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	08/06/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 62 residents. The sample included 16 residents, with one reviewed for discharge. Based on record review and interview, the facility failed to notify the Office of the Long-Term Care Ombudsman (LTCO- a public official who works to resolve resident issues in nursing facilities) of Resident (R) 1 and R67's. The facility also failed to develop a discharge summary that included a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) of the resident's stay for R67's unplanned discharge. This placed the residents at risk for uninformed care choices and impaired rights.Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit). R1's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R1 had pneumonia. R1's Care Plan, revised 07/14/25, documented R1 had Parkinson’s and instructed staff to monitor, document, and report to the physician as needed (PRN) any signs and symptoms of aspiration or dysphagia (swallowing difficulty), choking, fever, and or coughing. R1's Progress Notes dated 06/30/25 at 03:18 AM documented the resident was transferred to the hospital. R1's clinical record lacked evidence the LTCO was notified of the hospital transfer. On 08/05/25 at 10:45 AM, R1 ambulated around the facility with a walker without signs of shortness of breath. On 08/05/25 at 02:10 PM, Administrative Staff B stated she was responsible for notifying the LTCO when a resident was transferred to the hospital. Administrative Staff B verified she had not notified the LTCO when R1 was transferred to the hospital on [DATE]. Administrative Staff B stated she must have missed it. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Resident Admission, Transfer, and Discharge Rights Policy, undated, documented that the facility must send a copy of the transfer or discharge notice to the LTCO program promptly after issuing the transfer notice to the resident. - R67’s Electronic Medical Record (EMR) documented diagnoses of chronic iron deficiency (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), low back pain, Barrett’s esophagus (a condition caused by inflammation and damage to the lining of the esophagus), and cognitive communication deficit (an impairment in organization, sequencing, attention,, memory, planning, problem-solving, and safety awareness). The” Quarterly Minimum Data Set” (MDS), dated [DATE], documented R67 had intact cognition. R67 was independent with all activities of daily living (ADL), had disorganized thinking, rejection of care for four to six days during the look-back period, and had no medications. The MDS further documented R67 did not want any agency referrals before discharge. R67’s “Care Plan,” dated 06/09/25, initiated on 11/6/24, documented staff would provide R67 with options related to discharge planning, medication education, and community health services. The care plan further documented, R67 planned to discharge to the street, as he had been homeless for many years, and he chose to live that way. The “Nurse’s Note,” dated 06/20/25 at 09:16 AM, documented R67 was adamant about leaving AMA (against medical advice) today. R67 had his wagon packed up with his things, and he reiterated his wishes as above. The nurse asked him to sit tight until she was able to consult with management and his physician. The note further documented, the nurse left R67 in the front commons area while notifying management of the situation, and the social worker was requested to consult with the resident. The” Nurse’s Note,” dated 06/20/25 at 11:16 AM, documented the social worker was notified that R67 planned to leave the facility. She spoke with him about how they were in the summer season and how hot it was going to be in the coming days, but he stated he was a country boy and that he was used to the heat. R67 stated he did not need any medications or medical interventions as he had lived off the land, and living inside was killing him. The note further documented that other staff members tried to talk him into staying in the facility. APS (Adult Protective Services) and the local police department were notified of his discharge. R67’s clinical record lacked evidence that the ombudsman was notified of the discharge. R67's EMR lacked evidence that a thorough recapitulation of R67’s stay was developed. On 08/05/25 at 10:05 AM, Administrative Nurse E stated she did not know what a recapitulation was and that she only completed a nursing discharge when a resident left the facility. On 08/05/25 at 10:15 AM, Administrative Staff B stated she did not notify the ombudsman when R67 was discharged from the facility and only notified the ombudsman for hospital discharges. