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 _____	04/05/2023

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 The following citations represent of a Health Resurvey and Complaint Investigation #KS 00175049. The 2567 was sent electronically on 04/19/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

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 _____	04/05/2023

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 550	Continued From page 1	F 550		

resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents, with two reviewed for dignity. Based on observation, record review, and interview, the facility failed to promote care in a manner to maintain and enhance dignity and respect for two sampled residents, Resident (R) 33, who was unnecessarily exposed from the waist down, and R20, who was taken to the dining room with soiled pants. This placed the resident's at risk for undignified care and services.

- The Electronic Medical Record for R33 documented diagnoses of type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), hyperlipidemia (condition of elevated blood lipid levels), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), urinary retention (a lack of ability to urinate and empty the bladder).

R33's "Admission Minimum Data Set" (MDS), dated 12/04/22, documented R33 had intact

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 _____	04/05/2023

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 550	Continued From page 2	F 550		

cognition and required extensive assistance of one staff for transfers, dressing, toileting, and personal hygiene. The MDS further documented R33 required the use of an indwelling Foley catheter (tube used for draining urine from the bladder and having an inflatable part at the bladder end that allows the tube to be kept in place for variable time periods), was always incontinent of bowel, and had a urinary tract infection (an infection in any part of the urinary system) in the last 30 days.

The "Quarterly MDS," dated 03/02/23, documented R33 had intact cognition and required extensive assistance of two staff for transfers, toileting, and extensive assistance of one staff for bed mobility. The MDS further documented R33 had an indwelling Foley catheter and was frequently incontinent of bowel.

The "Urinary Catheter Care Plan," dated 03/16/23, initiated on 2/13/22, directed staff to ensure catheter care was performed every shift and as needed, if staff notice R33's urine turning darker in color, encourage good fluid intake. The plan directed if she was experiencing burning, cloudy or foul odor from the urine, let her physician know right away, and replace her catheter as ordered by the physician. Monitor urine output each shift, if staff notice a low urine output, sediment in her urine, abnormal urine color, notify the physician. The update dated 03/16/23 further directed staff to apply a urinary catheter leg drainage bag to R33's catheter when she was out of her bed or up ambulating.

On 04/04/23 at 08:15 AM, observation revealed R33 laid in bed. Certified Nurse Aide (CNA) O and CNA P applied gloves and pulled down the

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 _____	04/05/2023

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 550	Continued From page 3	F 550		

resident's incontinence brief and pants. CNA O took R33's catheter bag, still full of urine, and guided the bag up the inside of the right pant leg and out the top of R33's pants. Further observation revealed CNA O and CNA P stood there as R33 was exposed from the waist down and discussed who would complete the catheter care and who would drain the catheter bag. Continued observation revealed CNA P took an incontinence wipe, performed incontinence care, and ran out of wipes before she could do catheter care. CNA P opened R33's nightstand drawer with soiled hands and was unable to find gloves. CNA O looked for more incontinence wipes in R33's dresser drawer and stated "Well, I guess we need to stock these rooms" and took R33's roommates' s incontinence wipes. Observation revealed R33 continued to be exposed from the waist down as the CNAs looked for incontinence wipes. CNA P took an incontinence wipe and wiped around the catheter tubing at the insertion site but did not cleanse the catheter tubing. With the same soiled gloves, CNA P and CNA O pulled up R33's incontinence brief and pants. Further observation revealed CNA O sat a container on the floor to drain the catheter bag, and spilled urine on the floor. CNA O stated, "how did it get spilled onto the floor?" CNA O failed to cleanse the port of the catheter tubing before clamping the tubing, took the catheter bag and down the top of R33's pants, down the inside of the right pant leg and held onto it as he assisted R33 into her recliner and asked her where she wanted him to place the catheter bag. R33 instructed CNA O to put the catheter bag in the dignity bag and lay it on top on her trash can.

On 04/04/23 at 12:20 PM, CNA P verified they had not covered R33 up when looking for extra

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 _____	04/05/2023

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 550	Continued From page 4	F 550		

gloves.

On 04/05/23 at 11:56 AM, Administrative Nurse D stated staff should not leave residents exposed if they are not providing cares.

Upon request, a policy for dignity was not provided by the facility.

The facility failed to promote care in a manner to maintain and enhance dignity and respect for R33, who was exposed from the waist down without cares being given. This placed the resident risk for undignified care and services.
- R20's Electronic Medical Record (EMR), recorded diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), low back pain, overactive bladder, chronic kidney disease, peripheral vascular disease (abnormal condition affecting the blood vessels) and behavioral disturbance.

The "Quarterly Minimum Data Sheet" (MDS), dated 03/16/23, documented R20 had moderately impaired cognition, required limited assistance of one person for activities of daily living, and physical help of one staff for bathing. R20 had occasional incontinence of urine and bowel, was not steady but able to stabilize without staff assistance.

The "Urinary Incontinence Care Area Assessment", dated 09/26/22, documented R20 was occasionally incontinent of urine per voiding diary, required limited assistance with toileting and toileting hygiene, and wore incontinent products to help clothing and promote dignity. R20 had been open toilet with cueing and the

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 _____	04/05/2023

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 550	Continued From page 5	F 550		

facility planned for incontinence with the start of toileting program of cueing to toilet at 06:00 AM, after meals, midafternoon and at bedtime to help promote continence.

The "Progress Note", dated 03/22/23 at 04:16 PM, documented R20 had not walked to the dining room for meals. R20 sat in her walker/wheelchair at the opening to her room and yelled for help. R20 reported she could not walk, but with staff encouragement she did walk to the dining room.

On 04/03/23 at 08:03 AM observation revealed R20 walked into the dining room escorted by a Certified Medication Aide (CMA) R. R20's pants, on her buttocks area, were visibly wet. R20's pants sagged with wetness/weight of an incontinent brief. Survey team member brought the wet pants to CMA R's attention. CMA R instructed the hospitality aide to take R20 to the bathroom. The hospitality aide informed CMA R she could not take R20. Licensed Nurse (LN) H identified the name of R20 to the surveyor, and the survey told LN H R20 pants were wet, LN H looked at R20's pants and did not direct staff to provide assistance with the incontinence. Staff then sat R20 in a dining room chair for breakfast. R20 had uncombed oily hair.

On 04/03/23 at 12:11 PM observation revealed staff pushed R20 while she sat on the seat of her walker. R20 had uncombed, oily hair. Staff encouraged and assisted R20 into a dining chair with a gait belt. As R20 stood, a round, wet circle was visible on the back of her pants and her incontinent product sagged between her legs. Staff preceded to sit R20 in the chair to eat her breakfast.

