| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175191 | A. BUILDING _____ B. WING _____ | C 07/22/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **STONEYBROOK RETIREMENT COMMUNITY** | **2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503** |

| (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<br><br>The following citations represent the findings of complaint investigation #154254. The 2567 was electronically sent to the facility on 07/28/2020. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) 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); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or | F 580 | | |

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 |
|---|---|---|---|
| | 175191 | A. BUILDING _____ B. WING _____ | C 07/22/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **STONEYBROOK RETIREMENT COMMUNITY** | **2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503** |

| (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 580 | Continued From page 1 | F 580 | | |

State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 42 residents. Based on record review and interview, the facility failed to notify Resident (R) 1's physician of concerns following catheterization (insertion of a a flexible tube inserted through a narrow opening into a body cavity) and failed to notify R1's family in a timely manner of her emergency room transfer.

Findings included:

- Review of the medical records documented the facility admitted R1 on 07/05/20. R1's "Physician Order Sheet," dated 07/05/20, documented the following diagnoses: acute kidney failure (the kidneys suddenly lose their filtering ability, and the blood's chemical makeup may get out of balance at dangerous levels), dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, bipolar disorder (major mental illness that caused people to have episodes of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175191 | A. BUILDING _____ B. WING _____ | C 07/22/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **STONEYBROOK RETIREMENT COMMUNITY** | **2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503** |

| (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 580 | Continued From page 2 | F 580 | | |

severe high and low moods), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin, disorder of electrolyte (minerals that help keep the body's fluid levels in balance, necessary to help the muscles, heart and other organs work properly), altered mental status, gastro esophageal reflux disorder (GERD-backflow of stomach contents to the esophagus), and muscle weakness.

The "Admission Minimum Data Set" (MDS), dated 07/09/20, recorded the resident had severe cognitive impairment, required supervision and assistance of one staff with eating, dressing and mobility. The MDS recorded the resident received scheduled pain, antipsychotic (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) medications.

The "Care Area Assessments " (CAA) had not been completed related to the resident's short stay.

The "Initial Care Plan," dated 07/05/20, documented the resident required one staff assistance with toilet use, dressing, and mobility and was in room isolation for 14 days. The document directed staff to immediately notify the resident's family of care plan updates and changes.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175191 | A. BUILDING _____ B. WING _____ | C 07/22/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONEYBROOK RETIREMENT COMMUNITY | 2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503 |

| (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 580 | Continued From page 3 | F 580 | | |

The "Nursing Progress Note," dated 07/11/20 at 06:01 AM, documented at 05:15 AM the resident vomited watery, brown in color with coffee ground sediment liquid. The note documented staff notified the physician who directed staff to send the resident to the emergency room. The note documented the resident left the facility at 06:00 AM. The note lacked documentation the facility notified the resident's family of the resident's condition or transfer.

On 07/22/20 at 02:13 PM, Licensed Nurse (LN) G reported the resident ate about half of her meals and had nausea and vomiting the evening before admission to the hospital. LN G reported the resident had not voided on her shift and LN G obtained a physician order to catheterize (insertion of a catheter into the bladder to drain the urine) the resident. LN G stated the catheter returned a small amount of dark colored urine and LN G stated she did not notify the physician. LN G reported she passed the information onto the following night shift staff who would pass the information to the day shift nurse to obtain orders for a urinalysis.

On 07/22/20 at 03:17 PM, Administrative Nurse D stated she expected staff to notify the physician of abnormal resident assessments and conditions, and document physician communication and orders. Administrative Nurse D stated at 09:59 AM on 07/11/2020 she contacted R1's family to report the resident had been transferred to the emergency room (4 hours earlier). Administrative Nurse D stated when R1's transfer was reported to her, the family had not been notified of the transfer. Administrative Nurse D stated she called the family herself and the family should have been notified right away when

