STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N081001	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026

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

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S0000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint 2746283 at the above named assisted living facility conducted 03/18/26-03/19/26.	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) The facility reported a census of 34 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 service needs and preferences for resident (R)1 and R2. Findings included: - Record review for R1 revealed an admission date of	S3085		

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

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S3085 SS = E	Continued from page 1 08/13/24 with diagnoses including dementia, Parkinson's, and diabetes mellitus type two. The 02/03/26 Functional Capacity Screen (FCS) identified R1 required physical assistance with bathing and management of medications and treatments; required supervision with dressing and toileting; and was independent with transfers, walking/mobility, and eating. She had no cognitive difficulties, was understandable and understood others during communication, was frequently incontinent of bladder, and was at risk of falls. The 02/03/26 "SvcPln/Negotiated Scvs Agrmt" is the facility's combined Negotiated Service Agreement and Healthcare Service Plan (NSA/HSP) which acknowledged facility staff provided standby assistance with bathing. R1 can perform transfers, walking, and eating by self. Facility staff provided management of medications. R1 was to call staff if needed help for prevention of falls. Review of nurse note dated 01/08/26 at 00:35 AM documented R1 had an unwitnessed fall in her room while standing alone and reaching for her dresser. Fall prevention prior to the fall was use of an assistive device and call light. The note failed to indicate what intervention was put into place to prevent future recurrence. Review of nurse note dated 03/16/26 at 09:44 PM documented R1 sustained a fall and already had frequent visual checks and assistive device in place to prevent falls. The note failed to indicate what intervention was put into place to prevent future recurrence. On 03/19/26 at approximately 02:15 PM R1 was unable to recall any new services the facility provided after her last two falls. On 03/19/26 at approximately 11:30 AM Administrative Staff C stated they currently do not have a way to communicate newly implemented interventions to staff. She confirmed R1's NSA failed to describe the services provided for prevention of falls. The administrator failed to ensure R1's NSA described	S3085		

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S3085 SS = E	Continued from page 2 services to prevent falls according to her service needs. - Record review for R2 revealed an admission date of 06/13/24 with a diagnosis of seizures. The 03/18/26 FCS identified R2 needed supervision with bathing, walking, and toileting; was independent with transferring, dressing, and eating; required assistance with management of medications and treatments; was identified as having impaired vision; and was at risk for falls. R2 had no cognition or communication difficulties. The 03/18/26 combined NSA/HSP identified R2 dressed and toileted self, was independent with walker for mobility, and staff assisted with stand by assist for bathing. Facility staff provided management and administration of medications and ensured pathways were clear and non-slip socks worn for prevention of falls. Review of nurse note dated 02/05/26 at 03:01 PM revealed R2 attempted to transfer self to a standing position from recliner and slid down front of chair onto floor. The nurse documented the care plan was reviewed and updated as indicated but no intervention was indicated in note. Review of nurse note dated 12/29/25 at 09:01 AM revealed R2 sustained a fall while turning with his walker and his “feet got tangled up.” The nurse documented the care plan was reviewed and updated as indicated but no intervention was indicated in note. Review of nurse note dated 12/26/25 at 06:17 PM revealed R2 sustained a fall while reaching for a towel. Fall intervention was high visibility area and walker. Review of nurse note dated 12/12/25 at 11:52 AM revealed R2 leaned too far forward in recliner and slid off the chair. The note failed to indicate an intervention to prevent future recurrence. On 03/19/26 at approximately 02:33 PM R2 was unable to recall interventions put into place after his falls.	S3085		

