STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via Christi Village Manhattan, Inc	2800 Willow Grove Road Manhattan, KS 66502

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 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. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 54 and R4 and their representatives received a written notification of transfer that included a statement of the residents' appeal rights and the state ombudsman information, as soon as practicable upon their emergent transfer to the hospital. Findings included:1. R54's Electronic Medical Record (EMR) contained a scanned Discharge/Transfer, Room Change, Roommate Notice form dated 11/30/25. R54 was transferred to the hospital for a higher level of care. The resident and his representative were notified. The Discharge/Transfer form lacked a statement of the right to appeal and the state ombudsman information. 2. R4's EMR contained a scanned Discharge/Transfer, Room Change, Roommate Notice form dated 02/17/26. R4 was transferred to the hospital for a higher level of care. The resident and his representative were notified. The Discharge/Transfer form lacked a statement of the right to appeal and the state ombudsman information. On 04/30/26 at 11:49 AM, Social Services X stated that she was responsible for providing the bed hold and notice of transfer to the resident and their representative upon transfer to the hospital. Social Services X stated they were not aware that the discharge/transfer form had to have a statement of the right to appeal and the state ombudsman information. Social Services X stated the discharge/transfer form would be revised to include that information. On 04/30/26 at 12:50 PM, Administrative Staff A stated she had been made aware by Social Services X that the facility's Discharge/Transfer form needed to be updated to include information on the right to appeal and the ombudsman information. Administrative Staff A stated the form would be revised and updated to include the required information. The facility's Transfer or Discharge Notice policy dated December 2025 documented the community will notify resident and/or resident representative at least 30 days before the discharge or transfer or as soon as practicable, under certain conditions, the resident /resident representative will be notified in writing of the following information: the reason for the transfer or discharge; the effective date of the transfer or discharge; the location to which the resident is being transferred or discharged ; a statement of the resident's rights to appeal the transfer or discharge, including: the name, address, email and telephone number of the entity which receives such requests; information about how to obtain, complete and submit an appeal form; and how to get assistance completing the appeal process; the community bed-hold policy; the name, address, e-mail and telephone number of the Office of the State Long-term Care Ombudsman; the name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies); the name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies); and the name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via Christi Village Manhattan, Inc	2800 Willow Grove Road Manhattan, KS 66502

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide tube feeding management services consistent with the standards of practice when staff failed to verify placement of the feeding tube before administering medications and nutritional feeding for Resident (R) 8. Finding included: - R8's Electronic Health Record (EHR) revealed diagnoses of recorded a diagnosis of dysphasia (swallowing disorder), and cerebral infarct (damage to tissue in the brain due to loss of oxygen in the area). R8's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R8 had a Brief Interview Status of 11 (which indicated moderate cognitive impairment). The MDS recorded R8 required staff assistance with transfers, bed mobility, dressing, toilet use, and personal hygiene. The MDS recorded R8 had a feeding tube. And received 51percent or more by the feeding tube. R8's Care Plan, dated 04/03/26, recorded R8 required a feeding tube for nutritional maintenance related to dysphagia and aspiration pneumonia. The care plan directed the staff to administer tube feedings per physician order, assess tube placement, patency, and placement of tube before each feeding by two means. The care plan documented R8 was at a high risk for tube feeding dislodgement and aspiration and directed staff to check R8's tube to ensure it was patent, in the correct placement, and auscultate lung sounds daily. R8's Physician Order dated 04/17/26, directed the staff to administer Jevity (fiber-fortified, high protein liquid nutritional supplement), 1.5 calorie per milliliter (ml), eight ounces (oz) per feeding tube three times a day. The order directed staff to crush medications, and dissolve them in water, then administer the medication with 15 cubic centimeters (cc) of water between each medication and 30 cc before and after the medication administration. On 4/27/26 at 12:10 PM, Licensed Nurse (LN) I administered 90 cc water, followed by four oz. of Jevity (because the resident did not want the full eight oz.) followed by 90 cc of water. LN I did not assess for placement or check stomach residual prior to administration of the nutritional supplement. On 4/28/26 at 09:25 AM, LN I crushed R8's medications, added a small amount of water to dissolve each medication separately. LN I administered 30 ml of water before and after the medication administration. LN I did not assess or listen for placement or check stomach residual prior to administration of medications. On 04/30/25 at 08:10 AM, Administrative Nurse D verified the nursing staff was to check placement prior to administering medication and feedings. Administrative Nurse D verified she would have an in-service to re-educate the staff regarding the feeding tube protocol, including how and when to check placement. The facility's Enteral Tube Use and care policy, dated January 2026, documented the policy of the facility is to provide adequate nutritional support through enteral feeding to residents as ordered. Staff caring for residents with feeding tubes should be trained on how to recognize and report complications associated with the insertion and/or use of a feeding tube, such as aspiration. Risk of aspiration should be assessed by the nurse and physician and addressed in the individual care plan. Risk of aspiration may be affected by failure to confirm placement of the feeding tube prior to initiating the feeding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via Christi Village Manhattan, Inc	2800 Willow Grove Road Manhattan, KS 66502