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 0805/25 at 11:00 AM, Administrative Nurse D stated she was unsure what a recapitulation was but verified that the discharge summary that was completed was not a thorough representation of R67’s stay in the facility. Administrative Nurse D further stated, the ombudsman should have been notified of his discharge. The facility’s “Resident Admission, Transfer, and Discharge Rights” undated policy documented that the facility shall not request or require residents to waive any rights related to admission, transfer, or discharge. Residents would be admitted , transferred, or discharged only for reasons permitted by law and by established procedures that safeguard their rights. The facility must send a copy of the transfer or discharge notice to the Long-Term Care Ombudsman program promptly after the resident is discharged . Regular audits and case reviews would be conducted to ensure the Ombudsman was properly and promptly notified. The facility’s “Discharge summary” undated policy documented that the facility shall prepare and provide a discharge summary, including a recapitulation of stay. The recapitulation shall include the disposition of pre- and post-medications, diagnoses and conditions, course of their illness and treatment, pertinent lab, other diagnostic tests, and results. The recapitulation shall also include documented consultations, physician verification for discharge and/or transfer, and any other pertinent information.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 62 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 9's comprehensive care plan was revised with information about his dialysis (a procedure where impurities or wastes were removed from the blood). This deficient practice placed R9 at risk for missed dialysis visits and complications related to dialysis. Findings included:- R9's EMR documented diagnoses of end-stage renal disease (ESRD- a terminal disease of the kidneys) and dependence on renal dialysis.R9's admission Minimum Data Set (MDS) dated 04/01/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R9 had functional limitation in range of motion impairment on both lower extremities. R9 used a walker and a wheelchair to assist with his mobility. R9 required substantial staff assistance with toileting and was dependent on staff for bathing. R9 was on a dialysis program.R9's Functional Abilities Care Area Assessment (CAA) dated 04/01/25 documented he had a diagnosis of stage renal disease. R9 has a central venous catheter (CVC- a thin, flexible tube inserted into a large vein to provide long-term access to the bloodstream for medical purposes) port in the right chest and a shunt (tube or device implanted in the body to redirect a body fluid from one cavity to another) in his left arm. R9's dialysis days are Tuesday, Thursday, and Saturday. R9 was alert and oriented with clear speech. R9's hearing and vision was adequate. R9 was currently on physician therapy and occupational therapy services and would be on a restorative program upon completion. R9's Care Plan dated 03/25/25 directed staff that he had end-stage renal disease. The Care Plan directed staff that R9 had a shunt for dialysis in his left arm. Staff were directed to monitor, document, and report any signs and symptoms of infection to his dialysis access site to the physician. The Care Plan directed staff not to take blood pressure in the left arm. The Care Plan directed staff to monitor the access site for bleeding for 24 hours after he returned from his dialysis treatment. The Care Plan lacked staff direction on the dialysis center location and contact information. The Care Plan lacked staff direction on the days that R9 had his dialysis treatment. R9's Orders tab of the EMR lacked the physician's order for dialysis. R9's Misc. tab of the EMR did contain a scanned Communication Form that documented pre- and post-dialysis vital signs. The form also contained information on any labs drawn or new orders from the dialysis clinic. On 08/05/25 at 12:58 PM, R9 sat in his wheelchair in his room and stated that he had returned from his dialysis appointment earlier. R9 stated that he went to dialysis on Tuesdays, Thursdays, and Saturdays early in the morning.On 08/06/25 at 09:15 AM, Certified Nurse Aide (CNA) N stated that the nurses usually told the CNAs which residents were on dialysis or hospice. CNA N stated the nurse would usually tell staff in the mornings which resident had dialysis that day. CNA N stated he could not say if R9's care plan had dialysis information in it that he was aware of.On 08/06/25 at 09:30 AM, Licensed Nurse (LN) G stated R9 should have his dialysis information in his care plan. LN G stated that R9 had dialysis on Tuesdays, Thursdays, and Saturdays out of town. LN G stated R9's pre-dialysis form and vital signs were completed prior to his transportation to his dialysis appointments.On 08/06/25 at 11:15 AM, Administrative Nurse D stated that R9's care plan did contain the dialysis provider name in his care plan but not the information on the days that R9 went to dialysis. Administrative Nurse D stated that it must have been overlooked upon R9's return from the hospital in April. Administrative Nurse D stated R9 did go to dialysis out of town on Tuesday, Thursday, and Saturday mornings, the pre-dialysis form was completed by the nurse before each visit and the form was returned with the resident post-clinic.The facility's Care Plan Revisions policy dated 08/01/25 documented changes in a resident's condition always required changes to be made in the plan of care, either by a change in the individual approaches or by the addition of new problems to the plan of care. All physician orders, progress notes, and consultant notes would be reviewed and appropriately added to the care plan. The revisions to the care plan would be the responsibility of a licensed nurse in collaboration with the resident, the representative/family, direct care staff, and the entire interdisciplinary team, and changes would be communicated with all staff and all shifts.