STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N031003	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Senior Life	**1417 W ASH ST , JUNCTION CITY, Kansas, 66441**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	INITIAL COMMENTS The following represents the findings of a resurvey at the above-named assisted living facility conducted 03/25/26-03/26/26.	S0000		
S3085 SS = E	Negotiated Service Agreement CFR(s): 26-41-202 (a) (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-202(a)(1)(2) The facility reported a census of 12 residents with three residents included in the sample. Based on interview, observation, and record review the administrator failed to ensure the Negotiated Service Agreement (NSA) was fully developed based on the resident's Functional Capacity Screen (FCS), service needs, and preferences for resident (R)1, R2, and R3 including a description of the services the resident received and the provider of each service. Findings included:	S3085		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S3085 SS = E	Continued from page 1 - Record review for R1 revealed an admission date of 10/27/25 with diagnoses including Autistic disorder, dementia, and diabetes mellitus type two. The 10/27/25 FCS identified R1 required supervision with bathing; physical assistance with management of medications and treatments; was independent with dressing, toileting, transfers, mobility, and eating; had short-term memory, long-term memory, and memory recall difficulties; and was at risk of falls and had impaired vision. The 10/27/25 NSA acknowledged facility staff provided setup of medications. R1 needed assist with the part of dressing including putting on shoes and setup of showers but lacked provider of the service. He could perform activities of daily living by self. The NSA/HSP failed to describe services provided for cognition difficulties, prevention of falls, and impaired vision. The 10/27/25 “Service Plan Report” which is the facility’s Healthcare Service Plan (HSP) instructed staff to remind R1 of daily activities for cognition. The HSP failed to include instructions to staff for dressing, including putting on shoes, and for setting up and supervising R1’s showers. - Record review for R2 revealed an admission date of 06/18/22 with diagnoses of mild cognitive impairment, cerebral aneurysm, dysphagia, depression, and urinary incontinence. The 07/15/25 FCS identified R2 required supervision with bathing; was independent with transferring, mobility, dressing, toileting, and eating; required assistance with management of medications and treatments; had short-term memory, memory recall, and decision-making difficulties; was at risk of falls; and had impaired vision and decision making. The 07/15/25 NSA identified R2 needed supervision with bathing and assist with washing back and hair without who provided the service, and she required assistance with peri care at times without who provided the service. R2 was able to self-administer insulins after setup. The NSA failed to describe services provided or provider for impaired vision, impaired decision making,	S3085		

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S3085 SS = E	Continued from page 2 or prevention of falls. The 07/15/25 HSP instructed staff to cue and redirect R2 when she was confused and trying to help others and staff were to make sure stool is not unattended in laundry room to prevent falls. R2 was to wear shoes on outings, ask for assistance with arranging items, and sleep in middle of bed without instructing staff what to do with each of these interventions. Review of nurse note dated 03/21/26 at 20:34 PM documented R2 tried to go to the bathroom on 03/20/26 and 03/22/26 and slid off the edge of her bed. No intervention was documented to prevent future recurrence or falls. On 03/26/26 at approximately 12:55 PM R2 stated she injects her insulin after staff prepares the pen. She mentioned a restriction in activities she used to enjoy like planting due to her frequency of falls. On 03/26/26 at 12:25 PM Administrative Staff B stated R2 required physical assistance with her shower by staff. - Record review for R3 revealed an admission date of 12/30/25 with diagnoses of fibromyalgia, unsteadiness on feet, and atrial fibrillation. The 12/31/25 FCS identified R3 required supervision with bathing, physical assistance with management of medications, and was independent with toileting, transfers, walking/mobility, and eating. She was occasionally incontinent of urine; had long-term memory and memory recall cognitive difficulties and at risk of falls. The 12/31/25 NSA identified R3 was provided supervision with bathing and reminder to get up in the morning without listing who provided the service. Staff managed medications according to the NSA. The NSA failed to include services provided to prevent falls. The 12/31/25 HSP failed to instruct staff how to prevent R3 from falling. The HSP documented R3 required setup for bathing without listing who was responsible.	S3085		