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 _____	04/05/2023

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 550	Continued From page 6	F 550		

On 04/03/23 at 01:06 PM observation revealed R20 made it to her room, from the dining room, and called for help as staff were bringing other residents to their rooms. Staff inquired what R20 needed and R20 told them she wanted to go upstairs. Staff then assisted R20 back to the dining room in her walker chair and placed her in front of her plate.

On 04/03/23 at 01:29 PM Administrative Nurse D assisted R20 to stand and R20 continued to have a wet spot on the back of her pants. Staff assisted R20 to her room in a wheelchair. Staff assisted R20 to her recliner. Surveyor alerted staff R20 had wet pants and a filled, sagging brief. Staff looked at each other and asked each other if they saw the wetness. Staff then assisted resident to the bathroom and assisted to change R20's pants and brief, before returning R20's recliner. R20's hair remained uncombed and oily in appearance.

On 04/03/23 at 01:32 PM Certified Nurse Aide (CNA) O stated R20 had a toileting routine. The routine was to toilet R20 when she got up in the morning, after breakfast, before lunch, the middle of the afternoon, then R20 would sleep until supper time. CNA O was unsure of the toileting schedule for the other shifts.

On 04/03/23 at 01:29 PM CMA S stated R20 took usually toileted independently. CMA S stated R20 usually wore pullup undergarments. CMA S stated she was unsure when R20 had changed incontinent undergarment to tabbed briefs from pull ups.

On 04/04/23 at 03:00 PM, Administrative Nurse D

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 _____	04/05/2023

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 550	Continued From page 7 stated R20 should be assisted with her toileting needs. She verified R20 should not have wet clothing in public spaces and should have clean and combed hair, for the resident's dignity. Administrative Nurse D stated she expected the staff to provide ADL cares including combing hair and other grooming needs and she also expected staff to provide bathing for all resident as directed by their care plan and preferences. The facility's "Activities of Daily Living" policy, dated 04/27/18, documented residents will be given the appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living. The facility will provide care and services based on the comprehensive assessment of the resident and consistent with his/her needs or choices for the following activities of daily living. Residents who are unable to carry out activities of daily living and are dependent on staff will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to provide a dignified experience for R20 which placed the resident at risk of impaired dignity and decreased psychosocial wellbeing.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		

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 _____	04/05/2023

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 8	F 580		

physician intervention;
(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);
(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
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(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.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or 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

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 _____	04/05/2023

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 9	F 580		

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 40 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to notify Resident (R) 29's physician of his decline in respiratory status and extremely high blood pressures, which placed R20 at risk for delayed treatment.

Findings included:

- R29's Electronic Medical Record (EMR) recorded diagnoses of degenerative (progressively worsening) disease of nervous system, essential hypertension (elevated blood pressure), memory deficit following cerebral infarction (stroke), personal history of COVID-19 (a very contagious respiratory virus capable of progressing to severe symptoms and in some cases death), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), morbid obesity, adult obstructive sleep apnea (absence of breathing), and major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The "Quarterly Minimum Data Set" (MDS), dated 01/12/23, documented R29 had intact cognition, was independent with set up assistance for activities of daily living (ADL). R29 was continent of urine and bowel and was steady at all times with transitions and walking. R29 received an antipsychotic (class of medications used to treat

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 _____	04/05/2023

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 10	F 580		

psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions) routinely.

The "Continuous Positive Airway Pressure [CPAP -respiratory therapy in which air is pumped into the lungs through the nose and mouth]/Oxygen Care Plan" initiated on 05/11/22, documented R29 would keep oxygen saturation level above 90 percent (%), and directed staff to check oxygen saturation levels according to the doctor's orders or anytime R29 became short of breath or complained of feeling as if he could not catch his breath.

R29's EMR included "Special Instruction" on admission which directed staff to notify the physician if systolic blood pressure (SBP-maximum blood pressure during a contraction of the heart) of greater that 160 or less than 90, the diastolic blood pressure (DBP-measurement during pause before next heartbeat) greater than 100 or less than 60, resting pulse greater than 100 or less than 50, respirations greater than 28 or less than 10, and oxygen saturation less than 90%.

The "Physician Order Sheet" (POS), dated 03/08/23, directed staff to administer:
Diovan (medication used to treat high blood pressure and heart failure) 320 milligrams (mg) by mouth one time a day for hypertension.
Norvasc (medication used to treat high blood pressure and chest pain) 10 mg by mouth daily at bedtime.
Zebeta (medication used to treat high blood pressure) 10 mg by one time a day for hypertension; hold the medication and contact the

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 _____	04/05/2023

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 11	F 580		

physician for pulse less than 50.

Review of the March 2023 EMR revealed the following blood pressure results above physician ordered parameters:
03/06/23 blood pressure of 162/95 millimeters (mm) of Mercury (Hg)
03/20/23 blood pressure of 179/95 mmHg
03/21/23 blood pressure of 179/90 mm/Hg
03/22/23 blood pressure of 160/109 mm/Hg
03/23/23 blood pressure of 191/100 mm/Hg
03/27/23 blood pressure of 175/96 mm/Hg
03/29/23 blood pressure of 165/105 mm/Hg

Review of the April 2023 EMR revealed the following blood pressure results above physician ordered parameters:
04/01/23 blood pressure of 167/90 mm/Hg
04/03/23 blood pressure of 215/136 mm/Hg

The "Progress Note" dated 04/04/23 at 10:05 AM recorded R29 had shortness of breath and grunting respirations. R29 reported he felt poorly, had trouble breathing, and was having problems catching his breath. R29 had a blood pressure reading of 151/96 mm/Hg, oxygen saturation of 68%, a temperature of 98.0 Fahrenheit (F) and a pulse of 68. Staff called the physician and reported the vital signs, and the facility received a call back from the physician's office to send R29 to the hospital immediately per emergency medical services (EMS).

On 04/03/23 at 08:15 AM observation revealed R29 walked through the dining room, slowly, with deep growling/grunting respirations and a moist cough. R29 ate only cereal for breakfast.

On 04/03/23 at 12:30 PM observation revealed

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 _____	04/05/2023

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 12	F 580		

R29 walked through the dining room with a slower gait and continued with growling/grunting respirations and a moist cough. R29 did not eat well again, took only a few bites, and left the table with a slow and slightly unsteady gait.