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 62 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 2's physician ordered fluid restriction was followed by staff. This placed R2 at risk of fluid overload and possible complications.Findings included:- R2's Electronic Medical Record (EMR) documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), respiratory failure (a condition where the lungs cannot adequately exchange oxygen and carbon dioxide between the blood and the air, leading to insufficient oxygen or excessive carbon dioxide in the bloodstream), and hypertension (HTN- elevated blood pressure).R2's Significant Change Minimum Data Set (MDS) dated 01/31/25 documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. R2 used a wheelchair to assist with mobility. R2 had a functional limitation in the range of motion with impairment on one side of her lower extremity. R2 required partial assistance from staff with dressing, required substantial assistance with bathing, and was dependent on staff with toileting and lower body dressing. R2 had a pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) that was present on admission. R2 required oxygen therapy.R2's Nutritional Status Care Area Assessment (CAA) dated 02/03/25 documented a recent hospitalization from 01/19/25 to 01/24/25. R2 was on a 2000 milliliter (ml) fluid restriction per 24 hours. Dietary allowed 16 ounces(oz) (480 mL) beverage of choice with meals to equal 48 oz (1440 mL) per 24 hours. Nursing allowed 18 oz (560 mL) per 24 hours. R2 was to have no bedside water pitcher. The Registered Dietitian was to remain available to assist with R2's nutritional needs and concerns as identified. R2's Care Plan last revised on 06/24/25 directed staff of her 2000 ml fluid restriction in 24 hours, dietary allowed 16 ounces(oz) (480 mL) beverage of choice with meals, 48 oz (1440 mL) per 24 hours; nursing allowed 18 oz (560 mL) per 24 hours. R2 was to have no bedside water pitcher. The Care Plan directed staff that R2 was on a no-added salt diet.R2's Orders tab documented a physician's order dated 05/15/25 for a fluid restriction 2000 ml daily. Nursing may provide 500 ml between meals with med pass per shift. Dietary may provide 500 ml with each meal. Review of R2's June 2025 Treatment Administration Record (TAR) revealed that R2's physician ordered 2000 ml fluid restriction was exceeded on 10 of 30 days.Review of R2's July 2025 TAR revealed that R2's physician ordered 2000 ml fluid restriction was exceeded on three of 31 days.Review of R2's August 2025 TAR revealed that R2's physician ordered 2000 ml fluid restriction was exceeded on two of six days.On 08/05/25 at 01:15 PM, R2 sat in her wheelchair in her room, her supplemental oxygen on. R2 stated she did not always follow her fluid restriction. On 08/06/25 at 09:15 AM, Certified Nurse Aide (CNA) N stated that R2 used to be the director of nursing at this facility, so she was one who was going to do just what she wanted to. CNA N stated R2 knew about her fluid restriction, but she did not always follow it.On 08/06/25 at 09:30 AM, Licensed Nurse (LN) G stated R2 was a special resident. LN G stated R2 was a former director of nursing at the facility. LN G stated R2 did have a fluid restriction that included how much fluid she could have a meals and how much other fluid she could have throughout the day. LN G stated R2 did not always follow her fluid restriction and was aware of what that could cause with her health.On 08/06/25 at 09:34 AM, Administrative Nurse D stated that R2 knew of her fluid restriction but would not always follow the orders and would drink more than she should. Administrative Nurse D stated R2 was a former nurse and director of nursing here at this facility, and had told staff that she would drink as much fluids as she wanted, regardless of what the doctor said.The facility's Fluid Restrictions policy dated 08/01/25 documented that fluid restrictions ordered by a physician were carried out by the nursing and dietary departments. Unless otherwise specified, the nursing department, in collaboration with the registered dietician, determined the allotment of fluids for meal trays, med-passes, and water provided in the room. Nursing would record the residents' consumption of fluids in the room, during meals, and during med passes using facility input and output documentation. A CNA would review fluid restrictions documented on the resident's individualized, comprehensive care plan to make sure that allotted amounts were not exceeded on meal trays and in-room water services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 62 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 9's dialysis (a procedure where impurities or wastes were removed from the blood) physician order was in his orders of the Electronic Medical Record (EMR). This deficient practice placed R9 at risk for missed dialysis visits and complications related to dialysis.Findings included:- R9's EMR documented diagnoses of end-stage renal disease (ESRD- a terminal disease of the kidneys), and