STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175100	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/06/2026

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

(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
F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigation 3054899. The census was 88. The sample included 3 residents.	F0000		
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.	F0582		

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 reverse for further 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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F0582 SS = D	Continued from page 1 (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to inform Resident (R)1 about the potential of non-coverage and the option to continue services with the beneficiary accepting liability for those services when staff failed to provide the CMS 10055, “Advanced Beneficiary Notice” (ABN), in a timely manner to Resident (R) 1’s representative. Findings included: - The Medicare ABN form informed the beneficiaries Medicare may not pay for future therapy. The form included options for the beneficiary to (1) receive specified services listed, and bill Medicare for an official decision on payment. I understand if Medicare does not pay, I will be responsible for payment but can appeal to Medicare. (2) receive therapy listed but do not bill Medicare; I am responsible for payment of services. (3) I do not want the listed services. The facility provided R1 with the Notice of Medicare Non-Coverage (NOMNC), form 10123, on June 29, 2026, notifying R1’s representative R1’s last day of coverage would be 07/02/2026. The facility failed to provide the ABN until 07/06/2026. On 07/06/2026 at 01:30 PM, Social Services Designee (SSD) X stated she had given the ABN to R1’s representative on 07/06/2026. SSD X stated the ABN was late.	F0582		

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F0582 SS = D	Continued from page 2 On 07/06/2026 at 02:30 PM, Administrative Nurse D stated SSD X had provided R1, who was moderately cognitively impaired, and R1 refused to sign the ABN. Administrative Nurse D stated according to the facility's policy, the facility allowed residents with a Brief Interview for Mental Status (BIMS) score of 12 (moderately cognitively impaired) to be able to sign legal papers without their representative. The facility did not provide an ABN policy.	F0582		