On 04/04/23 at 08:17 AM observation revealed R29 sat in the dining room, with a breakfast plate in front of him. R29 had obvious respiratory difficulties as evidenced by growling/grunting respirations, cough, and nasal congestion.

On 04/04/23 at 08:19 AM Licensed Nurse (LN) H stated that R29's blood pressure sometimes ran high, and she had not notified the physician of the out of parameter readings. LN H reported R29 had been tested for COVID-19 and result had been negative but did not know date of last test.

On 04/04/23 at 04:08 PM, Administrative Nurse D reported R29 admitted to the hospital, and was positive for COVID 19. Administrative Nurse D reported facility staff initiated COVID-19 testing for all the residents.

On 04/05/23 at 08:19 AM, LN I reported there were no positive COVID-19 residents. LN I confirmed R29 was admitted to the hospital and was treated for COVID-19.

On 04/05/23 at 10:30 AM, Administrative Nurse D stated R29's elevated blood pressures should have been reported to the physician, and verified the record lack physician notifications. Administrative Nurse D stated the medical record also lacked documentation of oxygen administration when the resident had respiratory distress and had an oxygen saturation of 68%. Administrative Nurse D stated oxygen should

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 _____	04/05/2023

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 13	F 580		

have been administered.

The facility's "Clinician Notification" policy, dated 11/28/17, documented that notification of physicians and other clinicians will be done on a timely basis. The resident's physician and/or other pertinent clinicians will be notified of a significant change in the resident's physical, mental, or psychosocial status (that is deterioration in health mental or psychosocial status in either life-threatening conditions or clinical complications). A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Decision making regarding notification parameters for clinical signs and symptoms will be based on physician orders and physician specific parameters and "Interact Acute Change in Condition File Cards and Care Plans."

The facility's "Clinician Notification" policy, dated 11/28/17, documented that notification of physicians and other clinicians will be done on a timely basis. The resident's physician and/or other pertinent clinicians will be notified of a significant change in the resident's physical, mental, or psychosocial status (that is deterioration in health mental or psychosocial status in either life-threatening conditions or clinical complications). A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Decision making regarding notification parameters for clinical signs and symptoms will be based on physician orders and physician specific parameters and Interact Acute Change in Condition File Cards and Care Plans.

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 _____	04/05/2023

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 14 The facility failed to ensure staff notified R29's physician for R29's significantly high blood pressure, which were out of parameter, and R29's respiratory distress which placed R29 at increased risk for physical complication, adverse outcomes, and delayed treatment.	F 580		
F 582 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	F 582		

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 _____	04/05/2023

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 582	Continued From page 15	F 582		

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.
(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:
The facility had a census of 40 residents, with three reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on record review and interview, the facility failed to provide the estimated cost and resident or representative's choice for continued skilled services for the three reviewed residents on the Advanced Beneficiary Notice the (ABN), CMS form 10055. (Resident (R) 31, R38, and R93). This placed the residents at risk for uninformed decisions regarding skilled services.

Findings included:

- The Medicare ABN form informed the

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 _____	04/05/2023

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 582	Continued From page 16	F 582		

beneficiaries that Medicare may not pay for future skilled therapy and did not provide an estimated cost to continue their services. The form included an option 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 lacked documentation staff provided R31 (or their representative) the estimated cost or choice of option 1, 2, or 3 on the ABN form 10055 when the resident's skilled services ended 02/02/23.

The facility lacked documentation staff provided R38 (or their representative) the estimated cost or choice of option 1,2 or 3 on the ABN form 10055 when the resident's skilled services ended 11/11/22.

The facility lacked documentation staff provided R93 (or his representative) the estimated cost or choice of option 1,2, or 3 on the ABN form 10055 when the resident's skilled services ended 02/07/23.

On 04/04/23 at 02:45 PM, Administrative Staff A verified the facility had not provided the information in the above findings on their ABN form 10055.

On 04/04/23 at 3:00PM, Administrative Nurse D stated social service designee was responsible for providing the information to the residents or their representatives listed above on their ABN

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 _____	04/05/2023

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 582	Continued From page 17 form 10055. Upon request the facility failed to provide a policy regarding beneficiaries. The facility failed to provide R31, R38, and R93 with the cost estimate for further services and choice for continued services on the ABN form 10055. This placed the residents at risk for uninformed decisions regarding skilled services.	F 582		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		

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 _____	04/05/2023

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 656	Continued From page 18	F 656		

rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for Resident (R) 29, who had elevated blood pressure and treatment with antihypertensive (medications used to treat high blood pressure) medications. This placed R29 at risk for complications related to complications related to uncommunicated or unmet care needs.

Findings included:

- R29's Electronic Medical Record (EMR) recorded diagnoses of degenerative (progressively worsening) disease of nervous system, essential hypertension (elevated blood pressure), memory deficit following cerebral

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 _____	04/05/2023

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 656	Continued From page 19	F 656		

infarction (stroke), personal history of COVID-19 (a very contagious respiratory virus capable of progressing to severe symptoms and in some cases death), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), morbid obesity, adult obstructive sleep apnea (absence of breathing), and major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The "Quarterly Minimum Data Set" (MDS), dated 01/12/23, documented R29 had intact cognition, was independent with set up assistance for activities of daily living. R29 was continent of urine and bowel and was steady at all times with transitions and walking. R29 received an antipsychotic (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions) routinely.

R29's "Care Plan" lacked a hypertension problem goals, and treatment interventions.

The "Physician Order Sheet" (POS), dated 03/08/23, directed staff to administer:
Diovan (medication used to treat high blood pressure and heart failure) 320 milligrams (mg) by mouth one time a day for hypertension.
Norvasc (medication used to treat high blood pressure and chest pain) 10 mg by mouth daily at bedtime.
Zebeta (medication used to treat high blood pressure) 10 mg by one time a day for hypertension; hold the medication and contact the

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 _____	04/05/2023

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

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F 656	Continued From page 20	F 656		

physician for pulse less than 50.

R29's EMR included "Special Instruction" on admission which directed staff to notify the physician if systolic blood pressure (SBP-maximum blood pressure during a contraction of the heart) of greater that 160 or less than 90, the diastolic blood pressure (DBP-measurement during pause before next heartbeat) greater than 100 or less than 60, resting pulse greater than 100 or less than 50, respirations greater than 28 or less than 10, and oxygen saturation less than 90 percent (%).

