STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175233	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Galena Nursing & Rehab Center	1220 E 8th Street Galena, KS 66739

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure Resident (R) 1 remained free from abuse. On 03/21/26 at around 10:30-11:00 PM Certified Nurse Aide (CNA) M identified bruising on R1's right leg and reported it to Licensed Nurse (LN) G. LN G determined the bruising was probably from the wheelchair but did not report the bruises of unknown origin to the administrator. Around 04:20 AM on 03/22/26, CNA M reported to LN G that R1 had vaginal bleeding. LN G instructed the CNA to apply antifungal powder or cream but did not assess the area. The resident remained in her room with her representative, the alleged perpetrator (AP), with the door closed. At 06:00 AM, LN G told LN H and LN I that R1 had some vaginal bleeding. At 08:00 AM, CNA O provided peri care to R1 and identified dried blood on R1's labia and reported to LN I. At 08:30 AM LN I assessed R1 and noted dried blood on the labia and vaginal area, and bruising to the right hip and leg. LN I notified LN H. Around 02:22 PM, LN H and LN I assessed R1 and noted a large bruise on her right hip, purple bruises to R1's outer vaginal area and upward into the vagina with bleeding and notified Administrative Nurse D of the potential abuse at 03:00 PM; Administrative Nurse D notified the Administrative Staff A, approximately 16 hours after the initial bruising of unknown origin, allowing the AP to be alone with R1 resulting in progressive injuries and signs of sexual abuse. The facility failed to ensure R1 remained free from preventable and intentional physical and sexual abuse and psychosocial trauma which placed R1 in immediate jeopardy. Findings Included:- Review of the Electronic Medical Record (EMR) documented R1 had diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (damage to the left hemisphere of the brain, typically resulting in right-sided body weakness and often speech/language deficits). R1's admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. R1 required substantial to maximum assistance for eating and bathing and was dependent on staff for all other activities of daily living (ADL). She was able to communicate with clear speech. The MDS documented R1 had no signs of depression and no behaviors; she had no skin conditions. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/28/26, documented it triggered secondary to R1's orientation, memory, and recall deficits noted during BIMS interview with contributing factors including short-term and long-term memory loss. R1's Care Plan, dated 02/03/26, documented R1 liked to participate in individual and group activities and directed staff to provide R1 with an activities calendar and encourage her to participate in activities of her choice. R1's Care Plan did not address the AP's involvement in care and listed the other son as the Durable Power of Attorney (DPOA). The 02/23/26 at 12:22 PM Nurse Advanced Skilled Evaluation documented no skin issues identified. The evaluation further documented two very small bruises, one on the left outer thigh and one on the abdomen. The 02/24/26 at 12:14 PM Nurse Advanced Skilled Evaluation documented no skin issues identified. The 03/03/26 at 10:48 AM Nurse Advanced Skilled Evaluation documented no skin issues were identified. Review of all Nurse Advanced Skilled Evaluation assessments from 03/03/26 through 03/22/26 revealed no mention of bruising or vaginal bleeding. R1's 03/09/26 Licensed Nurse Weekly Skin Assessment, documented R1 (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	sheering to R1's left inner labia; staff notified Administrative Nurse D. LN I's Notarized Witness Statement, dated 03/23/26, documented she was called to R1's room (on 03/22/23) by CNA O to observe blood on R1's peri-area and upon assessment she found dried blood on R1's labia and vaginal opening. LN I noted that she then reported this to LN H (R1's nurse), and that the AP was present during the assessment. LN I also documented that she assessed R1 with LN H later that afternoon and discovered dark bruised areas that were visible on R1's labia and into her vagina and there was bruising to the right hip and leg and bruising visible on the lower abdomen and what appeared to be a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma). LN I also documented that the AP would not make eye contact at that time and left the room for that assessment; she notified Administrative Nurse D. CNA Q's Notarized Witness Statement, dated 03/24/26, documented that when she performed cares and changed R1's wet brief the AP remained in the room and watched her actions closely. CNA Q's facility Witness Statement Form dated 03/24/26 documented that R1's room door was closed most of the time during 06:00 AM - 05:00 PM, 03/21/26 or 03/22/26, and the AP was in R1's room during that time. LN H's facility Witness Statement Form dated 03/24/26, documented that it was noticed the AP was alone in the room with R1 and he would remain in the room during cares and assessments. CNA R's facility Witness Statement Form dated 03/24/26, documented the AP would remain in R1's room all the time unless he had to go home to do laundry or let animals out. She further documented the AP left frantically after R1's injuries were noticed. CNA S's facility Witness Statement Form, dated 03/25/26, documented that when her and another CNA were getting R1 up for the day and providing peri-care, R1 told them not to touch her and when trying to change her shirt R1 said, Stop that son. CNA O's facility Witness Statement Form dated 03/25/26, documented that the AP remained in the room when cares were provided at 08:00 AM and remained in the room with R1 with the door closed after cares were completed at 08:30 AM. CNA O further documented the AP remained alone in the room, with the door closed, as cares were completed at 11:30 AM and remained in the room during the cares. LN G's facility Witness Statement Form dated 03/25/26, documented that during her shift she took R1's vitals and performed her skilled assessment and that it did not take very long. LN G also documented the AP would spend the night with R1 and he kept the door shut. CNA M's facility Witness Statement Form dated 03/26/26, documented that the AP usually stayed in the room when care was provided to R1 and the AP would stay in R1's room all night with the door closed. On 03/30/26 at 09:40 AM, Administrative Staff A stated the incident occurred on the night of 03/22/26 [sic] and R1 was sent to the hospital in [NAME], MO and the hospital refused to perform the SANE examination because they did not get consent from R1's legal representative because he had left. R1 was then released and sent back to the facility and Administrative Staff A took R1 to the hospital in Pittsburg, KS and they informed her that they did not have a qualified SANE nurse to perform the proper examination. Administrative Staff