STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003438	A. BUILDING: _____ B. WING _____	C 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALENA STAUSS NURSING HOME	215 SUMMIT STREET GALENA, IL 61036

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S 000	Initial Comments FRI of 8/12/2024/IL177220	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3 300.1210d)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	S9999		

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S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal 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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 were NOT MET as evidenced by:

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.

The findings include:

R1's Admission Record (Face Sheet) showed an original admission date of 1/31/23 with diagnoses to include partial left and right leg amputation; 2

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S9999	Continued From page 2	S9999		

diabetes; and mild cognitive impairment.

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 depenedent upon staff for transfers from the bed to chair.

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.

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.

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..."

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."

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

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S9999	Continued From page 3	S9999		

(evening) pills. (Pills administered the evening of 8/12/24) ..."

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.

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.

R1's 8/13/24 Incident Note from 11:08 AM showed R1 was reporting neck "pain."

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S9999	Continued From page 4	S9999		

R1's 8/14/24 Incident note from 12:41 PM, showed R1 was reporting a "sore" neck.

R1's 8/18/24 Health Status Note showed R1 continued to experience neck pain with her hoist mechanical lift.

R1's 8/21/24 Leave of Absence note from 9:30 AM showed R1 left the facility for a neck X-ray.

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) ..."

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.

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.

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

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S9999	Continued From page 5	S9999		

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..."

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...."

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...."

(A)