STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185360	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gallatin Nursing and Rehab	499 Center Street Warsaw, KY 41095

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, record review, and review of facility policy, the facility failed to sufficiently monitor residents for behaviors that might cause a reaction in other residents, such as cursing or physically slapping another resident, for 2 of 42 sampled residents, (Resident (R)118 and R78). The findings include:1). Review of the facility's, admission Record revealed the facility admitted R118 on 03/21/2018, with a medical history that included diagnoses of Parkinson's disease, schizoaffective disorder bipolar type, anxiety disorder, and borderline intellectual functioning. Further review of the admission Record revealed R118 was discharged from the facility on 12/17/2025.Review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 11/02/2025, revealed the facility assessed R118 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. Further review of the MDS revealed the facility assessed R118 to have exhibited no behaviors during the assessment lookback period.Review of the facility's Care Plan Report, for R118 revealed it included a focus area initiated 04/12/2021, that noted the resident had significantly complex behavioral symptoms. Per review, the interventions included staff to encourage activities as the resident would allow and to firmly redirect when R118 displayed demanding or aggressive behaviors. Continued review of the Care Plan Report revealed it included a focus area initiated 06/21/2021, R118 needed assistance with activities of daily living (ADLs), with interventions that included staff to redirect the resident's behaviors as the resident was unaware of social norms.2). Review of the admission Record for R78 revealed the facility admitted the resident on 05/08/2025, with a medical history that included diagnoses of unspecified dementia with other behavioral disturbances, unspecified mood disorder, and depression.Review of the Quarterly MDS Assessment, with an ARD of 01/06/2026, revealed the facility assessed R78 to have a BIMS score of 12 out of 15, which indicated moderate cognitive impairment. Review of the facility's Care Plan Report, for R78 revealed it included a focus area for behavior initiated 05/20/2025, that noted the resident could be unpleasant and flat related to placement in the long term care facility. Further review revealed the interventions included for staff to report any declines and report any behaviors to social services (SS).Review of the facility's, Initial Report, dated 11/03/2025, revealed R 118 and R78 were in the dining room on 11/03/2025 at 3:35 PM. Per review, R78 made contact with R118 with their open hand. Review of the facility's, Final Report/5 Day Follow-up, dated 11/06/2025, revealed there were no witnesses to the incident that occurred on 11/03/2026, involving R118 and R78. Continued review of the Report revealed R78 stated she hit R118 after R118 called her a name. Review of the facility's typed document titled, 11/3/25 reportable statements, revealed R118 reported she wheeled towards R78 to ask if there was anyone in the kitchen as she wanted a drink. Continued review of R118's statement revealed R78 did not answer her, so she kept asking the same question. Per review of R118's statement, R78 continued to not answer, which upset R118. Further review of R118's statement revealed she called R78 an expletive and then R78 slapped R118 in the face. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the facility's 11/3/25 reportable statements, document revealed R78 reported she purposely ignored R118 and R118 called her an expletive. Further review of R78's statement revealed she slapped R118 in the face.In interview on 01/29/2026 at 8:50 AM, Licensed Practical Nurse (LPN) 1 stated she led the investigation into the resident-to-resident allegation involving R118 and R78. LPN 1 said upon being notified of the incident, the residents had already been separated and were safe. She stated she notified the Administrator. LPN 1 explained R118 reported R78 hit her while they were in the doorway to the dining room. LPN 1 reported R118 and R78 had no history of being provoked by each one another before the incident. She further stated when she interviewed R78, the resident said she hit R118 after R118 called her an expletive.During interview on 01/29/2026 at 9:46 AM, Activities Assistant (AA) 3 stated on the day of the incident involving R118 and R78 she had been sitting at her desk, which was located inside the dining room. She said she heard R118 yell out; however, had not known R118 had entered the dining room. She explained she had not heard any conversation between the two residents. AA 3 reported R118 said R78 slapped her and said R78 admitted doing that. She said she immediately notified the Social Services Director (SSD) and LPN 2, who came to the dining room. AA 3 further stated R78 said she told R118 to stop hollering and then R118 called her an expletive, so she slapped R118.In interview on 01/29/2026 at 9:56 AM, the SSD stated she had been called to the dining room for an alleged resident-to-resident incident. She said when she arrived in the dining room R118 had already wheeled herself to go get a drink. The SSD reported when she interviewed R78 the resident said she slapped R118 but did not say where the slap had been. She explained staff asked R78 to demonstrate the slap, and the resident displayed an open hand to the left side of the cheek. The SSD stated she interviewed R118 who admitted to calling R78 an expletive but had not been bothered by the incident. She additionally said there had been no red marks observed on R118's face. During interview on 01/29/2026 at 2:06 PM, the Director of Nursing (DON) stated AA 3 had been in the dining room at the time of the incident involving R78 and R118. She said AA 3 heard the commotion of R118 trying to get a drink. The DON stated LPN 1, the SSD, and AA 3 all reported to her that R78 said she slapped R118. She further stated both residents reported the incident occurred; however, no staff members witnessed it, and the assessment of R118 did not reveal physical contact had been made.During interview on 01/29/2026 at 2:32 PM, the Administrator stated on the day of the incident, R118 had been looking for a drink and asked another resident (R78) if staff were in the kitchen. She said when R78 did not respond R118, the resident called R78 an expletive, and R78 responded in a physical nature. The Administrator reported to the best of her knowledge, R78 made contact, but the event was not witnessed, and the skin assessment had not shown any signs of contact. She further stated based on the facility's interview with R118, R78 had slapped her in the face.