STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175100	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	**2800 WILLOW GROVE ROAD , MANHATTAN, Kansas, 66502**

(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
F0000	INITIAL COMMENTS The following citations represent the findings of a Partial Extended, Complaint Survey regarding allegations in complaint investigation(s) 2726253 and 273532 on 02/24/26. On 02/24/26 at 02:05 PM the facility was provided the Immediate Jeopardy template and informed the facility failure to ensure R1 remained free from a significant medication error, when staff administered another resident's medication to R1 and R1 required emergent administration of Narcan and admitted to the ICU with unintentional overdose, placed R1 in immediate jeopardy at F760. The immediate jeopardy started on 02/04/26, when CMA R administered the incorrect medications to R1, and ended on 02/05/26 when the facility completed corrective actions. The facility identified and implemented immediate corrective actions, which were completed on 02/05/26, that included the following: Due to the corrective actions completed prior to the onsite visit, the deficient practice was deemed Past Non-Compliance (PNC) at a "J" (Isolated, actual harm) scope and severity.	F0000		
F0760 SS = SQC-J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 89 residents, with three residents reviewed for medication errors. Based on record review, observation and interview, the facility failed to ensure Resident (R) 1 remained free from significant medications errors. On 02/04/26, Certified Medication Aide (CMA) R administered R1 another resident's medications, which included multiple medications that affected the central nervous system	F0760	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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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F0760 SS = SQC-J	Continued from page 1 and had psychotropic qualities including Paxil (antidepressant), lorazepam (antianxiety), tizanidine (muscle relaxant), and clozapine (antipsychotic), as well as other medications including Cardizem (antihypertensive), metformin (diabetic medication), and furosemide (diuretic). At around 08:30 AM, R1 reported to Licensed Nurse (LN) G she felt she had received the wrong medication. At 10:00 AM, LN G went to R1's room to provide care and noted R1 slurring her words and was minimally responsive. Staff notified the provider, who gave orders to provide Narcan (opioid antagonist) and to send the resident to the Emergency Room. R1 was admitted to the Intensive Care Unit and had a diagnosis of primary unintentional overdose. The significant medication error placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR), documented R1 had diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), coronary artery disease (CAD-abnormal condition that may affect the flow of oxygen to the heart), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). The "Quarterly Minimum Data Set (MDS) dated 12/26/25 documented R1 had a Brief Interview for Mental Status score of 14, which indicated intact cognition. The MDS documented R1 had functional range of motion limitations on one side of the lower extremity. The MDS documented that R1 required substantial/maximum staff assistance for toileting, bathing, dressing, bed mobility, lying-to-sitting on the side of the bed, and transfers. The "Comprehensive Activities of Daily Living (ADL) Care Area Assessment (CAA)", dated 09/23/25, documented R1 required assistance with her ADLs due to a right ankle fracture with nonunion (when a broken bone stops healing and fails to mend on its own), DM, and morbid obesity. The "Psychotropic (alters mood or thought) Medication Use CAA," dated 09/23/25, documented R1 used psychotropic medications to treat anxiety and	F0760		

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F0760 SS = SQC-J	Continued from page 2 depression. Staff were ordered to monitor signs and symptoms of depression and anxiety. The “Care Plan,” dated 09/15/25, documented R1 would have her safety and psychosocial needs met. R1’s pain would be managed at an acceptable rate of pain and directed staff to administer medications as needed. R1 was on psychotropic medications and directed staff to monitor for an increase in depressive/behavioral symptoms and to monitor R1 for drug-related complications. The “Nurse’s Note,” dated 02/04/26 at 10:47 AM, documented R1 stated at 08:50 AM she thought maybe she received the wrong medication as there had been a fish oil in her pill cup. LN G asked CMA R if she had mistakenly administered the wrong medications to the wrong resident. CMA R stated she was sure that she did not, however she might have put fish oil in with R1’s pills. R1 went back to her room, and LN G notified Certified Nurse’s Aide (CNA) M to keep an eye on R1 just in case something happened. At 09:15 AM, CNA M went and checked on R1, and R1 had normal mentation, and her vital signs were within normal limits. LN G went to R1’s room at 10:00 AM to provide care and noted R1 to be lethargic and minimally responsive. LN G called LN H to help assess R1. LN H notified R1’s provider and was given an order for Narcan (medication used to rapidly reverse life-threatening opioid overdose) and Epinephrin (a medication used to treat emergency life-threatening allergic reactions, cardiac arrest, or severe asthma). Both medications were given with minimal response. 911 was called during the medication administration. Emergency Medical Services arrived at 10:10 AM. Report was given to them of the possible erroneous medication administration. R1 left the facility at 10:20 AM. LN G’s “Notarized Witness Statement,” dated 02/04/26, documented R1 told LN G she was concerned she may have received the wrong medication, as her pills had fish oil in it and she did not take fish oil. LN G questioned CMA R about the meds. CMA R stated she knew she did not give R1 another resident’s meds, but she may have put fish oil in the meds by accident. LN G asked R2 (a resident with the same first name as R1 and who was sitting at the same table as R1, who did take fish oil) if she had received her meds, and she said she did. R1 went back to her room around 08:45 AM. LN G informed CNA M that LN G wanted to keep an eye on R1 just in case. CNA M checked on R1 around 09:15 AM, R1’s	F0760		