A returned to the facility and coordinated with local Law Enforcement (LE) and she then took R1 to the county Health Department, along with local LE, and the health department performed the SANE examination. She said that staff had not reported concerns about the DPOA prior to this incident. On 03/30/26 at 09:50 AM, Law Enforcement Officer (LEO) KK said he had spoken with the hospital nurses, including the SANE nurse, and they told him R1's wounds were some of the worst wounds they had assessed. LEO KK also said that since LE was notified of R1's assault allegations, LE had not been able to contact the AP, the AP had not answered any phone calls, and the AP had not answered the door when LE went to his residence. LEO KK further said that LE had to obtain a warrant for the SANE exam to be completed because the AP had been listed as R1's legal representative and the hospital was not able to obtain authorization before the AP had left the hospital the evening of 03/22/26. On 03/30/26 at 10:12 AM, Administrative Staff A stated that she was notified of the incident at 03:25 PM on 03/22/26. She also said the AP never did anything suspicious, but she did have an odd vibe regarding him. She also said there had never been any complaints about the AP with this visit or previous visits. Administrative Staff A reported that every (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	time the AP stayed, which was 24 hours a day, seven days a week, the door would remain closed, and this happened with this stay and the previous two stays; he would only leave for 30 minutes to an hour and would return. On 03/30/26 at 10:20 AM, Administrative Nurse D stated she was notified by staff around 03:00 PM on 03/22/26 of suspected abuse with R1 and she proceeded to go to the facility and notified Administrative Staff A around 03:25 PM while she was driving to the facility; she further said that she should have been notified much sooner about the injuries to R1. She reported that the AP would always be sitting directly next to R1 and always would be holding her hand, and the room door was always closed, and he stayed 24/7 and anytime he would leave it would only be an hour at the most and when he returned, he would quickly walk through the halls back to R1's room. She also said that the AP would act fidgety and nervous anytime staff would interact with him or when cares were performed, and he would stand next to staff or at the end of R1's bed when cares were performed and that staff had reported that he would often interrupt and take over cares which included incontinent cares. She said that staff reported to her that they felt awkward performing cares on R1 while the AP was present. When Administrative Nurse D arrived on the evening of the allegations the AP was present and acted more nervous than usual. Administrative Nurse A also reported that R1 would act more relaxed and comfortable whenever the AP was not present and when the AP was around, she was quiet and would not participate in activities, the AP would keep her isolated. On 03/30/26 at 10:37 AM, CNA O stated that she and another CNA (CNA P) performed peri care on R1 around 08:00 AM on 03/22/26 and there were small cuts/lacerations around R1 vaginal area but did not notice bruising because she kept R1 covered for dignity and warmth. She said that the AP was present in the room and was standing at the foot of the bed watching the cares be performed. CNA O then informed the other CNA to remain with R1 and she then immediately notified the charge nurse (LN I) and LN I immediately arrived and examined R1 and told the CNAs that it was reported the night before that there was vaginal bleeding. CNA O also stated that there were several times that she felt awkward and uncomfortable with the AP, and he would get upset and refuse to leave when asked. CNA O had reported her discomfort and concerns to the charge nurse more than once and the response she received was that they did not take it seriously and nothing was done. She also reported that the AP stayed in R1's room [ROOM NUMBER]/7 and the door was always closed, when staff would leave the door open or cracked, the AP would close it. On 03/30/26 at 10:55 AM, CNA P stated that she assisted CNA O with performing peri cares on R1 around 08:00 AM on 03/22/26 and when doing so they noticed blood in the vaginal area of R1 and they reported it to the nurse and found out that night shift had reported it to the nurse, they also noticed wounds in the vaginal area. CNA P also said that the AP was in the room and at the end of the bed watching and would always be present during cares. She also stated that she felt unsettled when performing cares on R1 and the AP being present. CNA P also said that she had reported her concerns with the AP to the charge nurse previously and was told to honor the AP's wishes of being present and let it be. On 03/30/26 at 11:55 AM, LN I stated that she was the nurse on the south hall on 03/22/26 and she was notified by CNA O around 08:00AM that R1 needed to be seen by a nurse. She said that she went to R1's room and saw that R1 had blood and dried blood around her vaginal area along with vaginal bruising, LN I then found LN H, the nurse for that hall, and reported to her that R1 had bleeding and bruising around the vaginal area and informed her that further assessment was needed after the CNAs had finished with cares and cleaned her. LN I then stated that after 02:00 PM she and LN H assessed R1 and discovered extensive bruising on her thighs and abdominal area and the vaginal bruising was darkened. LN I also said that the AP was always present, even during intimate cares, and would not make eye contact at that time. LN I then notified Administrative Nurse D of the situation. On 03/30/26 at 12:25 PM, LEO JJ stated that she arrived at the emergency department (ED) in [NAME], MO and the AP had already left. She said she was unable to contact R1's other son and was informed by the hospital nurse that the AP had acted frantic and was yelling in the lobby before he left. On 03/30/26 at 01:35 PM, LEO II stated that he responded to the initial call and then passed the case onto the county detectives due to (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(ANE) for all facility staff. Additionally, a protection plan was implemented for R1 that included all cares were performed with two staff, the room door was to remain open unless private cares were provided. Also included in the protection plan, if the AP entered the facility, then law enforcement (LE) was to be notified immediately, and a staff member was to go to R1's room and remain with her until LE arrived. The facility also implemented a sign-in sheet for all visitors to the facility and included a specific visitor log for R1. Due to the corrective actions the facility completed prior to the onsite visit, the deficient practice was deemed past non-compliance and existed at a J (isolated, immediate jeopardy) scope and severity based on reasonable person concept.

