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	06/24/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the Long-Term Care Ombudsman in writing of Resident (R) 41's discharge to the community. Findings included: -The Entry Minimum Data Set (MDS), dated [DATE], documented the resident admitted to the facility on [DATE]. R41's 05/19/2026, Medicare 5-day MDS revealed the resident had a Brief Interview for Mental Status, (BIMS) score of 15, indicating intact cognition. It further revealed an anticipated discharge date of three or fewer months. R41's Discharge MDS, dated 05/20/2026, documented the resident discharged to the community on 05/20/2026. A Social Service Progress Note, dated 05/15/2026 at 02:37 PM, revealed Social Service Staff X spoke with the resident regarding a projected discharge date of 05/26/2026. A Social Service Progress Note, dated 05/19/2026 at 2:24 PM, revealed R41 requested to discharge from the facility on 05/20/2026. The note revealed R41's physician wrote the discharge order. A Nursing Progress Note, dated 05/20/2026 at 10:47 AM, revealed R41 discharged from the facility to the community and left via private transport. Review of the monthly Ombudsman Discharge/Transfer Notification Log, for May 2026 lacked notification of R41's discharge on [DATE]. During an interview on 06/23/26 at 02:30 PM, Social Service Staff X confirmed she did not notify the ombudsman when residents discharged to the community. She stated she notified the ombudsman if residents went to the emergency room, and was not aware she should notify the ombudsman of discharge of residents to their home or community in her monthly report. Review of the facilities policy titled Transfer and Discharge (including AMA (Against Medical Advice)), dated 2025, revealed the facility would provide transfer/discharge notification to the ombudsman as indicated including non-emergency transfers and discharges.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to provide appropriate activity of daily living (ADL) cares for three dependent Residents (R) 3, R24, and R9, who had long, jagged, dirty nails. Findings included:1. R3's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R3's Significant Change Minimum Data Set (MDS), dated [DATE], documented R3 had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She was dependent on staff for personal hygiene. R3's Activity of Daily Living (ADL) Care Area Assessment (CAA), dated 04/16/2026, did not trigger. R3's Modification of the Quarterly MDS, dated [DATE], documented the resident had a BIMS score of three, indicating severe cognitive impairment. She required substantial to maximal staff assistance with personal hygiene. R3's Care Plan, revised 06/23/2026, instructed staff R3 was dependent for personal hygiene cares. R3's EMR under the Task tab, from 05/26/2026 through 06/23/2026 (30 days), documented R3 was dependent on staff for personal hygiene, including nail care. On 06/22/2026 at 10:31 AM, R3 sat in her wheelchair in the front commons area. She had long, jagged, dirty fingernails. On 06/23/2026 at 07:50 AM, R3 continued to have long, jagged, dirty fingernails. 2. R9's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R9's admission Minimum Data Set (MDS), dated [DATE], documented R9 had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She was dependent on staff for personal hygiene. R9's Activity of Daily Living (ADL) Care Area Assessment (CAA), dated 04/16/2026, did not trigger. R9's Quarterly MDS, dated [DATE], documented a BIMS score of three, indicating severe cognitive impairment. She was dependent on staff for personal hygiene. R9's Care Plan, revised 06/01/2026, instructed staff R9 was dependent on staff for personal hygiene. R9's EMR under the Task tab, from 05/25/2026 through 06/22/2026 (30 days), documented R9 was dependent on staff for personal hygiene, including nail care. On 06/22/2026 at 09:49 AM, R9 sat in her wheelchair in front of the nurse's station. Her fingernails were long, jagged, and dirty. On 06/22/2026 at 02:30 PM, Certified Nurse Aide (CNA) M and CNA N provided R9 with peri-care before taking in her wheelchair back to sit in front of the nurse's station. R9s continued to have long, jagged, dirty fingernails. On 06/23/2026 at 07:50 AM, R9 sat at the dining table eating breakfast. Her fingernails remained long, jagged, and dirty. On 06/22/2026 at 02:30 PM, CNA M stated staff provided nail care on their shower days. On 06/23/2026 at 07:50 AM, R3 continued to have long, jagged, dirty fingernails. 3. R24's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R24's admission Minimum Data Set (MDS), dated [DATE], documented R24 had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She was dependent on staff for personal hygiene. R24's Activity of Daily Living (ADL) Care Area Assessment (CAA), dated 04/16/2026, did not trigger. R24's Care Plan, revised 06/07/2026, instructed staff R24 required substantial to maximal staff assistance with personal hygiene. R24's EMR under the Task tab, from 05/25/2026 through 06/22/2026 (30 days), documented R24 required partial to moderate staff assistance with personal hygiene, including nail care. On 06/23/2026 at 07:50 AM, R24 sat in her wheelchair at the dining table eating breakfast. Her fingernails were long, jagged, and dirty. On 06/24/2026 at 09:10 AM, R24 was participating in therapy. Her fingernails remained long, jagged, and dirty. On 06/23/2026 at 02:13 PM, Certified Nurse Aide (CNA) N stated staff do nail care on the resident's shower days and as needed (PRN). On 06/24/2026 at 09:20 AM, CNA O stated staff do nail care on resident's shower days. On 06/24/2026 at 02:57 PM, Administrative Nurse D stated it was the expectation for staff to ensure resident's fingernails are kept smooth and clean at all times. The facility's undated Resident Rights policy included: Residents have the right to a dignified existence with access to persons and services inside and outside of the facility.