Review of the March 2023 EMR revealed the following blood pressure results above physician ordered parameters:
03/06/23 blood pressure of 162/95 millimeters (mm) of Mercury (Hg)
03/20/23 blood pressure of 179/95 mmHg
03/21/23 blood pressure of 179/90 mm/Hg
03/22/23 blood pressure of 160/109 mm/Hg
03/23/23 blood pressure of 191/100 mm/Hg
03/27/23 blood pressure of 175/96 mm/Hg
03/29/23 blood pressure of 165/105 mm/Hg

Review of the April 2023 EMR revealed the following blood pressure results above physician ordered parameters:
04/01/23 blood pressure of 167/90 mm/Hg
04/03/23 blood pressure of 215/136 mm/Hg

On 04/03/23 at 12:30 PM observation revealed R29 walked through the dining room with a slower gait and continued with growling/grunting respirations and a moist cough. R29 did not eat well again, took only a few bites, and left the table with a slow and slightly unsteady gait.

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 _____	04/05/2023

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 656	Continued From page 21 On 04/04/23 at 08:17 AM observation revealed R29 sat in the dining room, with a breakfast plate in front of him. R29 had obvious respiratory difficulties as evidenced by growling/grunting respirations, cough, and nasal congestion. On 04/05/23 at 10:30 AM, Administrative Nurse D stated R29's elevated blood pressures should have been called/reported the physician. Administrative Nurse D verified the care plan lacked a hypertension problem with goals and interventions. The facility's "Care Plan" policy, dated 11/28/17, documented a care plan will be developed for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs and are consistent with the resident's desires and preferences. The comprehensive care plan will be developed after completion of the MDS and CAA s with the input from the care planning team, the resident and the resident's family and/or representative. The facility failed to develop a comprehensive care plan related to elevated blood pressure and treatment of antihypertensive medication which placed the resident at risk for complications related to uncommunicated or unmet care needs.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		

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 _____	04/05/2023

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 677	Continued From page 22	F 677		

by:
The facility had a census of 40 residents. The sample included 14 residents, with nine reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide consistent bathing services for four sampled residents, Resident (R)17, R38, and R2. This placed the residents at risk for complications related to poor hygiene.

Findings included:

- The Electronic Medical Record (EMR) for R17 documented diagnoses of hypertension (high blood pressure), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing).

The "Admission Minimum Data Set" (MDS), dated 02/08/23, documented R17 had intact cognition and required limited assistance of one staff for personal hygiene, bed mobility, transfers, and supervision with one staff for locomotion. The MDS further documented R17 required extensive assistance for bathing.

The "ADL Care Plan," dated 02/16/23, documented R17 preferred to bathe twice per week, was scheduled for Wednesday and Saturday evening, preferred to use the shower chair for bathing, and required partial assistance with bathing tasks. The care plan further documented R17 needed assistance to wash her legs, back, and perineal area.

The "February and March 2023 Bathing Report," documented R17 was scheduled for Wednesday

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 _____	04/05/2023

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 677	Continued From page 23	F 677		

and Saturday, and documented R17 had not received a bath or shower during the following days:
02/01/23 - 02/17/23 (17 days)
02/19/23 - 03/06/23 (16 days)
03/08/23 - 03/26/23 (19 days)

The EMR documented R17 refused a bath or shower on 03/11/23, 03/22/23, and 03/25/23.

On 04/03/23/ at 07:35 AM, observation revealed R17 sat on the edge of her bed. Her hair was greasy and disheveled.

On 04/04/23 at 01:30 PM, observation revealed R17 with greasy, disheveled hair; her sweatshirt had dried stains on it.

On 04/05/23 at 12:15 PM, observation revealed R17 with greasy, disheveled hair.

On 04/04/23 at 09:10 AM, Certified Nurse Aide (CNA) Q stated at the beginning of the shift, staff checked the computer to see which residents were scheduled for bathing. CNA Q stated if the resident refused, the aides asked the resident twice and if the resident continued to refuse, the aides gave a refusal sheet for the nurse to document on and document the refusal.

On 04/04/23 at 12:02 PM, Licensed Nurse (LN) H stated R17 did refuse her baths and staff were to have the resident sign a refusal sheet.

On 04/05/23 at 12:00 PM, Administrative Nurse D stated staff asked the residents if they want their bath or shower and if the residents refused, staff filled out a refusal sheet.

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 _____	04/05/2023

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 677	Continued From page 24	F 677		

The facility's "Bath and Shower" policy, dated 11/28/17, documented the facility ensures the residents' baths and showers are performed and documented as scheduled according to resident preference to maintain each resident's hygiene and dignity. The charge nurse was to add the resident's name to the bath/shower schedule on the day's resident prefers, indicating the resident's preference of a shower or bath and on the shift that accommodates the time the resident prefers. The person that gives the resident his/her bath is to document the date, day of the week, type of bath and/or hair care given, and signature on the touchscreen which ensures documentation is included in the resident's electronic medical record. The Director of Nursing or designated personnel would review the Bathing Report to ensure each resident was receiving bath/showers and hair care as required.

The facility failed to provide R17 consistent bathing services as care planned, placing her at risk for complications related to poor hygiene.

- The Electronic Medical Record (EMR) for R38 documented diagnoses of delusional disorder (a type of mental health condition which a person cannot tell what is real from imagined), depression (a mental disorder characterized by persistently depressed mood or loss of interest in activities), and hypertension (high blood pressure).

The "5-day Medicare Minimum Data Set" (MDS), dated 10/26/22, documented R38 had intact cognition and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting and limited assistance of one staff for personal hygiene. The MDS further documented

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 _____	04/05/2023

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 677	Continued From page 25	F 677		

R38 required extensive assistance of one staff for bathing.

R38's "Quarterly MDS," dated 03/09/23, documented R38 had intact cognition and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting and limited assistance of one staff for personal hygiene. The MDS further documented R38 required extensive assistance of one staff for bathing.
The "ADL Care Plan," dated 03/23/23, documented, R38 liked to bathe two to three times a week on Monday, Wednesday, and Friday in the evening. R38 preferred to use the shower chair for bathing and required partial assistance with bathing tasks. The care plans further documented R38 needed assistance to wash her legs, back, and perineal area.

The "January 2023 Bathing Record" documented R38 was scheduled for Monday, Wednesday, and Friday, and documented R38 had not received a bath or shower during the following days:
01/14 - 01/29 (16 days)

The "February and March 2023 Bathing Record" documented R38 was scheduled for Monday, Wednesday, and Friday, documented R38 had not received a bath or shower during the following days:
02/01/23 - 02/24/23 (24 days)
02/28/23 - 03/07/23 (8 days)
03/09/23 - 03/19/23 (11 days)
03/23/23 - 03/31/23 (9 days)

The EMR documented R38 refused a shower on 02/24/23 and 03/10/23.