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	175233	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Galena Nursing & Rehab Center	1220 E 8th Street Galena, KS 66739

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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 - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure staff identified Resident (R) 1's signs of physical and sexual abuse, and report to the Administrator immediately and the appropriate state entities within the required time. On 03/21/22 at around 10:30-11:00 PM Certified (CNA) M and CNA N identified bruising on R1's right leg and reported it to Licensed Nurse (LN) G. LN G spoke to the resident's representative, the alleged perpetrator (AP), who offered a rationale for the injury which LN G accepted without investigation. Around 04:20 AM on 03/22/26, CNA M reported to LN G that R1 had vaginal bleeding. LN G instructed the CNA to apply topical cream but failed to assess the area. LN G did not document the bruising, the conversation with the AP or the change in condition of R1's vaginal area and failed to report bruising or vaginal bleeding to Administrative Staff A. At 06:00 AM, LN G told LN H and LN I that R1 had some vaginal bleeding and bruising. Neither LN H or LN I identified the injuries and vaginal changes as potential sexual abuse and reported to Administrative Staff A, Law Enforcement (LE) or the State Survey Agency (SA). At 08:00 AM, CNA O provided peri care to R1 with the AP present and identified dried blood on R1's labia and reported to LN I. At 08:30 AM LN I visualized R1's peri-area, confirmed the dried blood and bruising on R1's labia and vaginal area and reported it to LN I but did not report to Administrative Staff A, LE, or SA. Around 02:22 PM, six hours later, LN H accompanied LN I to R1's room and assessed R1. They noted a large bruise on R1's right hip, purple bruises to R1's outer vaginal area and upward into the vagina with active bleeding. LN I and LN H then notified Administrative Nurse D of the potential sexual abuse at 03:00 PM and Administrative Nurse D notified Administrative Staff A at 03:25 PM. During the delay in reporting, after identification of injuries of unknown origin and signs of physical and sexual abuse yielding serious bodily injury, R1 remained in the room alone with the AP.Findings Included:- The facility's investigation for the incident dated 03/22/26 and signed by Administrative Staff A on 03/27/26 documented at around 10:10 PM on 03/21/26, CNA M and CNA N provided personal care to R1 with the AP present. The AP was R1's Durable Power of Attorney (DPOA) and primary caregiver when R1 was at home. The CNA staff noted bruising and reported it to LN G. The AP suggested the bruising could be from therapy and was unsure of its origin; there was no blood present at that time. At 04:20 AM on 03/22/26, the same CNA staff provided personal care to R1 with the AP present. There was bright red blood in R1's brief, on her labia and around the vaginal area. The AP suggested the bleeding might be due to itching and recommended medication to prevent itching; this was reported to LN G who instructed the CNA staff to apply antifungal powder, suspecting a yeast infection. The investigation documented that there was no labia bruising at that time. At 06:00 AM, LN G passed on the report of vaginal bleeding suspected to be caused from itching or a yeast infection to LN I and LN H and recommended contacting R1's provider. At 08:00 AM, CNA O provided personal care to R1 with the AP present. She noted dried blood on R1's labia and reported it to the nurses. LN I assessed R1, noted the blood, bruising on R1's hip and laceration to R1's labia, and suspected the injuries were caused by itching and with no suspicion of abuse. At 03:00 PM [sic], LN H and LN I conducted a two-nurse skin assessment. During this assessment the AP left the room, which was unusual because he typically remained present and observed care. The nurse noted a large bruise on R1's right hip and leg resembling the shape of a hand. Additional bruising and injuries were noted on the labia and vaginal areas, including maroon/purple bruising, a small laceration on the posterior vaginal opening and a circular skin abrasion resembling a shearing. The resident displayed increased anxiety during the assessment, repeatedly saying Oh God. The investigation noted R1 was unable to say what happened. The AP had been at the bedside and present during all cares over the previous 23 hours. The investigation documented the facility notified local LE but did not indicate the time though LE arrived at the facility at 05:25 PM per the investigation.Review of the email communication sent to the (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	SA from the facility with the initial reporting of an injury of unknown origin was time stamped 03/22/26 at 07:29 PM, almost 20 hours after the initial injury of unknown origin was identified and four hours after Administrative Staff A learned of the physical and sexual abuse.LN I's Nurse's Note dated 03/22/26 at 08:30 AM documented that the nurse was called to R1's room by the CNA. The nurse observed dried blood on R1 labia and vaginal opening that the CNA noticed while cleaning R1. The note documented R1 also had dark bruises present in that area and noted the resident's representative (AP) was concerned that R1 had some itching. LN I documented she reported the findings to R1's charge nurse [LN H].LN H's Late Entry Nurse's Note dated 03/22/26 at 02:22 PM documented R1 had a large bruise on right hip, and small dark purple bruising to her outer vaginal opening and upward into the vagina with vaginal bleeding present. Staff notified Administrative Nurse D and called Emergency Medical Services (EMS). Staff called the hospital to request a same [sic] nurse (SANE-Sexual Assault Nurse Examiner) nurse be present to examine R1 due to the type of injury.LN I's Nurse's Note dated 03/22/26 at 02:33 PM documented she went with R1's charge nurse [LN H] and observed bruising on R1 that included vaginal bruising and a very large bruise on R1's right hip. There was also a small bruise on the right outer thigh. R1 was unable to say how she got the bruises but stated she did not have any itching. LN I notified Administrative Nurse D.Administrative Nurse D's Nurse's Note: Late Entry dated 03/22/26 at 11:20 PM documented the nurse received report that R1 had vaginal bleeding and bruising. The initial assessment revealed a large bruise to R1's right hip and suspected bruising to the labia with small lacerations. The nurses completed an immediate follow-up assessment with a second licensed nurse due/ to concern for an injury of unknown origin. Administrative Nurse D documented she arrived at the facility within 15 minutes of receiving the report to assess the injuries and updated Administrative Staff A and the regional nurse