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F0760 SS = SQC-J	Continued from page 3 vital signs were within normal limits, and R1 was alert and oriented. LN G stated she entered R1's room at 10:00 AM, and R1 slurred her words, was hard to arouse, and was minimally responsive. LN G called LN H and notified her of the situation. LN G notified Administrative Nurse D. LN G notified R1's provider and received orders for STAT (immediately) Narcan and Epinephrine. Medication was obtained and administered. 911 was called, EMS arrived, report was given and R1 transferred to the local hospital emergency room. CMA R "Notarized Witness Statement," documented LN G came to CMA R and asked about R1's meds, and asked CMA R what meds I gave to R1. CMA R told LN G the meds were R1's. LN G asked CMA R why there was a fish oil pill. CMA R stated she was not sure why it did. CMA R stated she was sure she had given R1 the right ones. CMA R stated she went on to pass the rest of the medications and helped CNA M to answer call lights. CMA R stated she found out she had given R1 the wrong meds. The "Emergency Room Health and Physical (H and P), dated 02/04/26, documented R1 admitted to the ER with a report R1 was accidentally given another resident's medications. It was unclear at the time if R1 also received her own medications. R1 was hypoxic and was given doses of Narcan and Epinephrine, with some improvement. The medications accidentally given to the resident were multiple medications that affected the central nervous system and had psychotropic qualities, including Paxil, lorazepam, tizanidine, and clozapine, as well as other medications. R1 was noted to be non-sensical and somnolent. R1 started on intravenous (IV-administered directly into the bloodstream via a vein) fluids. R1 admitted to the intensive care unit (ICU) for observation. Plan: Given multiple centrally acting medications, hold centrally acting medications, neurological checks, closely monitor vital signs, and give supportive cares. The "Nurse's Note," dated 02/05/26, documented R1 re-admitted to the facility on 02/05/26 at 01:30 PM. R1 was alert and oriented to person, place, and time. R1 appeared calm, but five minutes after arrival, R1 was observed to be crying. When inquired resident stated, "I have a big gap of memory loss of what happened. This is my fault." Staff provided reassurance and emotional support to R1, and R1 calmed down. R1 was anxious again around 12:00 PM, and anti-anxiety medication was administered.	F0760		

