PRINTED: 10/31/2024 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6003438	B. WING		10/03/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
GALENA S	STAUSS NURSING HOM		WIT STREET			
0/0.15	STIMMADA ST.	ATEMENT OF DEFICIENCIES	IL 61036	PROVIDER'S PLAN OF CORRECTIO	N OVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
S 000	Initial Comments		S 000			
	Annual Licensure and	Certification Survey				
S9999	Final Observations		S9999			
	Statement of Licensu	re Violations				
	300.615e) 300.615f)					
	2-201.5(a) of the Act shall, within 24 hours resident, request a crecheck pursuant to the Information Act for all admission to the facilic check was initiated by Hospital Licensing Act be based on the resident of the Act). f) The facility shall cheon the Illinois Sex Off at www.isp.state.il.us of Corrections sex regwww.idoc.state.il.us to is listed as a registered.	iminal history background Uniform Conviction persons 18 or older seeking ity, unless a background v a hospital pursuant to the t. Background checks shall lent's name, date of birth, is required by the Police. (Section 2-201.5(b) eck for the individual's name ender Registration website and the Illinois Department gistrant search page at o determine if the individual				
	failed to submit backs	e Illinois State Police (ISP)				

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 10/18/24

PRINTED: 10/31/2024 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		IL6003438	B. WING		10)/03/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
GALENA	STAUSS NURSING HOM	E	MMIT STREET			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	A, IL 61036	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
S9999	Continued From page	e 1	S9999			
	This applies to 4 of 1 (R8,R42,R45,R96) th criminal backgrounds sample of 10.	at were reviewed for				
	The findings include:					
	showed R8 was adm home on 8/23/24. Th was submitted on 8/2	sheet printed on 10/2/24 itted to the facility from her e background check form 20/24, and the IDOC website were checked on 8/20/24, 3 on to the facility.				
	showed R42 was adr home on 8/26/24. Th was submitted on 8/1	sheet printed on 10/2/24 mitted to the facility from her background check form 6/24, and the IDOC website were checked on 8/16/24, 10 on to the facility.				
	showed R96 was adr home on 9/20/24. Th was submitted on 9/1	sheet printed on 10/2/24 mitted to the facility from her e background check form 8/24, and the IDOC website were checked on 9/18/24, 2 on to the facility.				
	showed R453 was ac local hospital on 8/28 form was submitted of website and the ISP	sheet printed on 10/2/24 dmitted to the facility from a dwww./24. The background check on 9/3/24, and the IDOC website were checked on R45's admission to the				
	"I thought as long as checks before they w	M, V1 (Administrator) stated, we did the background ere admitted we were okay. 5's) was done late, that is				

Illinois Department of Public Health

STATE FORM 6899 NZJE11 If continuation sheet 2 of 3

PRINTED: 10/31/2024 FORM APPROVED

Illinois Department of Public Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	BUILDING:	(X3) DATE SURVEY COMPLETED									
IL6003438 B. WI	WING	10/03/2024									
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS,	S, CITY, STATE, ZIP CODE										
GALENA STAUSS NURSING HOME 215 SUMMIT STREET GALENA, IL 61036											
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)										
See	9999										

Illinois Department of Public Health

STATE FORM 6899 NZJE11 If continuation sheet 3 of 3