28's room to provide cares. A gait belt was secured around V8's waist. Without placing a gait belt on R28, V8 asked R28 to stand from the toilet by holding onto the handles of the wheelchair located in front of her. R28 slowly stood, slightly bent over, resting her upper body on the wheelchair, without any physical assistance from V8. V8 wiped R28's buttocks and pulled up her pants. V8 then held onto R28's right arm and used her other arm to rotate R28's wheelchair. Once the wheelchair was in place, R28 sat down on the chair. On 12/1/25 at 11:45 AM, V9 Physical Therapist stated staff need to use a gait belt when transferring R28 for R28's safety. The facility's Transfer/Gait Belt policy (undated) showed, To promote resident comfort and safety and to prevent employee injuries, transfer belts shall be used. All nursing staff and the rehabilitation team shall utilize a transfer belt for resident mobility when the resident requires one or more to assist him/her during a transfer or ambulation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview and record review the facility failed ensure a resident's cannabidiol (CBD) medication was securely stored and inaccessible to a resident for 1 of 17 residents (R2) reviewed for medication storage in the sample of 17.The findings include:On 12/1/25 at 9:50 AM, R2 was seated in bed. A small silver tin container, covered with a lid labeled Extra Strength 1500 mg (milligram) CBD Balm, was noted on R2's bedside table. R2 pointed to the CBD balm and stated, I put that on my back and knees when they hurt. When R2 was asked how much balm does she apply with each application, R2 stated, However much I want. On 12/2/25 at 9:56 AM, R2 was asleep in bed. R2's tin of CBD balm remained on her bedside table.On 12/2/25 at 9:08 AM, V4 Registered Nurse (RN) stated R2 cannot self-administer any of her medications because R2 is confused on and off.On 12/2/25 at 11:59 AM, V1 Administrator stated, We do allow residents to receive CBD products here if they are prescribed. A resident will need a physician order for the CBD for us to be able to administer it.On 12/3/25 at 10:24 AM, V12 RN stated all CBD products require a physician order to be used in the facility. V12 stated, All CBD products must be stored in a secure med room or med cart. A resident must be cognitively intact to be able to keep these products in their room. (R2's) cognition is not high enough to allow her to keep CBD at her bedside.R2's November 2025 and current December 2025 Medication Review Reports showed no physician orders for R2's CBD balm. On 12/3/25 at 10:50 AM, V1 Administrator stated the facility had no policy on resident use of CBD products.The facility's Medication Administration/Control of Medications policy (undated) showed, Self-administration of medication is permitted only upon written order from the attending physician. Topical medications can be kept at the resident's bedside if specified in the physician orders.The facility's Storage of Medications policy (undated) showed, Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to implement Enhanced Barrier Precautions (EBP) for 2 of 17 residents (R6, R16) reviewed for infection control in the sample of 17.The findings include:A facility list dated 12/1/25 showed R6 was on Enhanced Barrier Precautions due to her having wounds to her buttocks and having a urinary catheter in place. The list showed R16 was also on EBP due to her having a urinary catheter in place.1.On 12/1/25 at 11:50 AM, R6 was in bed. An Enhanced Barrier Precautions (EBP) sign was noted on the door to R6's room. The sign showed staff were to wear a protective gown, gloves, and mask when providing high contact cares to R6. An isolation cart containing PPE (personal protective equipment) was noted in the hallway by the entrance to R6's room. At 11:52 AM, V5 Certified Nursing Assistant (CNA) entered R6's room to provide cares. V5 donned a mask and gloves upon entering R6's room but did not don a gown. From 11:52 AM-12:32 PM, V5 CNA provided a bed bath to R6, without donning a protective gown, which included cleansing the wounds to R6's buttocks and handling R6's urinary catheter. 2. On 12/1/25 at 9:37 AM, R16 was seated in a recliner in her room. R16's urinary catheter bag hung off the recliner. No EBP signage was noted on or around the doorway to R16's room. No PPE cart was noted in the hallway by R16's door. When R16 was asked if staff wore a gown and gloves when they provided cares to her, R16 stated, They used too but don't anymore.On 12/2/25 at 8:56 AM, R16 was again seated in the recliner in her room with her urinary catheter bag hanging off the recliner. No EBP sign was noted on the door to her room. No isolation cart was noted in the hallway by her door. On 12/3/25 at 10:17 AM, V12 Infection Preventionist (IP) stated both R6 and R16 are to be on EBP. V12 stated residents on EBP are to have an EBP sign on the door to their rooms and an isolation cart containing PPE out in the hallway near their rooms. V12 stated a bed bath or shower are both considered high contact care activities which would require staff to wear a gown, gloves and mask when providing cares to residents with wounds and/or urinary catheters.On 12/3/25 at 11:52 AM, V12 IP stated she was unable to find a facility policy on Enhanced Barrier Precautions.