STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey. The 2567 was sent elcetronically on 04/16/25.	F 000		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 23 residents. The sample included 13 residents, with one resident reviewed for trauma informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R) 2's post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization. These deficient practices placed R2 at risk for decreased psychosocial well-being and ineffective treatment. Findings included: - R2's Electronic Medical Record (EMR) from the	F 699		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

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F 699	Continued From page 1	F 699		

"Diagnosis" tab documented diagnoses of PTSD, schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Annual Minimum Data Set" (MDS) dated 03/10/25 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R2 had an active diagnosis of PTSD. The MDS documented R2 had daily behaviors that were not directed toward other residents. The MDS documented R2 had delusions (misconceptions or beliefs that are firmly held, contrary to reality) and hallucinations (perceptual experiences in the absence of real external sensory stimuli). The MDS documented R2 had received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), hypoglycemic (a class of medication used to lower blood sugar), and opioid (a class of controlled drugs used to treat pain).

R2's "Behavioral Symptoms Care Area Assessment" (CAA), dated 03/19/25 documented she had received several psychotropic medications to help control her mood and behaviors.

R2's "Care Plan" dated 04/15/22 documented she had a diagnosis of PTSD and the staff would complete an annual trauma-based assessment. The plan of care documented R2 had nightmares, avoided situations, felt guarded, and detached herself from activities. The plan of care dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 699	Continued From page 2	F 699		

02/09/23 documented the staff would complete her annual trauma-based assessment. The plan of care documented the nursing staff would notify the physician of any concerns or any abnormal behaviors. The plan of care lacked what trauma had caused her PTSD or what might possibly cause her to be retraumatized. The plan of care lacked personalized interventions to assist her with coping with her PTSD.

R2's EMR under the "Assessment" tab revealed the following "Primary Care PTSD Screen" dated 04/19/24 which documented R2 had answered yes to having nightmares or thoughts about her PTSD when she did not want to. The PTSD assessment documented R2 had answered she was constantly on guard, watchful, and was easily startled.

On 04/07/25 at 07:14 AM R2 stood in her room with the curtains pulled closed and the room light was off, as she looked through the top drawer of her dresser.

On 04/09/25 at 09:10 AM, Certified Nurse Aide (CNA) M stated he was not aware of any residents with the diagnosis of PTSD. CNA M stated a resident with PTSD would have it listed on their care plan with any events that would possibly retraumatize them.

On 04/09/25 at 09:20 AM, Licensed Nurse (LN) G stated staff could look in the resident's EMR under the diagnosis tab to find out who had a PTSD diagnosis and the type of trauma and any possible events that could cause them to be retraumatized. LN G stated everyone had access to the resident's care plan and their Kardex (nursing tool that gives a brief overview of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

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F 699	Continued From page 3 care needs of each resident). On 04/09/25 at 12:23 PM, Administrative Nurse D stated she expected a resident who had a diagnosis of PTSD to have a trauma-based assessment at the time of admission, annual, significant change, and as needed with any changes. The facility's "Trauma Informed Care" policy dated 1109/21 documented the facility would ensure residents who are trauma survivors received culturally competent, trauma-informed care accounting for the resident's experiences and preferences.	F 699		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 23 residents. The sample included 13 residents. Based on record review and interview, the facility failed to provide a Registered Nurse (RN) for at least eight	F 727		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 727	Continued From page 4	F 727		

consecutive hours a day seven days a week. This placed the residents at risk of decreased quality of care.

Findings included:

- The Payroll Based Journaling (PBJ) report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2024 quarter one, quarter two, quarter three, and quarter four indicated data was suppressed though the facility did not meet the reasons for suppressed data other than inaccurate data or failure to report.

The PBJ report indicated 74 days in FY 2024, the facility did not have a registered nurse (RN) for eight consecutive hours for each 24 hours. A review of the time clock information, and payroll data revealed the facility did not have eight consecutive hours of RN coverage for all but seven days (12/09/23, 01/14/24, 01/15/24, 01/16/24, 01/21/24, 01/24/24, and 07/07/24).

A review of the facility's monthly working nurses' schedule and RN clock in and clock out times from 10/01/24 to 03/31/25 revealed the facility did not have RN coverage for eight consecutive hours during each 24 hours for 44 of the 182 days.