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175191 | A. BUILDING _____ B. WING _____ | C 07/22/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONEYBROOK RETIREMENT COMMUNITY | 2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503 |

| (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 580 | Continued From page 4<br>the resident was transferred.<br><br>The facility's "Notification of Change" policy, dated 04/27/2018, directs staff to immediately inform the resident's physician of any changes in the resident's status and promptly notify the resident's representative of decision to transfer or discharge the resident from the facility.<br><br>The facility failed to notify R1's physician of concerns following catheterization and R1's representative of transfer to the emergency room in a timely manner, placing the resident at risk for continued decline and lack of representation during a hospital admission. | F 580 | | |
| F 692 SS=G | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care | F 692 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175191 | A. BUILDING _____ B. WING _____ | C 07/22/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONEYBROOK RETIREMENT COMMUNITY | 2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503 |

| (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 692 | Continued From page 5 | F 692 | | |

provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 42 residents. The sample included three residents reviewed for hydration. Based on interview and record review, the facility failed to provide one of three sampled residents, Resident (R) 1, assistance with hydration, failed to monitor her condition and continued nausea, dehydration, or notify the physician which caused the resident to hospitalized and placed in an Intensive Care Unit.

Findings included:

- Review of the medical records documented the facility admitted R1 on 07/05/20. R1's "Physician Order Sheet," dated 07/05/20, documented the following diagnoses: acute kidney failure (the kidneys suddenly lose their filtering ability, and the blood's chemical makeup may get out of balance at dangerous levels), dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin, disorder of electrolyte (minerals that help keep the body's fluid levels in balance, necessary to help the muscles, heart and other organs work properly), altered mental status, gastro esophageal reflux disorder (GERD-backflow of stomach contents to the esophagus), and muscle weakness.

The "Admission Minimum Data Set" (MDS), dated 07/09/20, recorded the resident had severe

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175191 | A. BUILDING _____ B. WING _____ | C 07/22/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONEYBROOK RETIREMENT COMMUNITY | 2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503 |

| (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 692 | Continued From page 6 | F 692 | | |

cognitive impairment, required supervision and assistance of one staff with eating, dressing and mobility. The MDS recorded the resident received scheduled pain, antipsychotic (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) medications.

The "Care Area Assessments " (CAA) had not been completed related to the resident's short stay.

The "Initial Care Plan," dated 07/05/20, documented the resident required one staff assistance with toilet use, dressing, and mobility and was in room isolation for 14 days. The document directed staff to immediately notify the resident's family of care plan updates and changes.

The "Change in Condition Report," dated 07/06/20 at 04:45 AM, recorded the resident was not oriented to time, place, or situation. The assessment recorded the resident had short term memory impairment, confusion, hallucinations (sensing things while awake that appear to be real, but the mind created), and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The assessment recorded the resident required assistance with eating, had nausea without emesis, and the physician ordered a Basic Metabolic Panel (BMP- blood test that gives

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175191 | A. BUILDING _____ B. WING _____ | C 07/22/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONEYBROOK RETIREMENT COMMUNITY | 2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503 |

| (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 692 | Continued From page 7 | F 692 | | |

doctors information about the body's fluid balance and level of electrolytes) and Zofran (a medication that can prevent nausea and vomiting).

The "Nursing Progress Note," dated 07/06/20 at 09:40 AM, recorded staff notified the on-call physician the resident felt nauseated and vomited a little orange juice.

Review of the resident's "July Physician's Orders" lacked an order for a BMP or Zofran.

Review of the "July Electronic Medication Administration Record" (MAR) recorded staff did not administer Zofran to R1.

The "Social Service Note," dated 07/08/20 at 01:00 PM, documented the resident refused to allow staff to assess her, stated to nursing staff she wanted to sleep, and her "tummy was upset."

The "Dietary Assessment," dated 07/10/20 at 03:42 PM, documented the resident received a low concentrated sweet diet, ate independently in her room at that time, had a poor appetite, and nausea.

The "Nursing Progress Note," dated 07/10/20 at 08:50 PM, documented the resident vomited, had not voided during the shift, had a poor appetite, and poor fluid intake. The note documented the resident had increased confusion and staff notified the physician.