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 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 observation, interview, and record review, the facility failed to notify the physician and follow the standing orders for Resident (R) 17's low blood sugar levels. Findings included:- R17's Electronic Medical Record (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), heart failure, and major depressive disorder (major mood disorder that causes persistent feelings of sadness) with recurrent severe psychotic (any major mental disorder characterized by a gross impairment in reality perception) symptoms. R17's Significant Change Minimum Data Set (MDS) dated [DATE], documented R17 had severe cognitive impairment. R17 required partial/moderate assistance with toileting hygiene, upper and lower body dressing, putting on and taking off footwear, and sitting to lying and lying to sitting on the edge of the bed. R17 had no pain, gained weight, and received a therapeutic diet. The MDS further documented that R17 received insulin (a hormone that lowers the level of glucose in the blood) injections, an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications sued to prevent the blood from clotting), hypoglycemic (a class of medication to lower blood sugars), and anticonvulsant. R17's Care Plan dated 03/23/26, documented R17 had potential for complications for type 2 diabetes mellitus. The plan directed staff to perform fingerstick blood sugars per the physician's orders and to obtain HbA1c (blood test used to evaluate the level of glucose control over the past 90 days) or other labs per orders and inform the physician of results. The plan instructed staff to administer medications per the physician's orders, monitor side effects, and notify the physician as needed (PRN). The Physician Standing Orders dated 01/27/26, stated for hypoglycemia with a blood glucose less than 70 milliliters (ml) per deciliter (dL)with or without symptoms such as shaky, sweating, weak, or altered mental status of consciousness, personality change (moody, irritable, agitated), treat with 15 grams of simple carbohydrates by mouth, may choose three glucose tablets, one tube of glucose gel, one half cup of fruit juice or regular soda. The standing order further directed staff to recheck the blood glucose 15 minutes after treatment and document results. If the blood glucose is less than 70 ml/dL, repeat treatment and call the primary care practitioner (PCP), and continue checking the blood glucose every 15 minutes and treat until blood glucose is greater than 70 ml/dL. The Physician Order dated 03/24/26, directed staff to administer insulin Aspart (insulin), two units subcutaneously (SQ-beneath the skin) every day before breakfast, and ensure the resident eats before administration. R17's EMR Treatment Administrative Record (TAR) April 2026, review revealed the following morning blood sugar results:On 04/01/26, the blood sugar level was 59 ml/dL, and insulin was not given.On 04/02/26, the blood sugar level was 54 ml/dL, and insulin was given.On 04/08/26, the blood sugar level was 62 ml/dL, and no insulin was given.On 04/11/26, the blood sugar level was 73 ml/dL, and insulin was not given.On 04/13/26, the blood sugar level was 60 ml/dL, and insulin was given.On 04/15/26, the blood sugar level was 68 ml/dL, and insulin was given.On 04/18/26, the blood sugar level was 72 ml/dL, and insulin was not given.On 04/19/26, the blood sugar level was 70 ml/dL, and insulin was not given.On 04/20/26, the blood sugar level was 58 ml/dL, and insulin was not given.On 04/24/26, the blood sugar level was 76 ml/dL, and insulin was not given.On 04/27/26, the blood sugar level was 68 ml/dL, and insulin was given. R17's EMR lacked evidence the treatment from the standing orders was implemented and lacked documentation of physician notification for the blood sugar levels below 70 ml/dL or when staff held the insulin. On 04/28/26 at 08:21 AM, R17 sat in the dining room, appropriately dressed and groomed for the day. R17 fed himself and then independently wheeled himself to his room. On 04/28/26 at 11:35 AM, Licensed Nurse (LN) I reported that if the physician had parameters for medications, the parameters would be included in the physician's orders (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via Christi Village Manhattan, Inc	2800 Willow Grove Road Manhattan, KS 66502

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and would be placed on the electronic medication and treatment records. LN I stated that the charge nurse usually obtained the blood sugar levels. LN I was unsure whether a call should have been placed to the physician for R17's low blood sugar readings. On 04/28/26 at 11:47 AM, Administrative Nurse D reported the physician had standing orders with parameters, and the staff was to call if the R17 was symptomatic. Administrative Nurse D stated their understanding of the order was if the resident was symptomatic, staff were to give a protein or a simple carbohydrate. On 04/28/26 at 12:16 PM, Consultant GG stated the facility staff should have notified the practitioner of blood sugar levels below 70 ml/dL. Consultant GG stated R17 wore a continuous glucose monitoring system that tracked blood sugar levels in real-time, and the levels could potentially be 14 points off and less accurate levels below 100. Consultant GG stated they would have had staff to do a fingerstick to verify the level if they had been notified. The facility's Administering Medications policy, dated 12/2024, documented that medications shall be administered in a safe and timely manner, and as prescribed. Medications shall be administered in accordance with the orders and within the allowable time frame per best practice/regulatory guidelines. The facility's Nursing Care of the Resident with Diabetes Mellitus policy, dated 11/2024, documented the purpose of the guideline to recognize, manage, and document the treatment of complications commonly associated with diabetes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via Christi Village Manhattan, Inc	2800 Willow Grove Road Manhattan, KS 66502

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly store medications when staff failed to discard Resident (R)3 insulin (a hormone that lowers the level of glucose in the blood) outdated flex pen. Findings included:- On [DATE] at 08:05 AM, observation of the F Court treatment cart revealed R3's Novolog (rapid-acting insulin) flex pen was labeled with an open date of [DATE] and a discard date of [DATE] (10 days expired). On [DATE] at 08:15 AM, License Nurse H verified the nurses should discard the outdated insulin flex pens. On [DATE] at 08:20 AM, Administrative Nurse D verified the nurse should check the insulin flex pens for expiration dates and discard if expired. Medlineplus.gov directs open, unrefrigerated Novolog can be used within 28 days; after that time, they must be discarded. The facility's Storage of Medications policy, dated [DATE], documented the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The medication/treatment cart and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with community/pharmacy process