of the report. A full head-to-toe skin assessment revealed the following findings: large ecchymosis (bruising) area noted to the right hip with surrounding smaller areas of bruising, scattered ecchymosis was present to bilateral lower extremities, bruising to lower abdomen extending from superior pubic area measuring approximately 6.5 centimeters (cm) by 4 cm, labial area with multiple dark maroon/purple areas of bruising surrounding vaginal opening with scattered petechiae (pinpoint red, purple, or brown spots caused by broken capillaries bleeding under the skin), small laceration noted to the posterior vaginal opening measuring approximately 0.2 cm, and shearing injury noted to the left labia measuring approximately 0.6 cm by 0.5 cm. Resident noted with vaginal bleeding at time of assessment.CNA M's Notarized Witness Statement dated 03/22/26 documented on 03/21/26, he noticed some significant bruising down R1's right leg. CNA M noted he reported the bruising to the charge nurse and it was left as bruising from her wheelchair. He noted that later in the shift, he noticed some bleeding from the inside of her private area and a small black circle on one side of R1's labia that he thought was clotted blood but may have been a sore. CNA M's statement documented that he immediately reported it to the nurse, but it was not viewed by a nurse until the next shift came on. He documented that he reported the bruising to the nurse at around 10:30 -11:00 PM and the bleeding from the vagina at 04:20 AM.CNA T's Notarized Witness Statement, dated 03/22/26, documented she was in the room with CNA M on 03/20/26 as he provided cares to R1. She noted she heard CNA M report bruising on R1 to the charge nurse and the AP was present in the room as care was provided.LN G's Notarized Witness Statement dated 03/22/26, documented that CNA M informed her that it looked like R1 had been scratching at her vaginal area and had blood on her brief. She documented the AP told her earlier in the shift that R1 had been scratching around the abdominal and thigh folds. LN G noted that CNA M showed her some antifungal powder, and she instructed the CNA to apply antifungal cream to R1's labia. She also noted that earlier in the shift, CNA M had informed her that R1 had bruising down the side of her right hip and leg. The bruises were small and linear and appeared old, and the AP had said he thought they happened in therapy. It appeared to be in a line from where R1 would sit down in the wheelchair and didn't get centered.CNA O's Notarized Witness Statement, dated 03/22/26, documented on 03/22/26 around 08:00 AM she and CNA P performed (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	cares on R1 and noticed dried blood all over R1's vaginal area and she had CNA P remain with R1 while she notified the nurse. CNA O also documented the AP remained in the room with R1 the entire time. CNA O also documented that for the rest of the day the AP remained with R1 and acted jittery, nervous and anxious. CNA O further documented that she escorted and remained with R1 when she was transported to the hospital and while at the hospital R1 asked her why I let that man do that? It was not documented if this statement was reported.CNA P's Notarized Witness Statement, dated 03/22/26, documented that while she performed cares on R1, R1 grabbed her hand and stated Son, why would you do this to me? The statement did not document if this was reported.CNA R's Notarized Witness Statement dated 03/22/26, documented that the AP frantically left the building on 03/22/26 after injuries were noticed on R1.LN H's Notarized Witness Statement, dated 03/22/26, documented that she was called into R1's room at 02:45 PM due to bruising on R1's right hip, right leg, posterior-outer labia and there was small sheering to R1's left inner labia and staff notified Administrative Nurse D.LN I's Notarized Witness Statement, dated 03/23/26, documented that she was called to R1's room by CNA O to observe blood on R1's peri-area and upon assessment she found dried blood on R1's labia and vaginal opening. LN I noted that she then reported this to LN H (R1's nurse), and the AP was present during the assessment. LN I also documented that she assessed R1 with LN H later that afternoon and discovered dark bruised areas that were visible on R1's labia and into her vagina and there was bruising to the right hip and leg and bruising visible on the lower abdomen and what appeared to be a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma). LN I also documented the AP would not make eye contact at that time and left the room for that assessment and she notified Administrative Nurse D.On 03/30/26 at 09:40 AM, Administrative Staff A stated that the incident occurred on the night of 03/22/26 [sic] and R1 was sent to the hospital in [NAME], MO and the hospital refused to perform the SANE examination because they did not get consent from R1's legal representative because he had left. R1 was then released and sent back to the facility and Administrative Staff A then took R1 to the hospital in Pittsburg, KS and they informed her that they did not have a qualified SANE nurse to perform the proper examination. Administrative Staff A returned to the facility and coordinated with local LE, and she then took R1 to the county Health Department, along with local LE, and the health department performed the SANE examination. She said that staff had not reported concerns about the DPOA prior to this incident.On 03/30/26 at 10:12 AM, Administrative Staff A stated that she was notified of the incident at 03:25 PM on 03/22/26. She also said that the AP never did anything suspicious, but she did have an odd vibe regarding him. She also said that there had never been any complaints about the AP with this visit or previous visits. On 03/30/26 at 10:20 AM, Administrative Nurse D stated that she was notified by staff around 03:00 PM on 03/22/26 of suspected abuse with R1 and she proceeded to go to the facility and notified Administrative Staff A around 03:25 PM while she was driving to the facility; she further said that she should have been notified much sooner about the injuries to R1. On 03/30/26 at 10:37 AM, CNA O stated that she and another CNA (CNA P) performed peri care on R1 around 08:00 AM on 03/22/26 and there were small cuts/lacerations around R1 vaginal area but did not notice bruising because she kept R1 covered for dignity and warmth. She said the AP was present in the room and was standing at the foot of the bed watching the cares be performed. CNA O then informed the other CNA to remain with R1 and she then immediately notified the charge nurse (LN I) and LN I immediately arrived and examined R1 and told the CNAs that it was reported the night before that there was vaginal bleeding. CNA O also stated there were several times she felt awkward and uncomfortable with the AP and he would get upset and