On 04/03/23 at 9:30 AM, observation revealed

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 _____	04/05/2023

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 677	Continued From page 26	F 677		

R38 sat at the dining table. Her hair was messy, and appeared greasy.

On 04/04/23 at 08:00 AM, observation revealed R38's hair remained disheveled and greasy.

On 04/04/23 at 09:10 AM, Certified Nurse Aide (CNA) Q stated at the beginning of the shift, staff checked the computer to see which residents were scheduled for bathing. CNA Q stated if the resident refused, the aides asked the resident twice and if the resident continued to refuse, the aides gave a refusal sheet for the nurse to document on and document the refusal.

On 04/04/23 at 12:02 PM, Licensed Nurse (LN) H stated R38 did refuse her baths and staff were to have the resident sign a refusal sheet.

On 04/05/23 at 12:00 PM, Administrative Nurse D stated staff asked the residents if they want their bath or shower and if the residents refused, staff filled out a refusal sheet.The facility's "Bath and Shower" policy, dated 11/28/17, documented the facility ensures the residents' baths and showers are performed and documented as scheduled according to resident preference to maintain each resident's hygiene and dignity. The charge nurse was to add the resident's name to the bath/shower schedule on the day's resident prefers, indicating the resident's preference of a shower or bath and on the shift that accommodates the time the resident prefers. The person that gives the resident his/her bath is to document the date, day of the week, type of bath and/or hair care given, and signature on the touchscreen which ensures documentation is included in the resident's electronic medical record. The Director of Nursing or designated

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 _____	04/05/2023

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 677	Continued From page 27	F 677		

personnel would review the Bathing Report to ensure each resident was receiving bath/showers and hair care as required.

The facility failed to provide R38 consistent bathing services as care planned, placing her at risk for complications related to poor hygiene.
- R2's Electronic Medical Record (EMR) recorded diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), mild intellectual disabilities (a diverse group of severe, chronic conditions due to mental and/or physical impairment. Individuals with developmental disabilities have problems with major life activities such as language, mobility, learning, self-help and independent living), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and chronic kidney disease.

The "Significant Change Minimum Data Set" (MDS), dated 03/14/23, documented R2 had severe cognitive impairment, rejected evaluation or care behavior which occurred one to three days during the look back period and behaviors worsened. R2 felt it was somewhat important to choose between a tub bath, shower, bed bath, or sponge bath. The MDS further documented R2 required extensive to total assistance of one to two staff for activities of daily living and bathing. Received hospice care.

The "Activity of Living Care Area Assessment" (CAA), dated 03/17/23, documented R2's

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 _____	04/05/2023

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 677	Continued From page 28	F 677		

baseline for activities of daily living, and staff to help anticipate needs such as hygiene and toileting. The CAA further documented there was no anticipation on improvement and R2 had recently admitted on hospice services.

The "Activity of Daily Living Care Plan", dated 03/23/23, documented R2 needed extensive assistance with bathing, preferred showers to be offered twice a week during the day on Thursday and Sunday. R2 often refused bathing and needed kind reminders of the importance of bathing. The care plan further directed staff if R2 refused a shower to offer her a bed bath. The care plan also included R2 facial hair tended to grow quickly and thick and should be shaved daily.

Bathing Task record review revealed bathing provided to R2 on:
01/06/23
01/15/23 (8 days)
02/03/23 (18 days)
02/26/23 (22 days)
03/04/23 (5 days provided by hospice staff)
03/20/23 (15 days provided by hospice staff)
03/23/23
03/24/23 (provided by hospice staff)
03/30/23 (5 days)
04/03/23 (provided by hospice staff)

The facility was unable to provide evidence of refusal sheets.

On 04/03/23 at 07:52 AM observation revealed R2 sat in the dining room in a wheelchair. R2's hair was unclean and she had thick; dark-colored facial hair around her mouth and down under her chin.

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 _____	04/05/2023

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 677	Continued From page 29 On 04/03/23 at 10:21 AM observation revealed R2 in her room with a hospice aide getting ready to bath the resident. On 04/03/23 at 11:48 AM R2 was brought to the dining room by facility staff. R2 no longer had dark facial hair. R2 had damp hair and requested a blanket due to being cold with damp hair. Staff provided R2 with a blanket. On 04/04/23 at 09:10 AM CNA Q reported the CNAs checked at the beginning of their shift who was scheduled for baths that day. CNA Q reported if a resident refused a bath the CNA's were to ask the resident twice, then fill out a refusal sheet and gave it to the nurses, and the nurses were to document in the resident's chart why the resident refused. 04/04/23 03:00 PM Administrative Nurse D stated the bathing should be completed as the resident's preference, if the resident refuses the staff are to be approaching the resident another time and then the charge nurse is to fill out a refusal form, she has instructed staff to bring the refusal forms to her Monday thru Friday so she may address what the issue is with bath refusals. The facility failed to ensure R2 had baths per resident preference. This placed R2 at risk for complications related to poor hygiene.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		

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 _____	04/05/2023

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

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F 684	Continued From page 30	F 684		

facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents with one resident reviewed for quality of care. Based on observation, interview, and record review, the facility failed to ensure staff provided assessment, ongoing monitoring, and physician involvement for Resident (R)29 who had elevated blood pressures out of physician ordered parameters and failed to identify the potential signs and symptoms of respiratory virus and provide appropriate follow up and screening. As a result, R29 was sent emergently to the acute hospital in distress, with a low oxygen saturation. This placed R29 at increased risk for physical complications, adverse outcomes, and delayed treatment.

Findings included:

- R29's Electronic Medical Record (EMR) recorded diagnoses of degenerative (progressively worsening) disease of nervous system, essential hypertension (elevated blood pressure), memory deficit following cerebral infarction (stroke), personal history of COVID-19 (a very contagious respiratory virus capable of progressing to severe symptoms and in some cases death), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), morbid obesity, adult obstructive

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 _____	04/05/2023

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 684	Continued From page 31	F 684		

sleep apnea (absence of breathing), and major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The "Quarterly Minimum Data Set" (MDS), dated 01/12/23, documented R29 had intact cognition, was independent with set up assistance for activities of daily living (ADL). R29 was continent of urine and bowel and was steady at all times with transitions and walking. R29 received an antipsychotic (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions) routinely.