On 04/09/25 at 12:33 PM, Administrative Nurse D stated she covered as the RN on duty a lot. Administrative Nurse D stated either herself or one of the corporate float RNs covered most of the required RN hours but did not always have an RN every weekend. Administrative Nurse D stated the facility did have an ad out for the need of an RN but had not had much luck with applicants.

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	17E591	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

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F 727	Continued From page 5 On 04/09/25 at 12:38 PM, Administrative Staff A stated the facility had Administrative Nurse D and one corporate RN that covered the RN hours. Administrative Staff A stated the facility had an ad out in the community for an RN position but had not been able to fill the position yet. Administrative Staff A stated the facility did their best to ensure an RN on duty daily, but was not always able to cover every day, mostly on the weekends. The "Competent and Sufficient Staffing" policy dated September 2024 documented the facility would provide the sufficient number of nursing staff with the skill sets and competency necessary to provide care and services for all residents in accordance with resident care plans and the "Facility Assessment". A licensed nurse, RN, or Licensed Practical Nurse (LPN) was designated as the charge nurse on each shift. The director of nursing (DON) may serve as the charge nurse only when the average daily occupancy of the facility was 60 or fewer residents. The RN provided services at least eight consecutive hours every 24 hours, seven days a week. RNs may be scheduled for more than eight hours depending on the acuity needs of the residents.	F 727		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

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F 757	Continued From page 6	F 757		

duplicate drug therapy); or

§483.45(d)(2) For excessive duration; or

§483.45(d)(3) Without adequate monitoring; or

§483.45(d)(4) Without adequate indications for its use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 23 residents. The sample included 13 residents, including five residents reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to ensure staff notified the physician when Resident (R) 11's physician ordered insulin (a hormone that lowers the level of glucose in the blood) was refused or held. This deficient practice placed R11 at risk of unnecessary medication administration and related complications.

Findings included:

- R11's Electronic Medical Record (EMR) documented diagnoses of type 2 diabetes mellitus (a chronic condition where the body either does not produce enough insulin or cannot effectively use the insulin it produces, leading to high blood sugar levels), schizoaffective disorder (a mental disorder characterized by gross

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 7	F 757		

distortion of reality, disturbances of language and communication, and fragmentation of thought), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid).

R11's "Annual Minimum Data Set (MDS)" dated 07/15/24, documented she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R11 was independent with most functional activities, but did require set-up and staff assistance for bathing and partial staff assistance with personal hygiene. R11 was continent of bladder and bowel. R11 received insulin injections daily, during the seven day lookback period. R11 also received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and a diuretic (a medication to promote the formation and excretion of urine) medication regularly.

R11's "Functional Abilities Care Area assessment (CAA)" dated 07/23/24 documented she was alert and able to make her needs known. R11 was mostly independent with her activities of daily living (ADL). She needed set-up help with showering, and supervision with eating. R11 needed redirection by staff and encouraging words. R11 would get anxious with her mental illness. Her level of assistance would depend on her mood and behaviors. Staff encouraged her to keep being as independent as possible, and staff helped as needed.

R11's "Care Plan" last revised on 04/07/25 directed staff to administer her insulin as ordered by her physician. Staff were directed to monitor the resident's blood glucose as ordered by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

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VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

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F 757	Continued From page 8	F 757		

physician and as needed. Staff were directed to notify the resident's physician if her blood sugars were not within parameters.

R11's "Order Summary" in the EMR recorded a physician's order dated 05/11/20 for blood glucose monitoring before meals related to her type two diabetes mellitus. Staff were to notify the physician if the resident's blood glucose was greater than 350 milligrams (mg) per deciliter (dl) (a unit of measurement used in medicine to express the concentration of a substance in a fluid sample, such as blood) or below 70 mg/dl.

R1's "Order Summary" in the EMR recorded a physician's order dated 06/04/24 for Novolog (a quick acting insulin used to lower blood sugars) solution 100 unit per milliliter (ml). Staff were to inject 55 units of the medication subcutaneously (SQ - beneath the skin) with meals for type 2 diabetes mellitus and administer within 15 minutes of the resident eating, twice daily. The order lacked parameters to hold or notify the physician.

A review of R11's "Medication Administration Record (MAR)" from November 2024 documented 90 opportunities for the administration of her scheduled Novolog of 55 units. R11 refused the administration of her Novolog on three of 90 opportunities. Staff held R11's Novolog due to her vitals being outside of parameters for administration on three of 90 opportunities.