The 07/10/20 "Nutritional Summary and Plan" recorded the resident was independent with meals in her room due to isolation restrictions, poor appetite, and nausea. The notes

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175191 | A. BUILDING _____ B. WING _____ | C 07/22/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONEYBROOK RETIREMENT COMMUNITY | 2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503 |

| (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 692 | Continued From page 8 | F 692 | | |

documented on 07/05/20 the resident's glucose was 116 milligrams/deciliter (mg/dl) (normal 70-130), BUN (blood, urea, nitrogen) 12 (normal 5-20 mg/dl), Creatinine 1.08 (normal 0.6-1.2 mg/dl), Sodium 139 (normal 135-145 milliequivalents per liter (mEq/L), and Potassium 3.4 (normal 3.5-5.1 mEq/L). The note documented nutritional risk factors - potential for poor intake, diagnosis of dementia, risk for dehydration, current or history of nausea, vomiting or diarrhea. The note lacked the recommended 24 hours fluid intake for the resident.

The "Nursing Progress Note," dated 07/11/20 at 06:01 AM, documented at 05:15 AM the resident vomited watery, brown in color with coffee ground sediment liquid. The note documented staff notified the physician who directed staff to send the resident to the emergency room. The note documented the resident left the facility at 06:00 AM.

R1's "July Fluid Intake Record" recorded the following daily intakes:
07/05/20 - 240 (ml) milliliters
07/06/20 - 720 ml
07/07/20 - 720 ml
07/08/20 - 480 ml
07/09/20 - 720 ml
07/10/20 - 380 ml

R1's "July Amount Eaten Record" recorded the following daily intakes:
07/05/20 - 100% of supper meal
07/06/20 - 0-25% of all three meals
07/07/20 - 75-100% of all three meals
07/08/20 - refused breakfast, 0-25% of lunch and supper

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175191 | A. BUILDING _____ B. WING _____ | C 07/22/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONEYBROOK RETIREMENT COMMUNITY | 2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503 |

| (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 692 | Continued From page 9 | F 692 | | |

07/09/20 - 100% of breakfast and lunch, 25% of supper
07/10/20 - 51-75 % of breakfast, refused lunch, 0-25% of supper
07/11/20 - 76-100 % of breakfast.

Review of R1's "Hospital History and Physical," dated 07/11/20 recorded the follow lab results obtained 07/11/20 at 06:37 AM: Sodium 130 mEq/L, Potassium 6.4 mEq/L, Creatinine 8.23 mg/dl.

Review of R1's "Hospital Record," dated 07/11/20 at 01:05 PM, recorded the resident admitted to the hospital with acute renal failure, poor oral intake, and renal failure most likely related to volume depletion. The resident stated she was thirsty/wanting to drink, had not been drinking well because no one brought her fluid, alert, and could follow simple commands.

On 07/22/20 at 12:45 PM, Certified Medication Aide (CMA) R stated the resident was very lethargic, vomited, and had trouble taking her medications. CMA R reported she informed the nurse and thought the nurse gave the resident something for nausea before the resident went to the hospital.

On 07/22/20 at 01:30 PM Certified Nurse (CNA) M stated when she cared for R1 the resident was unsteady and spilled her drinks, but CNA M did not help R1 eat or drink due to being the only aide working that hall and did not know the resident required assistance.

On 07/22/20 at 02:13 PM, Licensed Nurse (LN) G reported the resident ate about half of her meals and had nausea and vomiting the evening before

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175191 | A. BUILDING _____ B. WING _____ | C 07/22/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **STONEYBROOK RETIREMENT COMMUNITY** | **2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503** |

| (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 692 | Continued From page 10 | F 692 | | |

admission to the hospital. LN G reported the resident had not voided on her shift and LN G obtained a physician order to catheterize (insertion of a catheter into the bladder to drain the urine) the resident. LN G stated the catheter returned a small amount of dark colored urine and LN G stated she did not notify the physician.

On 07/22/20 at 03:17 PM, Administrative Nurse D stated she expected nursing staff to notify the physician of abnormal resident assessments and conditions, and document physician communication and orders.

On 07/22/20 at 04:55 PM, Administrative Nurse E reported on 07/06/20 the resident had a tele-med visit with the physician and at that time the physician gave orders for a BMP and Zofran. Administrative Nurse E stated the order was not sent to the facility, the facility did not follow up on the order, there was no record of the tele-visit, or physician progress note. Administrative Nurse D stated the facility staff should have followed up with the physician order and note.

Upon request, the facility failed to provide a hydration policy.

The facility failed to provide R1 assistance with hydration, failed to monitor her condition and continued nausea, dehydration, or notify the physician which caused the resident to hospitalized and placed in an Intensive Care Unit.