The "Continuous Positive Airway Pressure [CPAP -respiratory therapy in which air is pumped into the lungs through the nose and mouth]/Oxygen Care Plan" initiated on 05/11/22, documented R29 would keep oxygen saturation level above 90 percent (%), and directed staff to check oxygen saturation levels according to the doctor's orders or anytime R29 became short of breath or complained of feeling as if he could not catch his breath.

R29's EMR included "Special Instruction" on admission which directed staff to notify the physician if systolic blood pressure (SBP-maximum blood pressure during a contraction of the heart) of greater that 160 or less than 90, the diastolic blood pressure (DBP-measurement during pause before next heartbeat) greater than 100 or less than 60, resting pulse greater than 100 or less than 50, respirations greater than 28 or less than 10, and

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 _____	04/05/2023

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 684	Continued From page 32	F 684		

oxygen saturation less than 90%.

The "Physician Order Sheet" (POS), dated 03/08/23, directed staff to administer:
Diovan (medication used to treat high blood pressure and heart failure) 320 milligrams (mg) by mouth one time a day for hypertension.
Norvasc (medication used to treat high blood pressure and chest pain) 10 mg by mouth daily at bedtime.
Zebeta (medication used to treat high blood pressure) 10 mg by one time a day for hypertension; hold the medication and contact the physician for pulse less than 50.

Review of the March 2023 EMR revealed the following blood pressure results above physician ordered parameters:
03/06/23 blood pressure of 162/95 millimeters (mm) of Mercury (Hg)
03/20/23 blood pressure of 179/95 mmHg
03/21/23 blood pressure of 179/90 mm/Hg
03/22/23 blood pressure of 160/109 mm/Hg
03/23/23 blood pressure of 191/100 mm/Hg
03/27/23 blood pressure of 175/96 mm/Hg
03/29/23 blood pressure of 165/105 mm/Hg

Review of the April 2023 EMR revealed the following blood pressure results above physician ordered parameters:
04/01/23 blood pressure of 167/90 mm/Hg
04/03/23 blood pressure of 215/136 mm/Hg

The "Progress Note" dated 04/04/23 at 10:05 AM recorded R29 had shortness of breath and grunting respirations. R29 reported he felt poorly, had trouble breathing, and was having problems catching his breath. R29 had a blood pressure reading of 151/96 mm/Hg, oxygen saturation 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 _____	04/05/2023

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 684	Continued From page 33	F 684		

68%, a temperature of 98.0 Fahrenheit (F) and a pulse of 68. Staff called the physician and reported the vital signs, and the facility received a call back from the physician's office to send R29 to the hospital immediately per emergency medical services (EMS).

R29's EMR lacked evidence staff obtained an order and applied supplemental oxygen for R29's low oxygen saturation level of 68%.

On 04/03/23 at 08:15 AM observation revealed R29 walked through the dining room, slowly, with deep growling/grunting respirations and a moist cough. R29 ate only cereal for breakfast.

On 04/03/23 at 12:30 PM observation revealed R29 walked through the dining room with a slower gait and continued with growling/grunting respirations and a moist cough. R29 did not eat well again, took only a few bites, and left the table with a slow and slightly unsteady gait.

On 04/04/23 at 08:17 AM observation revealed R29 sat in the dining room, with a breakfast plate in front of him. R29 had obvious respiratory difficulties as evidenced by growling/grunting respirations, cough, and nasal congestion.

On 04/04/23 at 08:19 AM Licensed Nurse (LN) H stated that R29's blood pressure sometimes ran high, and she had not notified the physician of the out of parameter readings. LN H reported R29 had been tested for COVID-19 and result had been negative but did not know date of last test.

On 04/04/23 at 04:08 PM, Administrative Nurse D reported R29 admitted to the hospital, and was positive for COVID 19. Administrative Nurse D

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 _____	04/05/2023

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 684	Continued From page 34	F 684		

reported facility staff initiated COVID-19 testing for all the residents.

On 04/05/23 at 08:19 AM, LN I reported there were no positive COVID-19 residents. LN I confirmed R29 was admitted to the hospital and was treated for COVID-19.

On 04/05/23 at 10:30 AM, Administrative Nurse D stated R29's elevated blood pressures should have been reported to the physician, and verified the record lack physician notifications. Administrative Nurse D stated the medical record also lacked documentation of oxygen administration when the resident had respiratory distress and had an oxygen saturation of 68%. Administrative Nurse D stated oxygen should have been administered.

The facility's "Clinician Notification" policy, dated 11/28/17, documented that notification of physicians and other clinicians will be done on a timely basis. The resident's physician and/or other pertinent clinicians will be notified of a significant change in the resident's physical, mental, or psychosocial status (that is deterioration in health mental or psychosocial status in either life-threatening conditions or clinical complications). A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Decision making regarding notification parameters for clinical signs and symptoms will be based on physician orders and physician specific parameters and "Interact Acute Change in Condition File Cards and Care Plans."

The facility failed to ensure staff provided

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 _____	04/05/2023

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 684	Continued From page 35 assessment, ongoing monitoring and physician involvement for R29 who had significantly high blood pressure, which were out of parameters set forth by the facility, lacked documentation of continued elevated blood pressures and assessment of R29's respiratory distress as evident by grunting/growling, moist cough until survey team member inquired on R29's condition. This placed R29 at increased risk for physical complication, adverse outcomes, and delayed treatment.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 14 residents, with two reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure a safe, hazard free environment for Resident (R) 30, who had severe cognitive impairment and poor safety awareness. She was independently mobile and had a history of wandering throughout the facility. On 01/28/23 staff observed R30 at approximately 10:23 PM. Then, at 10:30 PM, staff noted the resident was not in her room and began a search for her. The facility staff searched every room and the perimeter outside of the facility but could not locate R30. At 11:23 PM,	F 689	Past noncompliance: no plan of correction required.	

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 _____	04/05/2023

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 689	Continued From page 36	F 689		

almost an hour after staff last saw the resident, staff located R30 on the floor in a closet, in the kitchen, which was supposed to be locked. The failure allowed R30 to wander unattended into the kitchen area, which had multiple safety hazards including a stove, knives, and chemicals stored in the unlocked kitchen closet, which placed R30 in Immediate Jeopardy.

Findings included:

- The Electronic Medical Record (EMR) documented R30 had diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), anxiety, mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and mood disorder category of mental health problems, feelings of sadness, helplessness, and guilt).

The "Quarterly Minimum Data Set Assessment" (MDS), dated 11/03/22, documented R30 had severely impaired cognition and required supervision with set-up assistance for locomotion. R30 was independent with transfers and ambulation. The MDS further documented R30 had an unsteady gait, no functional impairment, wandered one to three days, and had no falls.