dependence on renal dialysis.R9's admission Minimum Data Set (MDS) dated 04/01/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R9 had a functional limitation in the range of motion impairment on both lower extremities. R9 used a walker and a wheelchair to assist with his mobility. R9 required substantial staff assistance with toileting and was dependent on staff for bathing. R9 was on a dialysis program.R9's Functional Abilities Care Area Assessment (CAA) dated 04/01/25 documented he had a diagnosis of stage renal disease. R9 has a central venous catheter (CVC- a thin, flexible tube inserted into a large vein to provide long-term access to the bloodstream for medical purposes) port in the right chest and a shunt (tube or device implanted in the body to redirect a body fluid from one cavity to another) in his left arm. R9's dialysis days are Tuesday, Thursday, and Saturday. R9 was alert and oriented with clear speech. R9's hearing and vision were adequate. R9 was currently on physician therapy and occupational therapy services and would be on a restorative program upon completion. R9's Care Plan dated 03/25/25 directed staff that he had end-stage renal disease. The Care Plan directed staff that R9 had a shunt for dialysis in his left arm. Staff was directed to monitor, document, and report any signs and symptoms of infection to his dialysis access site to the physician. The Care Plan directed staff not to do blood pressure in the left arm. The Care Plan directed staff to monitor the access site for bleeding for 24 hours after he returned from his dialysis treatment. The Care Plan lacked staff direction on the dialysis center location and contact information. The Care Plan lacked staff direction on the days that R9 had his dialysis treatment. R9's Orders tab of the EMR lacked the physician's order for dialysis.R9's Misc. tab of the EMR did contain a scanned Communication Form that documented pre- and post-dialysis vital signs. The form also contained information on any labs drawn or new orders from the dialysis clinic. On 08/05/25 at 12:58 PM, R9 sat in his wheelchair in his room and stated that he had returned from his dialysis appointment earlier. R9 stated that he went to dialysis on Tuesdays, Thursdays, and Saturdays early in the morning.On 08/06/25 at 09:15 AM, Certified Nurse Aide (CNA) N stated that the nurses usually told the CNAs which residents were on dialysis or hospice. CNA N stated the nurse would usually tell staff in the mornings which resident had dialysis that day. CNA N stated the facility did not have a dialysis book for R9 that he was aware of.On 08/06/25 at 09:30 AM, Licensed Nurse (LN) G stated R9 should have his dialysis order on his Medication Administration Record (MAR) or Treatment Administration Record (TAR). LN G stated that R9 had dialysis on Tuesdays, Thursdays, and Saturdays. LN G stated R9's pre-dialysis form and vital signs were completed prior to his transportation to his dialysis appointments.On 08/06/25 at 11:15 AM, Administrative Nurse D stated that R9's order did not have his physician's dialysis order in it, but now it did. Administrative Nurse D stated that it must have been overlooked upon R9's return from the hospital in April. Administrative Nurse D stated R9 did go to dialysis out of town on Tuesday, Thursday, and Saturday mornings, the pre-dialysis form was completed by the nurse before each visit, and the form was returned with the resident post-clinic.The facility's Hemo-Dialysis Policy dated 08/01/25 documented the medical management of the resident receiving hemo-dialysis was under the direction of the resident's chosen attending primary care physician in collaborative consultation with the Medical Director of the dialysis unit. This facility would establish and maintain a written agreement with the renal dialysis unit that clearly identified the roles and responsibilities of each party for the care and services of the resident. Management of the resident's overall comprehensive plan of care was the responsibility of this facility in collaborative cooperation with the dialysis unit. Coordination of care included: times of dialysis therapy and dialysis access orders; dialysis clinic appointments and laboratory schedule; transportation arrangements; information transmitted to the dialysis unit by the facility prior to dialysis; and information transmitted to the facility by the dialysis unit after dialysis.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 62 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified Resident (R) 32's as-needed antianxiety (a class of medications that calm and relax people) without a stop date and R2's fluid restriction parameter monitoring with the use of a diuretic (a medication to promote the formation and excretion of urine). This placed the residents at risk for inappropriate and/or unnecessary medication.Finding included:- R32's Electronic Medical Record (EMR) included diagnoses of severe protein-calorie malnutrition, chronic kidney disease, major depressive disorder (major mood disorder that causes persistent feelings of sadness), non-pressure chronic ulcer of the left lower leg, paralytic syndrome (loss of muscle function leading to weakness or inability to move), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), disorder