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two Residents (R)3 and R9 remained free from unnecessary medications related to blood pressure medication. Findings included: - R3's Electronic Medical Record (EMR), included the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion) and hypertension (elevated blood pressure). R3's Significant Change Minimum Data Set (MDS), dated [DATE], documented she had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. R3's Care Plan, revised 06/23/2026, instructed staff to obtain blood pressure (BP) readings, as ordered. R3's EMR under the Orders tab included the following physician's orders: Clonidine (a HTN medication), 0.1 milligrams (mg), by mouth, as needed (PRN), every day, for a systolic blood pressure (SBP- the top number of a BP reading), greater than 160, one hour after medications, for a diagnosis of hypertension, ordered 01/14/2026. Obtain BP one hour after the administration of medications, ordered, 01/14/2026 R3's June Medication Medical Record (MAR), 2026, documented the following BPs taken one hour after the administration of hypertensive medications and the PRN Clonidine medication was not administered: On 06/11/2026, R3's BP was 163/75. On 06/13/2026, R3's BP was 170/88. On 06/14/2026, R3's BP was 164/78. On 06/21/2026, R3's BP was 193/67. On 06/24/2026 at 02:30 PM, Certified Medication Aide (CMA) R stated the PRN medication should have been given but was not. On 06/24/2026 at 02:57 PM, Administrative Nurse D confirmed the PRN medication had not been administered, as ordered. - R9's Electronic Medical Record (EMR) documented a diagnosis of hypertension (elevated blood pressure). R9's admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. R9's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 04/16/2026, documented the resident had short-term memory loss. R9's Quarterly MDS, dated [DATE], documented she had a BIMS score of three, indicating severe cognitive impairment. R9's Care Plan, revised 06/01/2026, instructed staff to administer her cardiac medications, as ordered. R9's EMR under the Orders tab included the following physician's order: Norvasc (a hypertensive medication), 2.5 milligrams (mg), by mouth, every morning, for a SBP greater than 155; hold the medication if the SBP is below 155, ordered, 05/04/2026. R9's June Medication Medical Record (MAR), 2026, documented the following BPs taken before the administration of Norvasc: On 06/07/2026, R9's BP was 153/74. On 06/14/2026, R9's BP was 144/65. On 06/20/2026, R9's BP was 150/74. The June MAR for R9 documented Norvasc 2.5 mg was given on the above dates and the SBP was under 155 reading and should have been held by staff. On 06/24/2026 at 02:30 PM, Certified Medication Aide (CMA) R stated the PRN medication should have been held per the order. On 06/24/2026 at 02:57 PM, Administrative Nurse D confirmed the PRN medication had not been administered, as ordered. The facility policy for Following Physician/Practitioner Orders included: The facility shall provide care and services in accordance with each resident's physician orders.

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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 utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which require targeted gown and glove use during high contact care) when providing direct care for Resident (R) 13 and 7 who had wounds and R1 for catheter care. Findings Included: - On 06/22/2026 at 11:27 AM, R1 rested in bed with the urinary catheter collection bag directly on the floor. The collection bag contained approximately 400 milliliters (mLs) of dark brown, tea colored urine. The door into R1's room had signage that read, This room is under Enhanced Barrier Precautions. The signage educated staff further on what to wear for Personal Protective Equipment (PPE) when in contact with wounds, urinary catheters, and infections, which included gown and gloves. On 06/22/2026 at 11:30 AM, Certified Medication Aide (CMA) L confirmed the catheter collection bag was directly on the floor and should be positioned off the floor. CMA L revealed the catheter bag would be sanitized after the contents of the bag were emptied. On 06/22/2026 at 11:31 AM, Licensed Nurse (LN) H entered the resident's room and CNA L notified LN H the residents full catheter bag was directly on the floor. CNA L held the full catheter bag in her ungloved hand. LN H instructed CNA L to sanitize the catheter collection bag. CNA L sanitized her hands, applied gloves retrieved a collection cylinder and emptied the urine from the resident's catheter bag without wearing a gown. On 06/22/2026 at 11:52 AM, R13 sat in the wheelchair (w/c) going through his dresser drawers. R13 had clean and intact dressings on bilateral legs from mid shin to ankles. His right leg had an uncovered, open lesion, with bright red blood and raised skin above the dressing. He reported prior to coming to the facility his legs blistered and broke open. He further stated he scratched the areas. R13 stated he had fluid retention in his legs and the fluid leaked out. R13 stated the staff use gloves when performing changes on his leg and during cares. He stated staff did not wear gowns during cares. On 06/23/2026 8:08 AM, R13's dressings to lower bilateral legs were clean and intact. Certified Nurse Aide (CNA) M and CNA O entered the resident room, sanitized hands and applied gloves. Staff failed to apply an isolation gown. CNA M and CNA O confirmed prior to entering the room staff should apply PPE. CNA