R30's "Fall Care Area Assessment (CAA)," dated 05/12/22, documented R30 was a fall risk due to her dementia diagnosis and she forgot her walker, at times R30 required supervision from staff to ensure she ambulated with her walker and appropriate footwear. The CAA further documented R30 wandered, at times, to places other than her room or common areas and required redirection.

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 _____	04/05/2023

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 689	Continued From page 37	F 689		

The "Elopement Care Plan," dated 02/16/23, initiated 05/27/21, directed staff to make sure all staff members knew of R30's safety risks. Make sure R30's Wander Guard (a monitoring system that triggers alarms for residents who wander) bracelet was on her left ankle and was functioning properly every shift. Take R30's picture and keep a record of her information in case she might ever leave the building unattended, so it could be provided to anyone helping to locate her. Direct R30 to her room or in the right direction if she forgets. The update dated 11/22/22, documented if R30 became confused to her location and talked about needing to leave the facility, and was not redirectable, staff should call R30's family and have them talk to her on the phone. If R30 verbalized wanting to leave the facility or was exit seeking, and was not redirectable, staff should perform visual checks on her every 15 minutes and notify the physician.

The "Elopement Assessment," dated 11/19/22, documented R30 had Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and she got confused regarding location/situation. R30 wandered but did not usually exit seek at doors but did voice "needing to leave" the facility.

The "Nurse's Note," dated 01/28/23 at 10:32 PM documented staff went to R30's room and could not locate her. The staff immediately began to sweep search throughout the hall looking for the resident and alerted the Certified Nurse Aides (CNA) on duty to search other halls and other resident rooms. The note further stated when R30 could not be located, one CNA went to the other side of the building, and one went outside

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 _____	04/05/2023

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 689	Continued From page 38	F 689		

and looked. The DON (Director of Nursing) was contacted and notified of staff's inability to locate R30. At 11:35 PM, a staff member went into the kitchen to search for the resident and located R30 lying on the floor in a closet. R30 was alert with her head facing the closet door, feet toward the wall, and her walker was to her left. The noted documented the DON arrived, assessed the resident, and no injury was found.

On 04/03/23 at 07:30 AM, observation revealed R30 walked down the hall with her walker and stopped and asked where she was supposed to go.

On 04/03/23 at 12:06 PM, observation revealed the door R30 entered was a dish room door. In order to get to the closet, R30 walked across the kitchen, passing the stove and knives. The stove did not have any safety mechanisms to prevent turning on, the knobs turned freely. The butcher block holder of knives was on a shelf, approximately four feet off the floor, on the east wall. R30 walked past a food preparation table and into a closed closet. Further observation revealed the closet contained supplies, gloves, liquid "Knack" pre-soak and destainer, and "Achieve" floor cleaner.

On 04/03/23 at 11:45 AM, Dietary Staff CC stated the door to the dish room had an automatic lock and she had not heard there were any problem with the lock when the door shut. Dietary Staff CC further stated she received education to make sure the doors to the kitchen locked when the door was shut.

On 04/03/23 at 11:55 AM, Administrative Nurse D stated the incident happened during the evening

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 _____	04/05/2023

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 689	Continued From page 39	F 689		

when there were not any dietary staff in the building. Administrative Nurse D said the door to the kitchen dish room had a keypad lock but did not lock automatically that evening, like it usually did. Administrative Nurse D further stated she looked at the facility cameras and saw that the resident went into the kitchen dish room. Administrative Nurse D stated it had been the last place staff checked when they could not locate her. Administrative Nurse D stated another staff member went in the kitchen getting a drink for a different resident but had not noted R30 in the kitchen. Administrative Nurse D stated she contacted Maintenance Staff U immediately to check the keypad and replace it.

On 04/03/23 at 12:10 PM, Dietary Staff BB stated no one in the kitchen knew there was a problem with the dish room door not locking automatically and the facility had since replaced it so that it locked when the door shuts.

On 04/03/23 at 12:19 PM, Administrative Staff A stated the keypad to the dish room door was not totally replaced, but the settings were changed for the door to lock automatically, once the door closed. At 12:27 PM, Administrative Staff A stated the chemicals in the closet the resident was in were very hard to open as the lids needed to be pushed down to open.

On 04/03/23 at 12:29 PM, Maintenance Staff U stated he checked the settings on the dish door keypad and noted it was set to lock after two minutes, so he changed it to lock automatically. Maintenance Staff U further stated he had not been checking the keypad on that door with his weekly checks, but had since started to do so.

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 _____	04/05/2023

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 689	Continued From page 40	F 689		

On 04/03/23 at 01:07 PM, an unsuccessful attempted to contact the Licensed Nurse (LN) on duty on 01/28/23, revealed she no longer worked for the facility.

On 04/03/23 at 01:29 PM, CNA M stated she saw R30 wandering in the hallway as she was answering other call lights, but when she went to look for R30 in her room, the resident was not there. CNA M further stated staff looked for the resident and she went outside to look for her but could not find her until about an hour later, when staff found R30 in the closet in the kitchen. CNA M stated R30 wanted off the floor and when staff assessed her, there were no injuries.

On 04/05/23 at 10:00 AM, CNA N stated staff had a lot of in-services regarding elopement and the incident with R30. The staff were also educated to keep an eye on R30 when she wandered.

On 04/05/23 at 10:38 AM, LN G stated staff were educated to make sure all the doors to the kitchen locked, once they closed.

The facility's "Elopement" policy, dated November 28, 2017, documented the facility would ensure that each resident received supervision and devices to deter elopement. And elopement risk assessment for each resident was to be completed upon admission to the facility, quarterly thereafter and with any significant change. Each resident would have his or her photograph taken, updated as needed, and the photograph would be scanned in the resident's clinical record to be kept in an area accessible to staff members. The residents care plan would be updated to ensure wandering and potential for elopement interventions are included and an

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 _____	04/05/2023

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 689	Continued From page 41 elopement monitoring bracelet would be utilized if the resident was determined to be at risk for elopement in facilities equipped with such a system. The facility failed to ensure a safe, hazard free environment when an unlocked kitchen door allowed cognately impaired R30 to wander unattended into the area. The deficient practice placed R30 in Immediate Jeopardy. On 01/31/23 the facility completed the following corrective actions: 1. The Administrator contacted the Maintenance Supervisor to fix the door lock and ensure that it worked properly. 2. Certified Dietary Manager provided education to her dietary staff to double check all door locks in the kitchen area and ensure they lock properly before they exit the facility. 3. The Director of Nursing educated all facility staff regarding the incident and the importance of checking all doors in the kitchen area, maintenance area, therapy room, laundry, supply room, and the main shower room to ensure they are locked. 4. Daily check of all doors in the kitchen area will continue to ensure they are locked. The deficient practice was deemed past non-compliance and existed at a "J" scope and severity, due to the facility identification and implementation of correction measures, prior to the date of survey.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		

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 _____	04/05/2023

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 690	Continued From page 42	F 690		

§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents with two residents sampled for bowel and bladder and catheter (tube inserted into the bladder to drain urine). Based on

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 _____	04/05/2023

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

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F 690	Continued From page 43	F 690		

observation, interview, and record review, the facility failed to provide assistance with Resident (R)20 for toileting and incontinence care, and failed to ensure R33, who had a history of urinary tract infection (UTI) received proper catheter cleansing technique. These deficient practices placed R20 and R33 at risk of complications and increased infections.