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S3085 SS = E	Continued from page 3 On 03/26/26 at approximately 11:54 PM Administrative Staff B confirmed R1, R2, and R3's NSAs failed to describe the services provided and providers of services listed on the NSA. The administrator failed to ensure R1, R2, and R3's NSAs described the services they received, and the provider of the service based on their FCS.	S3085		
S3175 SS = E	Self Administration of Medication CFR(s): 26-41-205 (a) (1) (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 12 residents with three included in the sample. Based on interview and record review the administrator failed to ensure a licensed nurse performed an assessment to determine if Resident (R) 1 and R2 could self-administer medications safely. Findings included: - Record review for R1 revealed an admission date of 10/27/25 with diagnoses including Autistic disorder, dementia, and diabetes mellitus type two. The 10/27/25 Functional Capacity Screen (FCS) identified R1 required physical assistance with management of medications and treatments.	S3175		

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S3175 SS = E	Continued from page 4 The 10/27/25 Negotiated Service Agreement (NSA) acknowledged facility staff provided setup of medications. The 10/27/25 “Service Plan Report” which is the facility’s Healthcare Service Plan (HSP) failed to instruct staff regarding medication administration. Review of R2's record revealed the lack of documentation a self-medication administration assessment was completed. On 03/26/26 at approximately 01:30 PM R1 stated he injected his own insulin after staff dialed up the dose. - Record review for R2 revealed an admission date of 06/18/22 with diagnoses of mild cognitive impairment, cerebral aneurysm, dysphagia, depression, and urinary incontinence. The 07/15/25 FCS identified R2 required assistance with management of medications and treatments. The 07/15/25 NSA identified R2 was able to self-administer insulins after setup. The 07/15/25 HSP documented “I [R2] am able to self administer my insulin after set up.” R2's record lacked evidence of documentation a medication self-administration assessment to administer insulin was completed. On 03/26/26 at approximately 01:32 PM R2 stated she administered insulin to herself when the staff brought it to her room. On 03/26/26 at 11:40 AM Administrative Nurse C confirmed staff prepared insulin pens for residents to self-inject and confirmed she had never completed self medication administration assessments for residents who self-administer insulin.	S3175		

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S3175 SS = E	Continued from page 5 On 03/26/26 at 11:45 AM Administrative Staff B confirmed R1 and R2's records lacked medication self-administration assessments. The administrator failed to ensure a licensed nurse performed an assessment to determine if R1 and R2 could self-administer medications safely.	S3175		
S3215 SS = F	Medication Storage CFR(s): 26-41-205 (h) (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-205(h) The facility reported a census of 12 residents. Based on observation and interview, the administrator failed to ensure medications were stored in accordance with	S3215		

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S3215 SS = F	Continued from page 6 each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations. Findings included: - Observation on 03/25/26 at 11:44 AM of the medication cart which contained medications for residents revealed the following medications: One tube 45-gram metronidazole 0.75% expired 12/2025 One 30-tablet card of naproxen 220 milligrams with 2 tablets left expired 03/28/25 One 30-tablet card of loratadine 10 milligram tablet expired 02/27/26 On 03/25/26 at approximately 11:48 AM Administrative Nurse C confirmed the medications were past date of use. - Observation on 03/25/26 at approximately 12:05 PM revealed the medication room had a refrigerator with two boxes of multi-dose vials of tuberculin. One was opened and contained an unsealed vial of tuberculin and lacked a date to indicate when it was opened, the other was labeled with an open date of 04/28/25. The boxes and the vials of tuberculin instructed to discard 30 days after opening. On 03/25/26 at approximately 12:10 PM Administrative Nurse C confirmed the tuberculin vials were opened and not dated or past the discard date. The facility's 01/15/25 "Medication Storage in the Facility" policy explained medications were stored following manufacturer or supplier recommendations. The policy instructed staff to immediately withdraw and dispose of medications that were outdated. The administrator failed to ensure medications were stored in accordance with each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations.	S3215		