of arteries, peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk).The Significant Change Minimum Data Set (MDS), dated [DATE], documented that R32 had mild cognitive impairment, was dependent on staff with toileting hygiene, bathing, and lower body dressing, and required partial/moderate assistance with upper body dressing. R32 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antianxiety, antidepressant (a class of medications used to treat mood disorders), antibiotic (a class of medications used to treat infections), diuretic (a medication to promote the formation and excretion of urine), opioid (a class of medication used to treat pain) and anticonvulsant (a class of medications used to treat seizures). R32 had pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). The MDS further documented that R32 had a condition or chronic disease that may result in a life expectancy of less than six months.R32's Care Plan dated 07/17/25, documented high-risk Black Box Warning (BBW- the highest safety-related warning that medications can have assigned by the Food and Drug Administration) use of lorazepam and opioids may result in profound sedation, respiratory depression, coma, and death.The Physician Order dated 07/07/25, directed staff to administer lorazepam, one to two milligram (mg) tablet by mouth every four hours as needed for agitation, anxiety, or shortness of air. The order lacked a stop/discontinue date.The CP monthly review dated 07/25/25 failed to identify R32's PRN lorazepam lacked a stop date and documented no recommendations.The Progress Note dated 07/07/25 at 11:25 AM documented that before the noon medication administration, R32 was minimally responsive. R32 was able to open eyes with tactile stimulation but was unable to vocalize anything; pupils were sluggish, and radial pulses bilaterally were faint. The Progress Note further documented that the noon medications were held due to R32's inability to safely swallow.On 08/05/25 at 09:37 AM, R32 sat in bed, on a low air loss mattress, watching TV with a breakfast tray on the overbed table. On 08/05/25 at 03:41 PM, Licensed Nurse (LN) H reported the PRN lorazepam did not have a stop date and was indefinite.On 08/05/25 at 09:43 AM, Administrative Nurse D reported that the PRN lorazepam order should have a stop date, and the facility generally implemented a stop date of six months from the original order; the CP should have caught the lack of a stop date.The facility's Drug Regimen Review Report Distribution policy, 08/01/25, documented the CP will report any recommendations of apparent irregularities resulting from the medication regimen review of each resident to the attending physician and/or the director of nursing on a medication regimen review report form. Each recommendation must be acted upon.

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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 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** The facility had a census of 62 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to obtain a stop date for Resident (R) 32's as-needed (PRN) antianxiety (a class of medications that calm and relax people) lorazepam, which placed R32 at risk of receiving unnecessary medication.Findings included:- R32's Electronic Medical Record (EMR) included diagnoses of severe protein-calorie malnutrition, chronic kidney disease, major depressive disorder (major mood disorder that causes persistent feelings of sadness), non-pressure chronic ulcer of the left lower leg, paralytic syndrome (loss of muscle function leading to weakness or inability to move), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), disorder of arteries, peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk).The Significant Change Minimum Data Set (MDS), dated [DATE], documented that R32 had mild cognitive impairment, was dependent on staff with toileting hygiene, bathing, and lower body dressing, and required partial/moderate assistance with upper body dressing. R32 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antianxiety, antidepressant (a class of medications used to treat mood disorders), antibiotic (a class of medications used to treat infections), diuretic (a medication to promote the formation and excretion of urine), opioid (a class of medication used to treat pain) and anticonvulsant (a class of medications used to treat seizures). R32 had pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). The MDS further documented that R32 had a condition or chronic disease that may result in a life expectancy of less than six months.R32's Care Plan dated 07/17/25, documented high-risk Black Box Warning (BBW- the highest safety-related warning that medications can have assigned by the Food and Drug Administration) use of lorazepam and opioids may result in profound sedation, respiratory depression, coma, and death.The Physician Order dated 07/07/25, directed staff to administer a lorazepam, one to two milligrams (mg) tablet by mouth every four hours as needed for agitation, anxiety, or shortness of air. The order lacked a stop/discontinue date.The Progress Note dated 07/07/25 at 11:25 AM documented before the noon medication administration, R32 was minimally responsive. R32 was able to open eyes with tactile