refuse to leave when asked. CNA O reported her discomfort and concerns to the charge nurse more than once and the response she received was that they did not take it seriously and nothing was done. She also reported that the AP stayed in R1's room [ROOM NUMBER]/7 and the door was always closed, when staff would leave the door open or cracked, the AP would close it.On 03/30/26 at 10:55 AM, CNA P stated that she assisted CNA O with performing peri cares on R1 around 08:00 AM (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	on 03/22/26 and when doing so they noticed blood in the vaginal area of R1 and they reported it to the nurse and found out that night shift had reported it to the nurse, they also noticed wounds in the vaginal area. CNA P also said the AP was in the room and at the end of the bed watching and would always be present during cares. She also stated that she felt unsettled when performing cares on R1 and the AP was present. CNA P also said she reported her concerns with the AP to the charge nurse previously and was told to honor the AP's wishes of being present and let it be.On 03/30/26 at 11:55 AM, LN I stated she was the nurse on the south hall on 03/22/26 and she was notified by CNA O around 08:00AM that R1 needed to be seen by a nurse. She said she went to R1's room and saw that R1 had blood and dried blood around her vaginal area along with vaginal bruising, LN I then found LN H, the nurse for that hall, and reported to her that R1 had bleeding and bruising around the vaginal area and informed her that further assessment was needed after the CNAs had finished with cares and cleaned her. LN I then stated that after 02:00 PM she and LN H assessed R1 and discovered extensive bruising on her thighs and abdominal area and the vaginal bruising was darkened. LN I also said that the AP was always present, even during intimate cares, and would not make eye contact at that time. LN I then notified Administrative Nurse D of the situation.On 03/31/26 at 08:06 AM, LN G stated that prior to returning a call to the state agency for interview she had spoken to Administrative Staff A and Consultant HH regarding the survey investigation, she then said that CNA M informed her that R1 had bruising that went down her right leg but did not recall the time. LN G said she looked at the bruising and the AP was in the room with R1, the bruise appeared to be linear and old. LN G also reported that she looked at the bruise with the AP and he told her that it was from therapy, and she said that she believed it was from the wheelchair and said that she reviewed the EMR and said that the bruise was noted on 03/02/26. She also said that R1 would sit down hard and felt that that was the root cause of the bruising. LN G also stated that earlier in her shift the AP had told her that R1 had scratched her vaginal area and had a yeast infection, LN g had then provided CNA M antifungal cream and instructed him to clean R1 and apply the cream to the area but she did not asses this and she did not recall anything being reported to her about any injuries or bleeding when she received her shift report.On 03/31/26 at 12:55 PM, LN H stated she took R1's vital signs the morning of 03/22/26 but had not assessed her because she was busy with another resident. She did not remember anything about wounds being reported during shift report that morning.The facility policy Abuse, Neglect and Exploitation, dated 2025, documented that the the facility would have reporting procedures for all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified time frames. The policy further documented that the facility would report immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.By 03/24/26, prior to the onsite survey, the facility completed all corrective actions which included reeducation and training of staff regarding recognizing signs or potential abuse, and reporting signs of potential abuse to the facility Administrator immediately, and LE and SA within the required timeframes. The deficient practice was deemed past noncompliance and existed at G (isolated, actual harm).

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to implement protective measures after injuries of unknown origin and signs of potential sexual abuse were identified to prevent further abuse. On 03/21/22 at around 10:30-11:00 PM Certified (CNA) M and CNA N identified significant bruising on R1's right leg and reported it to Licensed Nurse (LN) G. R1 was unable to state how she obtained the injuries. LN G spoke to the resident's representative, the alleged perpetrator (AP), who confirmed he did not know where the bruising came from but offered a rationale for the injury which LN G accepted without further investigation. Staff left R1 in the room with the AP. Around 04:20 AM on 03/22/26, CNA M reported to LN G that R1 had vaginal bleeding. LN G did not assess R1 but instructed the CNA to apply an antifungal to R1's peri area. After the care was completed, staff left R1 alone in the room with the AP, with the door closed. At 06:00 AM, LN G told LN H and LN I that R1 had some vaginal bleeding, but the nurses did not assess the situation at that time. At 08:00 AM, CNA O provided peri care to R1 with the AP present, identified dried blood all over R1's vaginal area and reported it to LN I. At 08:30 AM LN I assessed R1, confirmed the dried blood and bruise on R1's labia and vaginal area. LN I left R1 in the room with the AP and reported her findings to LN I. Around 02:22 PM, LN H accompanied LN I to R1's room and assessed R1. They noted a large bruise on R1's right hip, purple bruises to R1's outer vaginal area and upward into the vagina with active bleeding. Staff notified Administrative Nurse D of the potential abuse at 03:00 PM; Administrative Nurse D notified Administrative Staff A at 03:25 PM. R1 remained in the room alone with the AP during those 16 hours.Findings Included: - Review of the Electronic Medical Record (EMR) documented R1 had diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (damage to the left hemisphere of the brain, typically resulting in right-sided body weakness and often speech/language deficits). R1's admission Minimum Data Set (MDS), dated [DATE], documented that R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. R1 required substantial to maximum assistance for eating and bathing and was dependent on staff for all other activities of daily living (ADL). She was able to communicate with clear speech. The MDS documented R1 had no signs of depression and no behaviors; she had no skin conditions. The Cognitive Loss/Dementia CAA, dated 01/28/26, documented it triggered secondary to R1's orientation, memory, and recall deficits noted during BIMS interview with contributing factors including short term/and long-term memory loss. R1's Care Plan, dated 02/03/26, documented that R1 liked to participate in individual and group activities and