STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175126	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Senior Life	1417 W Ash St Junction City, KS 66441

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 - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 66 residents, with three residents reviewed for abuse and neglect. Based on record review, observation, and interview, the facility failed to protect Resident (R) 2, a cognitively impaired female, from sexual abuse. On 11/12/25 at 01:40 PM, staff found R2, who had severe cognitive impairment, was unable to consent to sexual relations, and had a history of wandering, in R1's room on his bed. R1, who had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) and a history of sexual behaviors, performed oral sex on R2. Staff separated the residents and placed R2 on one-to-one observation. This deficient practice placed R2 and other cognitively impaired female residents in Immediate Jeopardy.Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of lymphedema (swelling caused by accumulation of lymph), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hyperlipidemia (condition of elevated blood lipid levels), and chronic (persisting for a long period) kidney disease (a condition where the kidneys are damaged and lose the ability to filter blood properly).R1's Quarterly Minimum Data Set (MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 had no behaviors documented on the assessment. R1 required moderate staff assistance with bathing, supervision for dressing and was independent with all other activities of daily living (ADL).The ADL (Activities of Daily Living) Functional / Rehabilitation Potential Care Area Assessment (CAA) dated 04/16/25 documented R1 was at the facility for medication management and assistance with ADLs. The CAA documented R1 was dependent on staff for lower extremity dressing and noted R1 ambulated with a walker. R1's Care Plan, initiated on 04/23/24, documented R1 had inappropriate sexual behaviors, including sexually explicit comments, gestures, or attempts at contact. R1's goal, dated 10/10/25, documented R1 would have a reduction in frequency and severity of inappropriate sexual behaviors and maintain socially appropriate interactions with peers. The care plan documented R1 was started on Prozac (an antidepressant-class of medications used to treat mood disorders) for hypersexuality (a condition characterized by intense, uncontrollable sexual urges, thoughts, and behaviors) (10/10/25). The care plan documented R1 started making inappropriate comments and gestures towards females and asked a female to come to his room. R1 verbalized he was aware his behaviors were inappropriate but continued exhibiting the behavior. R1 was moved to a different room on the opposite side of the facility from a particular resident in an attempt to limit their interactions (10/10/25).The Social Services Progress Note dated 09/23/25 documented Social Service X received a report that a female resident (referred to R2 and verified with Social Service X) went into R1's room to visit him. Staff found R1 and R2 in R1's room in the dark with the door shut. Social Service X talked to R1 and asked him about what was going on. R1 stated he thought the female resident liked him and said the resident snuggled up to him and was very close to him. Social Service X explained to R1 that R2 could not give consent due to her cognition, and R2 could possibly be blamed for something that did not happen. R1 expressed understanding, and Social Service X told R1 to get help from staff if he had difficulty with R2. The Social Services Progress Note dated 09/29/25 documented staff reported R1 made an inappropriate sexual gesture to a female resident (verified with Social Service X, this was R2). Social Service X questioned R1, and he did not deny the accusation. R1 reported there was a temptation involved, but he knew it was wrong. Social Service X explained to R1 the situation could become a legal problem for him. R1 expressed understanding. R1 would be moved to another location in the facility in order to deter further inappropriate interactions.The Behavior Note dated 09/29/25 documented staff assisted in having a conversation with R1 regarding recent inappropriate conduct with another resident (R2). A staff member observed an inappropriate sexual gesture performed by R1. The other resident involved did not have the ability to consent to physical touch related to her cognitive status, and the female residents responsible party did not give consent. The possible implications included the resident being asked to leave the facility and/or having legal repercussions for any further involvement were discussed at length. R1 demonstrated understanding of the implications for his action and understood he would be relocated to another unit in the facility, and R1 was to have no physical or verbal interaction with the resident (R2). The primary care provider was notified of the situation. The Alert Note dated 09/29/25 documented R1 was transferred from one area of the facility to another related to inappropriate verbal and non-verbal gestures with another female resident (R2). All medications were transferred as well as R1's belongings. R1 was aware of the reasoning for the room change The Social