stimulation but was unable to vocalize anything; pupils were sluggish, and radial pulses bilaterally were faint. The Progress Note further documented that the noon medications were held due to R32's inability to safely swallow.The Progress Note dated 07/08/25 at 11:09 AM documented that facility staff spoke with R32 regarding his current health status and his recent decision to no longer pursue hospitalizations, blood transfusions, ectara. The facility staff discussed hospice services and benefits, and R32 was in agreement with hospice services at that time and would speak to his spouse and let the spouse know of his decision.On 08/05/25 at 09:37 AM, R32 sat in bed, on a low air loss mattress, watching TV with a breakfast tray on the overbed table.On 08/05/25 at 03:41 PM, Licensed Nurse (LN) H reported the PRN lorazepam did not have a stop date and was indefinite.On 08/05/25 at 09:43 AM, Administrative Nurse D reported the PRN lorazepam order should have a stop date, and the facility generally implemented a stop date of six months from the original order.The facility's Psychotropic Medication Use policy, dated 08/01/25, documented that the Centers for Medicare & Medicaid Services (CMS) regulations state that each resident's drug regimen must be free of unnecessary drugs and define what is considered an unnecessary drug. An unnecessary drug is any drug used in excessive doses, for excessive duration, without adequate indications, without adequate monitoring, or in the presence of adverse consequences, which indicate the dosage should be reduced or discontinued.

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	175126	A. Building B. Wing	08/06/2025

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Valley View Senior Life	1417 W Ash St Junction City, KS 66441

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. The facility identified a census of 62 residents. The facility had two medication rooms and three medication carts. Based on observation, record review, and interview, the facility failed to ensure staff locked and secured medications while away from the medication cart on the Sunshine Hall. This placed residents at risk for accidental ingestion of medication and adverse reactions.Findings included:- On 08/04/25 at 09:04 AM, on Sunshine Hall, the nurse's medication cart located beside the nurse's desk was found unattended and unlocked. At 09:05 AM, Administrative Nurse E walked down the hall to the medication cart and noticed it was unlocked. Administrative Nurse E locked the cart and stood beside the cart until Licensed Nurse (LN) I returned to her cart.On 08/04/25 at 09:07 AM, Administrative Nurse E stated to LN I, upon her return to her medication cart, that her cart should remain locked any time she was away from the cart. On 08/06/25 at 09:34 AM, Administrative Nurse D stated that all medication carts and rooms should remain locked when not in use or when staff walked away from direct sight of the medication cart.The facility's Medication Storage in the Facility policy dated 08/01/25 documented medications and biologicals were stored safely, securely, and properly following the manufacturer or supplier recommendations. The medication supply was accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms, carts, and medication supplies were locked or attended by a person authorized to access.

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 62 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to include a hospice (a program that gives special care to people who are near the end of life) plan of care that outlined visit frequency, medications, medical equipment, and the resident representative's preference for Resident (R) 4 and R32. This deficient practice placed the residents at risk of not receiving resident-directed end-of-life care.Findings included:- R4’s Electronic Medical Record (EMR) documented diagnoses of hemiplegia and hemiparesis (weakness and paralysis on one side of the body), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic kidney disease (a condition where the kidneys are damaged and are unable to filter blood effectively), and hypertension (HTN- elevated blood pressure). R4’s “Significant Change Minimum Data Set (MDS)” dated 04/17/25 documented she had a Brief Interview for Mental Status (BIMS) score of two, which indicated severely impaired cognition. R4 was independent with eating but dependent on staff for activities of daily living (ADL). R4 was on hospice services. R4’s “Functional Abilities Care Area Assessment (CAA)” dated 04/24/25 documented she was a significant change in status related to a recent hospitalization for gastrointestinal (GI) bleed and aspiration pneumonia (a lung infection caused by inhaling food, liquid, vomit, or saliva into the lungs). R4 returned to the facility on hospice services. R4 has had weight loss. R4 has had a deterioration in her ADLs and required two staff to assist for safety. R4 used a wheelchair for mobility, propelled by staff. R4’s “Care Plan,” revised on 07/22/25, directed staff that she was on hospice services. The Care Plan directed staff to refer to her notebook at the nurses' station related to her care and services from hospice. The Care Plan directed staff to work cooperatively with the hospice team to ensure the