directed staff to provide R1 with an activities calendar and encourage her to participate in activities of her choice. R1's Care Plan did not address the AP's involvement in care and listed the other son as the Durable Power of Attorney (DPOA). R1's EMR lacked documentation regarding the bruising to R1's right hip and/or thigh, as reported to LN G by CNA O on 03/21/26. LN I's Nurse's Note dated 03/22/26 at 08:30 AM documented the nurse was called to R1's room by the CNA. The nurse observed dried blood on R1's labia and vaginal opening. The note documented R1 also had dark bruises present in that area and noted the resident's representative (AP) was concerned that R1 had some itching. LN I documented she reported the findings to R1's charge nurse [LN H]. LN H's Late Entry Nurse's Note dated 03/22/26 at 02:22 PM documented R1 had a large bruise on right hip, and small dark purple bruising to her outer vaginal opening and upward into the vagina with vaginal bleeding present. Staff notified Administrative Nurse D and called Emergency Medical Services (EMS). Staff called the hospital to request a same [sic] nurse (SANE-Sexual Assault Nurse Examiner) nurse be present to examine R1 due to the type of injury. LN I's Nurse's Note dated 03/22/26 at 02:33 PM documented she went with R1's charge nurse [LN H] and observed bruising on R1 that included vaginal bruising and a very large bruise on R1's right hip. There was also a small bruise on the right outer thigh. R1 was unable to say how she got the bruises but stated she did not have any itching. LN I notified Administrative Nurse D. Administrative Nurse D's Nurse's Note: Late Entry dated 03/22/26 at 11:20 (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	PM documented the nurse received report that R1 had vaginal bleeding and bruising. The initial assessment revealed a large bruise to R1's right hip and suspected bruising to the labia with small lacerations. The nurses completed an immediate follow-up assessment with a second licensed nurse due to concern for an injury of unknown origin. Administrative Nurse D documented she arrived at the facility within 15 minutes of receiving the report to assess the injuries and updated Administrative Staff A and the regional nurse of the report. A full head-to-toe skin assessment revealed the following findings: large ecchymosis (bruising) area noted to the right hip with surrounding smaller areas of bruising, scattered ecchymosis was present to bilateral lower extremities, bruising to lower abdomen extending from superior pubic area measuring approximately 6.5 centimeters (cm) x 4 cm, labial area with multiple dark maroon/purple areas of bruising surrounding vaginal opening with scattered petechiae (pinpoint red, purple, or brown spots caused by broken capillaries bleeding under the skin), small laceration noted to the posterior vaginal opening measuring approximately 0.2 cm, and shearing injury noted to the left labia measuring approximately 0.6 cm x 0.5 cm. Resident noted with vaginal bleeding at time of assessment. R1's EMR lacked further notes regarding the incident until 03/23/26 at 09:33 AM, a Social Services Note documented R1 was sent to the emergency room (ER) due to vaginal bruising. R1's second representative was aware of and agreeable to the transfer. The note documented the ER Transfer Form was sent to R1's second representative and a linked correction at 11:17 AM documented a correction and the form was sent to the AP. The facility's investigation signed by Administrative Staff A on 03/27/26 documented at around 10:10 PM on 03/21/26, CNA M and CNA N provided personal care to R1 with the AP present. The AP was R1's Durable Power of Attorney (DPOA) and primary caregiver when R1 was at home. The CNA staff noted bruising and reported it to LN G. The AP suggested the bruising could be from therapy and was unsure of its origin; there was no blood present at that time. At 04:20 AM on 03/22/26, the same CNA staff provided personal care to R1 with the AP present. There was bright red blood in R1's brief, on her labia and around the vaginal area. The AP suggested the bleeding might be due to itching and recommended medication to prevent itching; this was reported to LN G who instructed the CNA staff to apply antifungal powder, suspecting a yeast infection. The investigation documented that there was no labia bruising at that time. At 06:00 AM, LN G passed on the report of vaginal bleeding suspected to be caused from itching or a yeast infection to LN I and LN H and recommended contacting R1's provider. At 08:00 AM, CNA O provided personal care to R1 with the AP present. She noted dried blood on R1's labia and reported it to the nurses. LN I assessed R1, noted the blood, bruising on R1's hip and laceration to R1's labia, and suspected the injuries were caused by itching and with no suspicion of abuse. At 03:00 PM [sic], LN H and LN I conducted a two-nurse skin assessment. During this assessment the AP left the room, which was unusual because he typically remined present and observed care. The nurse noted a large bruise on R1's right hip and leg resembling the shape of a hand. Additional bruising and injuries were noted on the labia and vaginal areas, including maroon/purple bruising, a small laceration on the posterior vaginal opening and a circular skin abrasion resembling a shearing. The resident displayed increased anxiety during the assessment, repeatedly saying Oh God. The investigation noted R1 was unable to say what happened. The AP had been at the bedside and present during all cares over the previous 23 hours. CNA M's Notarized Witness Statement dated 03/22/26 documented on 03/21/26, he noticed some significant bruising down R1's right leg. CNA M noted he reported the bruising to the charge nurse and it was left as bruising from her wheelchair. He noted that later in the shift, he noticed some bleeding from the inside of her private area and a small black circle on one side of R1's labia that he thought was clotted blood but may have been a sore. CNA M's statement documented that he immediately reported it to the nurse but that it was not viewed by a nurse until the next shift came on. He documented that he reported the bruising to the nurse at around 10:30 -11:00 PM and the bleeding from the vagina at 04:20 AM. LN G's Notarized Witness Statement dated 03/22/26, documented that CNA M had informed her that it looked like R1 had been scratching at her vaginal area and blood on her brief. She documented (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	that the AP told her earlier in the shift R1 had been scratching around the abdominal and thigh folds. LN G noted that CNA M showed her some antifungal powder, and she instructed the CNA to apply antifungal cream to R1's labia. She also noted that earlier in the shift, CNA M had informed her that R1 had bruising down the side of her right hip and leg. The bruises