O and CNA M reported R 13 did not have an infection, so they did not use gowns when providing care for R13. On 06/24/2026 at 11:10 AM, CNA O and CNA Q entered the resident's room with the full body lift to transfer R13 from the w/c to his bed. Staff failed to apply a gown prior to providing direct care with the resident. When asked by the surveyor, both CNA O and CNA Q applied gowns before continuing with the transfer. CNA O noted bright red blood on his glove and asked R13 where it came from. R13 stated it was his leg. Observation revealed R13 bleeding above the dressing on his right lower leg. Staff removed and disposed of PPE and sanitized hands prior to leaving the room. On 06/24/2026 at 11:40AM, Administrative Nurse D and Licensed Nurse (LN) H entered the resident's room. LN H sanitized her hands, applied a gown and gloves and informed R13 she was going to change his leg dressing. She attempted to remove the dressing from R13's left leg manually and could not get it loosened. She reported she did not bring her scissors with her. Administrative Nurse D left the room to retrieve bandage scissors from the desk and returned to the room and handed them to LN H. LN H placed the scissors blade directly under bandage of the left lower leg in direct contact to the leg. On inquiry, LN H stated she did not sanitize the scissors prior to removing the dressing to R13's left leg. LN H stated R13 scratched his legs and these areas were new. LN H did not place a dressing over the new areas to contain the wound and prevent exposure. LN H confirmed the open areas above the left leg dressing had multiple open superficial wounds from mid- calf to his knee, with exposed wound bed and blood present. LN H failed to remove gloves, sanitize hands, and apply new gloves and failed to sanitize scissors before she removed the blood-stained dressing from the right lower leg. LN H placed the bloody dressing on the side of the bed adjacent to residents left leg. LN H obtained clean dressing supplies from the resident's dresser with the same gloved hands. LN H removed old gloves, sanitized her hands, and applied new gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and cleansed the wounds on both legs with the same gloved hands. LN H sprinkled a white powdered substance on both lower legs and applied a non-adhesive dressing to the top of both lower legs. LN H then wrapped the legs with rolled gauze. LN H failed to sanitize hands and re-glove between the application of dressings to each lower leg. Administrative Nurse D instructed LN H that the new area should have a dressing to prevent exposure. LN H measured the right lower leg wound and applied a dressing to the wound. LN H failed to sanitize hands and change gloves prior to applying the dressing. On 06/24/2026 at 01:30 PM, Therapy Staff CC reported he provided upper body strengthening and range of motion modalities to R13 that he did not use enhanced barrier precautions to include gowns because the resident wounds were on his lower legs. On 06/24/2026 at 02:30 PM Administrative Nurse D and Consultant GG provided a resident roster indicating which residents were on Enhanced Barrier Precautions and the indication. The facility confirmed there were six current residents at EBP. Staff confirmed that during direct cares, staff must wear gowns and gloves. Review of the 01/2026 facility policy Enhanced Barrier Precautions documented Enhanced Barrier Precautions should be used when a resident has a wound that should be covered to contain and prevent increased potential for environmental contamination and risk for transmission of a pathogen. EBP includes hand sanitizing, gloves, and gown use. This should be completed prior to the entrance of the resident's room when performing transfers, working with residents in the therapy gym and participation in close physical contact.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interview, the facility failed to provide housekeeping and maintenance services to ensure a safe and sanitary environment in the facility laundry. This created the risk of impaired safety and cleanliness. Findings included: - On 06/23/2026 at 02:032 PM, laundry tour with Laundry Staff U revealed the following concerns:The soiled laundry area had an area of sheet rock that measured approximately three inches by two inches that was gouged and unable to be sanitized.The ceiling vent had peeling paint surrounding it.The floor near the sewer drains covered with metal plates had four broken floor tiles. The tiles had brown residue and debris embedded in the broken areas of the tile.The base of washing machine number one had rust that was unable to be sanitized.The base of washing machine number two had rust and missing flooring. The washing machine base had brown debris near the bottom. This area was unable to be sanitized.There were multiple broken and missing floor tiles and build-up behind washing machine number two. Interview at this time with Laundry Staff U stated the previous laundry chemical dispenser leaked and the flooring was pulled up on 03/17/2026.A wall mounted folding table had missing laminate surrounding the outer edge of the table and was unable to be sanitized. The table was used for residents' personal laundry and linens.Three wall mounted shelves used for storing clean laundry/linen with unsealed bare wood.An area of the baseboard was loose from the wall and dust, and debris was observed behind the loose board. On 06/23/2026 at 02:58 PM, Administrative Staff A and Maintenance Director V joined the tour and confirmed above findings.On 06/24/2026 at 03:26 PM, Administrative Staff A reported the facility lacked a policy to address the identified concerns with maintenance repair and sanitation of the laundry.