resident’s spiritual, emotional, intellectual, physical, and social needs were met. R4’s Care Plan lacked staff direction on the hospice contact information, the supplies and medications provided by hospice, and hospice staff and the frequency of visits. On 08/05/25 at 07:54 AM, R4 laid in her bed with her supplemental oxygen on via a nasal cannula (a device that gives you supplemental oxygen through your nose). On 08/06/25 at 09:15 AM, Certified Nurse Aide (CNA) N stated that residents who were on hospice each had a notebook at the nurse’s station that had the hospice information. CNA N stated he could not say what supplies hospice provided, and all that information was in their notebook. CNA N stated the nurse usually would relay any hospice information to them. On 08/06/25 at 09:30 AM, Licensed Nurse (LN) G stated that R4’s care plan had information about her being on hospice and the hospice provider. LN G stated that any other information about what hospice provided was in R4’s hospice book at the nurse’s station. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/06/25 at 09:34 AM, Administrative Nurse D stated R4’s care plan did let staff know she was on hospice services, but did not contain the hospice contact information, the medications, or supplies that hospice provided. Administrative Nurse D stated that R4’s hospice book at the nurse’s station contained all the information on what hospice provided, and staff could find the information there. Administrative Nurse D stated she had not thought about including that information on R4’s facility care plan. The facility’s “Hospice Services” policy dated 08/01/25 documented the facility would coordinate care planning with the hospice provider including all services and supplies provided by the hospice provider including: nursing services; nurse aide services; social service; chaplaincy services; durable medical equipment; medications; and grief support to family members. - R32’s Electronic Medical Record (EMR) included diagnoses of severe protein-calorie malnutrition, chronic kidney disease, major depressive disorder (major mood disorder that causes persistent feelings of sadness), non-pressure chronic ulcer of the left lower leg, paralytic syndrome (loss of muscle function leading to weakness or inability to move), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), disorder of arteries, peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk). R32’s “Significant Change Minimum Data Set” (MDS), dated [DATE], documented R32 had mild cognitive impairment, was dependent on staff with toileting hygiene, bathing, and lower body dressing, and required partial/moderate assistance with upper body dressing. R32 received scheduled and as-needed pain medication and had pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). The MDS further documented that R32 had a condition or chronic disease that may result in a life expectancy of less than six months and received hospice care. R32’s “Functional Abilities Care Area Assessment” (CAA), dated 07/17/25, documented R32 had been admitted to hospice for palliative care (treatment designed to relieve or reduce the intensity of uncomfortable symptoms) and would proceed to the Care Plan. R32’s “Care Plan” dated 07/17/25, documented R32 had a terminal prognosis related to severe protein-calorie malnutrition secondary to chronic kidney disease. The Care Plan directed staff to adjust provisions of Activities of Daily Living (ADL) to compensate for resident’s changing abilities, encourage participation to the extent the resident wishes, and a hospice notebook kept at the nurses’ station. The Care Plan further directed staff to work cooperatively with the hospice team to ensure R32’s spiritual, emotional, intellectual, physical, and social needs were met. The care plan lacked specifics of delegation of hospice staff services, visit frequency, medication, medical equipment, and supplies provided. The Hospice Physician Order” dated 07/09/25, documented R32 admitted to hospice services with a diagnosis of severe protein-calorie malnutrition secondary to kidney disease, and weight loss was expected due to the disease process. The patient’s life expectancy was six months or less if the disease followed natural progression. Discharge from hospice upon death. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The “Progress Note” dated 07/08/25 at 11:09 AM, documented that facility staff spoke with R32 regarding his current health status and his recent decision to no longer pursue hospitalizations, blood transfusions, ectara. The facility staff discussed hospice services and benefits, and R32 was in agreement with hospice services at that time and would speak to his spouse and let the spouse know of his decision. On 08/05/25 at 09:37 AM, R32 sat in bed, on a low air loss mattress, watching TV with a breakfast tray on the overbed table. On 08/05/25 at 03:41 PM, Licensed Nurse (LN) H reported that the facility care plan had included the name of the hospice provider, but lacked specifics related to supplies, medication, and treatment responsibilities for R32. LN H stated some of the information may be in the hospice notebook for R32, which was located at the nurses’ station. On 08/06/25 at 09:43 AM, Administrative Nurse D stated that each resident had a hospice notebook, which was located at the nurses’ station for review. Administrative Nurse D reported R32’s hospice provider did not specify when hospice staff was to visit the resident or specifics related to medications and supplies. The facility’s “Hospice Services” policy, dated 08/01/25, documented an interdisciplinary care plan that integrates the care and services provided by the facility and the hospice provider. The facility would coordinate care planning with the hospice provider, including all services and supplies provided by the hospice provider, including nursing services, nurse aide services, social services, chaplaincy services, durable medical equipment, medications, and grief support to family members.