were small and linear and appeared old, and the AP had said he thought they happened in therapy. It appeared to be in a line from where R1 would sit down in the wheelchair and didn't get centered. CNA O's Notarized Witness Statement, dated 03/22/26, documented that on 03/22/26 around 08:00 AM she and CNA P performed cares on R1 and noticed dried blood all over R1's vaginal area and she had CNA P remain with R1 while she notified the nurse. CNA O also documented that the AP remained in the room with R1 the entire time. CNA O also documented for the rest of the day the AP remained with R1 and acted jittery, nervous and anxious. CNA O further documented that she escorted and remained with R1 when she was transported to the hospital and while at the hospital R1 asked her why I let that man do that? It was not documented if this statement was reported. CNA P's Notarized Witness Statement, dated 03/22/26, documented that while she performed cares on R1, R1 grabbed her hand and stated Son, why would you do this to me? The statement did not document if this was reported. LN H's Notarized Witness Statement, dated 03/22/26, documented that she had been called into R1's room at 02:45 PM due to bruising on R1's right hip, right leg, posterior-outer labia and there was small sheering to R1's left inner labia; staff notified Administrative Nurse D. LN I's Notarized Witness Statement, dated 03/23/26, documented that she was called to R1's room by CNA O to observe blood on R1's peri-area and upon assessment she found dried blood on R1's labia and vaginal opening. LN I noted that she then reported this to LN H (R1's nurse), and that the AP was present during the assessment. LN I also documented that she assessed R1 with LN H later that afternoon and discovered dark bruised areas that were visible on R1's labia and into her vagina and there was bruising to the right hip and leg and bruising visible on the lower abdomen and what appeared to be a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma). LN I also documented that the AP would not make eye contact at that time and left the room for that assessment, and she notified Administrative Nurse D. CNA Q's Notarized Witness Statement, dated 03/24/26, documented when she performed cares and changed R1's wet brief the AP remained in the room and watched her actions closely. CNA Q's facility Witness Statement Form dated 03/24/26 documented that R1's room door was closed most of the time during 06:00 AM - 05:00 PM on 03/21/26 or 03/22/26, and that the AP was in R1's room during that time. LN H's facility Witness Statement Form dated 03/24/26, documented that she noticed that the AP was alone in the room with R1 and that he would remain in the room during cares and assessments. CNA R's facility Witness Statement Form dated 03/24/26, documented that the AP would remain in R1's room all the time unless he had to go home to do laundry or let animals out. She further documented that the AP left frantically after R1's injuries were noticed. CNA S's facility Witness Statement Form, dated 03/25/26, documented when her and another CNA were getting R1 up for the day and providing peri-care, R1 told them not to touch her and when trying to change her shirt R1 said, Stop that son. CNA O's facility Witness Statement Form dated 03/25/26, documented on 03/22/26, the AP remained in the room when cares were provided at 08:00 AM and remained in the room with R1 with the door closed after cares were completed at 08:30 AM. CNA O further documented the AP remained alone in the room, with the door closed, as cares were completed at 11:30 AM and remained in the room during the cares. LN G's facility Witness Statement Form dated 03/25/26, documented that during her shift on she took R1's vitals and performed her skilled assessment and that it did not take very long. LN G also documented that the AP would spend the night with R1 and he kept the door shut. CNA M's facility Witness Statement Form dated 03/26/26, documented that the AP would usually stay in the room when care was provided to R1 and that the AP would stay in R1's room all night with the door closed. On 03/30/26 at 09:40 AM, Administrative Staff A stated that the incident occurred on the night of 03/22/26 [sic] and R1 was sent to the hospital in [NAME], Missouri and the hospital refused to perform the SANE examination (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175233	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Galena Nursing & Rehab Center	1220 E 8th Street Galena, KS 66739

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F 0610 Level of Harm - Actual harm Residents Affected - Few	because they did not get consent from R1's legal representative because he had left. R1 was then released and sent back to the facility and Administrative Staff A then took R1 to the hospital in Pittsburg, KS and they informed her that they did not have a qualified SANE nurse to perform the proper examination. Administrative Staff A returned to the facility and coordinated with local LE, and she then took R1 to the county Health Department, along with local LE, and the health department performed the SANE examination. She said that staff had not reported concerns about the DPOA prior to this incident. On 03/30/26 at 10:12 AM, Administrative Staff A stated she was notified of the incident at 03:25 PM on 03/22/26. She also said that the AP never did anything suspicious, but she did have an odd vibe regarding him. She also said that there had never been any complaints about the AP with this visit or previous visits. Administrative Staff A reported that every time the AP stayed, which was 24/7, the door would remain closed, and this happened with this stay and the previous two stays; he would only leave for 30 minutes to an hour and would return. On 03/30/26 at 10:20 AM, Administrative Nurse D stated that she was notified by staff around 03:00 PM on 03/22/26 of suspected abuse with R1 and she proceeded to go to the facility and notified Administrative Staff A around 03:25 PM while she was driving to the facility; she further said that she should have been notified much sooner about the injuries to R1. She also said the AP would act fidgety and nervous anytime staff would interact with him or when cares were performed, and he would stand next to staff or at the end of R1's bed when cares were performed and staff had reported that he would often interrupt and take over cares which included incontinent cares. She said that staff reported to her that they felt awkward performing cares on R1 while the AP was present. When Administrative Nurse D arrived on the evening of the allegations, the AP was present and acted more nervous than usual. On 03/30/26 at 10:37 AM, CNA O stated that she another CNA (CNA P) performed peri-care on R1 around 08:00 AM on 03/22/26 and there were small cuts/lacerations around R1 vaginal area but did not notice bruising