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F0760 SS = SQC-J	Continued from page 4 On 02/24/26 at 10:30 AM, observation revealed R1 laid in bed with three to four covers over her. A fan was blowing to cool the room. The room was dark, and the blinds were closed. R1 was alert and oriented. On 02/24/26 at 10:30 AM, R1 stated, “The CMA was really distracted that morning. The other resident with the same 1st, R2 and I sat at the breakfast table next to the med cart and could hear CMA R talking to herself about her husband, who lives in the facility, being combative that morning. CMA R sat the med cup in front of me, and I kind of looked at them, but then just took them automatically. Then I got to thinking, I saw fish oil in there, and I didn’t take fish oil. So, the other [R2] and I got to talking, and she was still waiting for her pills, and R2 told me she took fish oil. So, we called the CNA over, and I told her I thought I was given the wrong pills. Then I walked into the bathroom, and I felt funny, but I guess I didn’t think anything about it and went and lay down. The next thing I knew, I was waking up in the ICU at 05:00 AM. I don’t remember anything, but I had very unsettling dreams, at least I think they were dreams. I was so scared because I did not know what was going on.” On 02/24/26 at 11:00 AM, LN G stated she asked the CMA if she had given R1 the wrong pills, and the CMA assured her she had not. LN G told the CNA they would keep an eye on R1 to make sure she was okay. At 10:00 AM, I went to do R1’s dressing change, and she was very out of it. On 02/24/26 at 01:45 PM, Administrative Nurse D stated she expected any staff passing meds to follow the five rights of medication administration and the medication administration policy. Administrative Nurse D stated the clinical staff were educated on not being distracted at the med cart and ensuring the right medications were given to the correct resident. All residents with the same names med cards were flagged with pink stickers to denote Same Name. Administrative Nurse D stated CMA R had worked at the facility for over 20 years, and if she had admitted to giving R1 the wrong medications initially, the facility could have gotten R1 the care she needed quicker. Administrative Nurse D stated CMA R had to be let go of her position at the facility. The facility’s “Adverse Effects and Medication Error	F0760		

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F0760 SS = SQC-J	Continued from page 5 Policy," revised December 2021, documented E. A "medication error" is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. F. Examples of medication errors include: 1. Omission – a drug is ordered but not administered 2. Unauthorized drug – a drug is administered without a physician's order 3. Wrong dose (e.g., Dilantin 12 mL ordered, Dilantin 2 mL given) 4. Wrong route of administration (e.g., ear drops given in eye) 5. Wrong dosage form (e.g., liquid ordered, capsule given) 6. Wrong drug (e.g., vibramycin ordered, vancomycin given) In the event of a significant medication-related error or adverse effect, immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant is defined as: 1. Requiring medication discontinuation or dose modification (A current list of medications that should not be abruptly discontinued should be consulted before discontinuing a medication.) 2. Requiring hospitalization, or extending a hospitalization 3. Resulting in disability 4. Requiring treatment with a prescription medication 5. Resulting in cognitive deterioration or impairment 6. Life threatening 7. Resulting in death L. The Attending Physician is notified promptly of any significant error or adverse effect. 1. The physician's orders are implemented, and the resident is monitored for 24 to 72 hours or as	F0760		

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F0760 SS = SQC-J	Continued from page 6 directed. M. The incident is described on the shift change report to alert associates of the need to monitor the resident N. The factual description of the error is entered in the resident's clinical record and the following persons are notified 1. Responsible Party 2. Director of Nursing Services 3. Quality Assurance Nurse 4. Neighborhood manager 5. Designated Risk Management associates O. Data regarding medication, adverse effects, and errors (e.g., total number of incidents, number of incidents by category/type, trends) will be compiled and presented to the Quality Assurance and Performance Improvement Committee on a monthly or quarterly basis On 02/24/26 at 02:05 PM the facility was provided the Immediate Jeopardy template and informed the facility failure to ensure R1 remained free from a significant medication error, when staff administered another resident's medication to R1 and R1 required emergent administration of Narcan and admitted to the ICU with unintentional overdose, placed R1 in immediate jeopardy at F760. The immediate jeopardy started on 02/04/26, when CMA R administered the incorrect medications to R1, and ended on 02/05/26 when the facility completed the below corrective actions. The facility identified and implemented immediate corrective actions, which were completed on 02/05/26, that included the following: The facility removed CMA R from the medication cart and terminated her employment. All residents residing on A and B neighborhoods (where CMA R administered meds) were evaluated for adverse reactions for 72 hours. If any of the residents showed ill effects, it would be reported to their PCP. An audit was performed for residents with the same name, and bright pink labels were placed on the med cards with “Same Name” to alert staff. Audits of the med cards will occur for the next 5 weeks. All clinical staff were re-educated by 02/05/26 or before their next shift on Same Name Alert, the 5 rights of medication administration, and	F0760		

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F0760 SS = SQC-J	Continued from page 7 distractions during medication administration. Due to the corrective actions completed prior to the onsite visit, the deficient practice was deemed Past Non-Compliance (PNC) at a "J" (Isolated, actual harm) scope and severity.	F0760		