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility had a census of 62 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to provide enhanced barrier precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) for Resident (R) 17. The facility staff failed to change gloves when providing incontinent care for R17. This deficient practice placed the residents at risk for possible exposure to infection.Findings included:- On 08/04/25 at 03:30 PM, observation revealed no EBP signage or personal protective equipment (PPE) outside or inside R17's room. On 08/04/25 at 03:34 PM, R17 sat in a chair in the living room area between all halls. Licensed Nurse (LN) F and Certified Nurse Aide (CNA) M assisted R17 using a walker and a gait belt to R17's room. LN F asked the resident if she could provide wound care to her left heel. R17 replied yes and smiled. CNA M applied gloves, cued R17 to sit on the bedside. LN F placed a barrier on the bed, put all items on it, applied gloves, and removed R17's heel protector boot from the left foot and sock to reveal a wound (without a dressing), with oval-shaped black eschar (dead tissue) with an opening above the eschar. Above this area was an open area with a small amount of serious (thin, clear) drainage. LN F applied wound wash on a 4 by 4 gauze pad and cleansed the wound, then removed and discarded gloves, applied new gloves, and placed betadine (prevents the growth of disease-causing microorganisms on the skin) on a 4x4 gauze pad and applied it to the wound. LN F then removed and discarded gloves, applied new gloves, and left the wound open to air. LN F placed R17's socks and heel protector back on. Further observation revealed CNA M assisted the resident to stand by the bed. R17 stood and took hold of her walker. Further observation revealed CNA M removed R17's wet incontinent brief, provided perineal (private area) care, then, without changing gloves, placed a new incontinent brief on R17, pulled R17's blouse down in the back, pulled up R17's pants up and placed blouse over her pants, then removed and discarded her gloves. When LN F was asked if R17 was on EBP, she stated she did not think so because she never used the PPE when providing wound care to R17's left heel.On 08/05/25 at 08:47 AM, Administrative Nurse D stated she was unaware R17 was not on EBP and stated the resident should be on them. When she first obtained the wound, the resident was not placed on EBP because it was not open, but on 07/30/25, the wound had serous drainage, and R17 should have been placed on EBP then.On 08/06/25 at 08:14 AM, Administrative Nurse D stated she would expect staff to change gloves between dirty and clean when providing incontinent care. The facility's Enhanced Barrier Precautions (EBP) documented that EBP would be implemented as one intervention this facility used to reduce transmission of resistant organisms that employs targeted personal PPE use during high-contact resident care activities. Standard precautions continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. The policy documented that EBP would be used for residents with any of the following: Central line (a type of intravenous (IV) line that is inserted into a large vein, typically near the heart, to administer medications, fluids, blood products, or nutrition, or to draw blood), Urinary Catheter (a tube inserted into the bladder to drain the urine into a collection bag), feeding tube (tube for introducing high-calorie fluids into the stomach), an tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted)/ventilator (a machine or device used medically to support or replace the breathing of a person, and infection with a novel or targeted multiple drug-resistant organisms (MDRO- common bacteria that have developed resistance to multiple types of antibiotics).The facility's Female Perineal Care Policy, revised 05/01/25, instructed staff, when providing perineal care, to use the following procedure: wash hands, collect equipment, explain the procedure to the elder, ask another staff member to assist them if the resident is anxious or needs assistance with turning and repositioning, close bedroom door, and if a semi-private room, ensure privacy curtain provides for complete perineal privacy. The policy instructed staff to wash their hands and put on gloves, clean the perineal area with a wet washcloth or perineal wipes, discard gloves into the wastebasket, wash hands and put on clean gloves, then assist the resident with clothing and remake the bed, if needed, and reposition the resident, etc.