R11's "Progress Notes" in the EMR from 11/01/24 to 11/30/24 lacked staff documentation that R11's physician was notified of the Novolog being held or R11's refusals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 9	F 757		

A review of R11's December 2024 "MAR" documented 93 opportunities for administration of her scheduled Novolog of 55 units. R11 refused administration of the Novolog on 12 of 93 opportunities and staff held R11's Novolog due to vitals being outside of parameters for administration on four of 93 opportunities.

R11's "Progress Notes" in the EMR from 12/01/24 to 12/31/24 lacked staff documentation that R11's physician was notified of the Novolog being held or R11's refusals.

A review of R11's January 2025 "MAR" documented 93 opportunities for administration of her scheduled Novolog of 55 units. R11 refused the administration of the Novolog on four of 93 opportunities. R11's Novolog was held due to vitals being outside of parameters for administration on four of 93 opportunities.

R11's "Progress Notes" in the EMR from 01/01/25 to 01/31/25 lacked staff documentation R11's physician was notified of the Novolog being held or R11's refusals.

A review of R11's February 2025 "MAR" documented 84 opportunities for the administration of her scheduled Novolog of 55 units. R11 refused the administration of the Novolog on two of 84 opportunities. R11's Novolog was held due to her vitals being outside of parameters for administration on four of 84 opportunities.

R11's "Progress Notes" in the EMR from 02/01/25 to 02/28/25 documented a "General Note" dated 02/03/24 stating the primary provider's office was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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
F 757	Continued From page 10	F 757		

notified of frequent refusals of her Novolog and no new orders were received. R11's "Progress Notes" lacked staff documentation that R11's physician was notified of the Novolog being held or R11's refusals after 02/03/25.

A review of R11's March 2025 "MAR" documented 93 opportunities for the administration of her scheduled Novolog of 55 units. R11 refused the administration of the Novolog on four of 93 opportunities. R11's Novolog was held due to vitals being outside of parameters for administration on three of 93 opportunities.

R11's "Progress Notes" in the EMR from 03/01/25 to 03/31/25 lacked staff documentation that R11's physician was notified of the Novolog being held or R11's refusals.

A review of R11's April 2025 "MAR" from 04/01/25 to 04/07/25, documented 21 opportunities for the administration of her scheduled Novolog of 55 units. R11 refused the administration of the Novolog on two of the 21 opportunities.

R11's "Progress Notes" in the EMR from 04/01/25 to 04/07/25 lacked staff documentation that R11's physician was notified of the Novolog being refused.

On 04/08/25 at 11:20 AM, R11 walked from her room to the dining room for lunch.

On 04/09/25 at 11:17 AM, Licensed Nurse (LN) G stated the physician should be notified any time that R11 had refused her Novolog. LN G stated R11 did not have hold parameters for her Novolog since it was a scheduled dose amount

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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
F 757	Continued From page 11 and not a sliding scale amount. LN G stated R11's Novolog should not be held if the order did not have specific hold parameters included. On 04/09/25 at 12:23 PM, Administrative Nurse D stated R11 did have scheduled Novolog she was ordered to receive three times daily. Administrative Nurse D stated R11's Novolog was a scheduled amount and did not have hold parameters in the order. Administrative Nurse D stated any time R11 refused or if the medication was held the nurse was expected to document that the physician had been notified. The "Notification of Changes" policy revised 04/27/18 documented the facility would inform the resident, the resident's physician, and the resident's representative of any changes in the resident's status. The facility would immediately inform the resident, consult the physician; and notify, consistent with his or her authority, the resident representative when there was a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).	F 757		
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update	F 838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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
F 838	Continued From page 12	F 838		

this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.

§483.71(a) The facility assessment must address or include the following:
§483.71(a)(1) The facility's resident population, including, but not limited to:
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20;
(iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;
(iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.71(a)(2) The facility's resources, including but not limited to the following:
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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
F 838	Continued From page 13	F 838		

rehabilitation therapies;
(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).

§ 483.71(b) In conducting the facility assessment, the facility must ensure:
§ 483.71(b)(1) Active involvement of the following participants in the process:
(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and
(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.
(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.

§483.71(c) The facility must use this facility assessment to:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	04/09/2025

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F 838	Continued From page 14	F 838		

§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).

§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.

§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.

§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.

§483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 23 residents. The sample included 13 residents. Based on record review and interview the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents during both day-to-day operations and emergencies. This failure affected all 23 residents in the facility.