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S3085 SS = E	Continued from page 3 On 03/19/26 at approximately 11:30 AM Administrative Staff C stated they currently do not have a way to communicate newly implemented interventions to staff. She confirmed R2's NSA failed to describe the services provided for prevention of falls. The facility's last revised 05/2019 "Assisted Living – Service Agreement/Service Plan" policy indicated the "NSA/SP" was based on the service needs and preferences of the resident. The plan was to "include the resident's unique physical and psychosocial needs." The facility's 11/2021 "Assisted Living – Fall Policy" indicated falls were reviewed for identification of individualized interventions to reduce the risk of falls. The administrator failed to ensure R2's NSA described services to prevent falls according to his service needs.	S3085		
S3211 SS = F	OVER THE COUNTER DRUGS CFR(s): 26-41-205 (g) (3) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-205(g)(3) The facility reported a census of 34 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of thirteen over-the-counter (OTC) medications in the medication carts.	S3211		

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S3211 SS = F	Continued from page 4 Findings included: - Observation on 03/18/26 at 11:27 AM revealed the first floor medication cart contained the following OTC medications were not labeled with residents' full names: Two bottles acetaminophen 500 milligram (mg), 500 caplets One bottle acetaminophen 500 mg, 250 caplets One bottle vitamin D3 1000 25 microgram (mcg), 500 softgels One bottle vitamin B12 500 mcg, 200 microlozenges One bottle famotidine 20 mg, 200 tablets One bottle multivitamin/multimineral supplement 100 tablets Two bottles saline nasal spray 1.5 fluid ounces One bottle eye relief dietary supplement 90 softgels On 03/18/26 at approximately 11:40 AM Certified Medication Aide (CMA) D confirmed the OTC medications were not labeled with residents' full names. - Observation on 03/18/26 at 12:22 PM revealed the second floor medication cart contained the following OTC medications were not labeled with resident's full names: One bottle acetaminophen 500 mg, 100 gelcaps One bottle acetaminophen 500 mg, 100 caplets One container Metamucil fiber gummies, 105 gummies On 03/18/26 at approximately 12:45 PM CMA E confirmed the OTC medications were not labeled with a resident's full name. - Observation on 03/18/26 at 12:44 PM revealed CMA E	S3211		

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S3211 SS = F	Continued from page 5 labeled over the counter medication containers with residents' names. On 03/18/26 at approximately 04:45 PM Administrative Staff C stated she expected licensed nurses to label the medications with resident names. The facility's "Storage and Labeling of Medications" policy last revised 11/2024 instructed staff to ensure all medications were labeled in accordance with applicable state requirements. Labels for individual drug containers should include the resident's name. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of thirteen OTC medications.	S3211		
S3280 SS = F	Disaster and Emergency Preparedness CFR(s): 26-41-104 (d) (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-104(d)(4) The facility reported a census of 34 residents. Based on record review and interview, the administrator failed to ensure disaster and emergency preparedness by ensuring the performance of an emergency drill annually with staff and residents to include an evacuation of	S3280		

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S3280 SS = F	Continued from page 6 the residents to a secure location. Findings included: - On 03/18/26 at 11:11 AM during entrance the last two annual evacuations was requested which the facility failed to provide. On 03/18/26 at 03:19 PM Unlicensed Staff H confirmed, via email, an annual evacuation had not been completed since last survey. The administrator failed to ensure disaster and emergency preparedness by the failure to ensure the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location.	S3280		
S3296 SS = F	Dietary Services Weekly Menu CFR(s): 26-41-206 (c) (1) (c) (1) Menu plans shall be available to each resident on at least a weekly basis. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-206(c)(1) The facility reported a census of 34 residents. Based on observation and interview the administrator failed to ensure the menu was available to all residents on at least a weekly basis. Findings included: - Observation on 03/18/26 at approximately 11:52 AM revealed a weekly menu was not posted for residents to access. On 03/19/26 at 01:51 PM R3 stated she only received a daily menu and had not seen a weekly menu before. On 03/19/26 at 03:25 PM R1 stated she had only ever received a daily menu.	S3296		

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S3296 SS = F	Continued from page 7 On 03/18/26 at 12:34 PM Dietary Staff F stated she gave the menu to Administrative Staff C for direct care staff to give to residents. On 03/18/26 at approximately 11:57 AM Dietary Staff G confirmed he did not see a weekly menu posted. The administrator failed to ensure a weekly menu was available to all residents.	S3296		