because she kept R1 covered for dignity and warmth. She said that the AP was present in the room and was standing at the foot of the bed watching the cares be performed. CNA O then informed the other CNA to remain with R1 and she then immediately notified the charge nurse (LN I) and LN I immediately arrived and examined R1 and told the CNAs that it was reported the night before that there was vaginal bleeding. CNA O also stated that there were several times that she felt awkward and uncomfortable with the AP and he would get upset and refuse to leave when asked. CNA O had reported her discomfort and concerns to the charge nurse more than once and the response she received was that they did not take it seriously and nothing was done. On 03/30/26 at 10:55 AM, CNA P stated that she assisted CNA O with performing peri-cares on R1 around 08:00 AM on 03/22/26 and when doing so they noticed blood in the vaginal area of R1 and they reported it to the nurse and found out that night shift had reported it to the nurse, they also noticed wounds in the vaginal area. CNA P also said that the AP was in the room and at the end of the bed watching and would always be present during cares. She also stated that she felt unsettled when performing cares on R1 and the AP being present. CNA P also said that she had reported her concerns with the AP to the charge nurse previously and was told to honor the AP's wishes of being present and let it be. On 03/30/26 at 11:55 AM, LN I stated she was the nurse on the south hall on 03/22/26 and she was notified by CNA O around 08:00 AM that R1 needed to be seen by a nurse. She said that she went to R1's room and saw that R1 had blood and dried blood around her vaginal area along with vaginal bruising, LN I then found LN H, the nurse for that hall, and reported to her that R1 had bleeding and bruising around the vaginal area and informed her that further assessment was needed after the CNAs had finished with cares and cleaned her. LN I then stated that after 02:00 PM she and LN H assessed R1 and discovered extensive bruising on her thighs and abdominal area and the vaginal bruising was darkened. LN I also said the AP was always present, even during intimate cares, and would not make eye contact at that time. LN I then notified Administrative Nurse D of the situation at that time. On 03/31/26 at 08:06 AM, LN G stated that prior to returning a call to the State Agency for interview she had spoken to Administrative Staff A and Consultant HH regarding the survey investigation, she then (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	said that CNA M informed her that R1 had bruising that went down her right leg but did not recall the time. LN G said that she looked at the bruising and the AP was in the room with R1, the bruise appeared to be linear and old. LN G also reported that she looked at the bruise with the AP and he told her that it was from therapy, and she said that she believed it was from the wheelchair and said that she reviewed the EMR and said that the bruise was noted on 03/02/26. She also said that R1 would sit down hard and felt that that was the root cause of the bruising. LN G also stated that earlier in her shift the AP had told her that R1 had scratched her vaginal area and had a yeast infection, LN G said she provided CNA M antifungal cream and instructed him to clean R1 and apply the cream to the area but she did not asses this and she did not recall anything being reported to her about any injuries or bleeding when she received her shift report. LN G confirmed she had not suspected abuse so had not reported the bruising or vaginal bleeding to anyone except the oncoming shift. On 03/31/26 at 12:55 PM, LN H stated she took R1's vital signs the morning of 03/22/26 but had not assessed her because she was busy with other residents and did not remember anything about wounds being reported during shift report that morning. LN H also said that she was called into R1's room around 02:30 PM in the afternoon on 03/22/26. On 04/01/26 at 02:07 PM, email correspondence was received from Consultant HH contained a Late Entry Nurse's Note with an effective date of 03/21/26 and time of 11:15 PM that was entered on 03/30/26 at 06:43 PM by LN G, after the surveyor had completed interviews with Administrative Staff A and Administrative staff D and other staff. The Late Entry Nurse's Note documented that the CNA had notified the nurse that R1 had bruising that ran down the right side of her leg. When the nurse went to R1's room the AP was at the bedside, and both appeared relaxed and were watching television. The nurse observed a row of small, old purplish, fading bruises that ran down the back side of her right-lower-extremity and started from the upper thigh/hip region. The nurse had asked the son if he knew what had happened and he told her he thought it could have been from something done in therapy. They also talked about how R1 tended to lean towards the right and did not completely get centered in the wheelchair during her transfer. It appeared as if R1 had attempted to sit down in the wheelchair and bumped the arm rest of the wheelchair due to linear appearance. R1 took blood thinning medications Plavix (a medication used to prevent blood from clotting) and aspirin (a medication used to thin blood) which can cause bruising more easily. The AP reported to the nurse that R1 had been scratching herself around the peri-area. Later in the shift the CNA told the nurse that while performing peri care it had appeared that she had been scratching around her vaginal area due to redness and scant amounts of blood on the brief. The nurse reported the findings to the oncoming day shift so they could attempt to notify the on-call or on the list to be seen during the Monday morning rounds. The facility policy Abuse, Neglect and Exploitation, dated 2025, documented that the facility would implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation. The policy further documented that the facility would ensure the health and safety of each resident regarding visitors such as family members or resident representatives. The likelihood of a serious adverse outcome is evidenced by the existence of physical sexual abuse injuries which progressed during the time the resident was left alone with the AP as well as the likelihood for severe psychosocial trauma related to sexual abuse. By 03/24/26, prior to the onsite survey, the facility completed all corrective actions which included reeducation and training to staff regarding recognizing signs or potential abuse and implementing immediate protective measures to prevent further abuse. The facility additionally implemented a visitors log to monitor visitors inside the facility including an individual log for R1 to ensure only authorized visitors attend R1. The deficient practice was deemed past noncompliance and existed at G (isolated, actual harm).