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F 838	Continued From page 15	F 838		

Findings Included:

- An inspection of the "Facility Assessment" dated January 2025 provided by the facility revealed the following:

The assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment further lacked the staffing levels required for each shift.

The assessment failed to identify the means of input gathered from the residents and their representatives when the assessment data was formulated.

On 04/09/25 at 12:38 PM, Administrative Staff A stated the facility staff and the quality assurance committee carefully went through each aspect of the facility assessment and tried to ensure all of the required areas were addressed. Administrative Staff A stated she thought it was sufficient to include the information needed to staff the facility each day and did not know that it needed broken down by shift and include the weekends.

The "Facility Assessment" policy revised on 04/27/18, documented a facility-wide assessment would be conducted to determine what resources were necessary to care for the residents. The facility assessment would be used to determine what resources were necessary to care for a resident competently during both day-to-day operations and emergencies. The facility

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F 838	Continued From page 16 assessment would be revised and updated at least annually and whenever there was a change that required substantial modifications to any part of the assessment. The facility failed to conduct a thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 23 residents in the facility.	F 838		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS	F 851		

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F 851	Continued From page 17	F 851		

complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(p)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(p)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(p)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 23 residents. Based on interview, and record review the facility failed to submit accurate staffing information to the federal regulatory agency through Payroll

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F 851	Continued From page 18	F 851		

Based Journaling (PBJ), when the facility failed to submit accurate registered nurse (RN) coverage hours.

Findings included:

- The PBJ report provided by the Centers for Medicaid and Medicare (CMS) for Fiscal Year (FY) 2024 quarter one, quarter two, quarter three, and quarter four FY 2024 documented the following triggered areas:

The quarter one PBJ documentation revealed the facility had a one-star staffing rating and documented no RN hours. The facility failed to have information for RN clock in and out times for staff hours on 10/01/23, 10/15/23, 10/28/23, 10/29/23, 11/05/23, 11/11/23, 11/12/23, 11/19/23, 11/22/23, 11/23/23, 11/24/23, 11/25/23 11/26/23, 12/03/23, 12/09/23, 12/10/23, 12/17 /23, 12/23/23, 12/24/23, 12/25/23, 12/30/23, and 12/31/23 during quarter one of FY 2024.

The PBJ report provided by CMS for FY 2024 for quarter two revealed the facility had a one star staffing rating, RN hours, and noted the facility failed to have licensed nurse coverage 24 hours per day.

The facility was unable to provide requested RN clock in and out times for staff hours on the following dates: 01/01/24, 01/06/24, 01/07/24, 01/14/24, 01/27/24, 01/28/24, 02/03/24, 02/04/24, 02/11/24, 02/17/24, 02/18/24, 02/25/24, 03/02/24, 03/03/24, 03/10/24, 03/16/24, 03/17/24, 03/30/24, and 03/31/24.

The facility was able to provide documentation of clock in and out times for RN coverage on

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F 851	Continued From page 19	F 851		

01/15/24, 01/16/24, 01/20/24, 01/21/24, and 01/24/24, but that information was not submitted in the PBJ as required.

The PBJ report provided by the CMS for FY 2024 quarter two revealed the facility had a one star staffing rating, RN hours, and noted the failed to have licensed nursing coverage 24 hours per day.

The facility was unable to provide the requested RN clock in and out times for staff hours on the following dates: 04/07/24, 04/21/24, 04/27/24, 04/28/24, 05/11/24/24, 05/12/24, 05/19/24, 05/25/24, 05/26/24, 05/27/24, 06/08/24, 06/22/24, 06/25/24,

The facility was unable to provide the requested RN clock in and out times for staff hours on the following dates: 07/04/24, 07/06/24, 07/14/24, 07/20/24, 07/21/24, 07/28/24, 08/03/24, 08/04/24, 08/11/24, 08/16/24, 08/17/24, 08/31/24, 09/02/24, and 09/19/24.

The facility was able to provide punch times for RN coverage on 07/07/24 and 09/19/24, but that information was not submitted in the PBJ as required.

On 04/09/25 at 12:38 PM, Administrative Staff A stated there were times when the facility had RN coverage, but did not have a way to log the hours when Administrative Nurse D and/or a corporate float RN worked so those hours were not submitted for the PBJ.

The facility failed to provide a policy regarding PBJ reporting.