Finding included:

- R20's Electronic Medical Record (EMR), recorded diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), low back pain, overactive bladder, chronic kidney disease, peripheral vascular disease (abnormal condition affecting the blood vessels) and behavioral disturbance.

The "Quarterly Minimum Data Sheet" (MDS), dated 03/16/23, documented R20 had moderately impaired cognition, required limited assistance of one person for activities of daily living, and physical help of one staff for bathing. R20 had occasional incontinence of urine and bowel, was not steady but able to stabilize without staff assistance.

The "Urinary Incontinence Care Area Assessment", dated 09/26/22, documented R20 was occasionally incontinent of urine per voiding diary, required limited assistance with toileting and toileting hygiene, and wore incontinent products to help clothing and promote dignity. R20 had been open toilet with cueing and the facility planned for incontinence with the start of toileting program of cueing to toilet at 06:00 AM, after meals, midafternoon and at bedtime to help

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 _____	04/05/2023

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 690	Continued From page 44	F 690		

promote continence.

The "Bowel and Bladder Care Plan" dated 01/23/23, documented R20 was usually continent of bowels and occasionally incontinent of bladder; R20 could perform toileting with partial assistance and cueing. The care plan directed staff R20 required wore incontinence product to protect clothing and promote dignity. The care plan directed staff to cue R20 to the bathroom within an hour of 06:00 AM, after meals, prior and after dinner, before going to bed, and as needed episodes.

The "Progress Note", dated 03/22/23 at 04:16 PM, documented R20 had not walked to the dining room for meals. R20 sat in her walker/wheelchair at the opening to her room and yelled for help. R20 reported she could not walk, but with staff encouragement she did walk to the dining room.

On 04/03/23 at 08:03 AM observation revealed R20 walked into the dining room escorted by a Certified Medication Aide (CMA) R. R20's pants, on her buttocks area, were visibly wet. R20's pants sagged with wetness/weight of an incontinent brief. Survey team member brought the wet pants to CMA R's attention. CMA R instructed the hospitality aide to take R20 to the bathroom. The hospitality aide informed CMA R she could not take R20. Licensed Nurse (LN) H identified the R20 to the surveyor, and the survey told LN H R20 pants were wet, LN H looked at R20's pants and did not direct staff to provide assistance with the incontinence. Staff then sat R20 in a dining room chair for breakfast. R20 had uncombed oily hair.

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 _____	04/05/2023

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 690	Continued From page 45	F 690		

On 04/03/23 at 12:11 PM observation revealed staff pushed R20 while she sat on the seat of her walker. R20 had uncombed, oily hair. Staff encouraged and assisted R20 into a dining chair with a gait belt. As R20 stood, a round, wet circle was visible on the back of her pants and her incontinent product sagged between her legs. Staff proceded to sit R20 in the chair to eat her breakfast.

On 04/03/23 at 01:06 PM observation revealed R20 made it to her room, from the dining room, and called for help as staff were bringing other residents to their rooms. Staff inquired what R20 needed and R20 told them she wanted to go upstairs. Staff then assisted R20 back to the dining room in her walker chair and placed her in front of her plate.

On 04/03/23 at 01:29 PM Administrative Nurse D assisted R20 to stand and R20 continued to have a wet spot on the back of her pants. Staff assisted R20 to her room in a wheelchair. Staff assisted R20 to her recliner. Surveyor alerted staff she had wet pants and a filled, sagging, staff looked at each other and asked each other if they saw the wetness. Staff then assisted resident to the bathroom and assisted to change R20's pants and brief, before returning R20's recliner.

On 04/03/23 at 01:32 PM Certified Nurse Aide (CNA) O stated R20 had a toileting routine. The routine was to toilet R20 when she got up in the morning, after breakfast, before lunch, the middle of the afternoon, then R20 would sleep until supper time. CNA O was unsure of the toileting schedule for the other shifts.

On 04/03/23 at 01:29 PM CMA S stated R20 took

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 _____	04/05/2023

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 690	Continued From page 46	F 690		

usually toileted independently. CMA S stated R20 usually wore pullup undergarments. CMA S stated she was unsure when R20 had changed incontinent undergarment to tabbed briefs from pull ups.

On 04/04/23 at 03:00 PM, Administrative Nurse D stated R20 should be assisted with her toileting needs. She verified R20 should not have wet clothing in public spaces and should have clean and combed hair, for the resident's dignity. Administrative Nurse D stated she expected the staff to provide ADL cares including combing hair and other grooming needs and she also expected staff to provide bathing for all resident as directed by their care plan and preferences.

The facility's "Activities of Daily Living" policy, dated 04/27/18, documented residents will be given the appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living. The facility will provide care and services based on the comprehensive assessment of the resident and consistent with his/her needs or choices for the following activities of daily living. Residents who are unable to carry out activities of daily living and are dependent on staff will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

The facility failed to provide R20 with assistance with her toileting and urine incontinence which placed the resident at risk for skin damage, infection and dignity concerns.

- The Electronic Medical Record for R33 documented diagnoses of type 2 diabetes mellitus (when the body cannot use glucose, not

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 _____	04/05/2023

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 690	Continued From page 47	F 690		

enough insulin made, or the body cannot respond to the insulin), hyperlipidemia (condition of elevated blood lipid levels), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), urinary retention (a lack of ability to urinate and empty the bladder).

R33's "Admission Minimum Data Set" (MDS), dated 12/04/22, documented R33 had intact cognition and required extensive assistance of one staff for transfers, dressing, toileting, and personal hygiene. The MDS further documented R33 required the use of an indwelling Foley catheter (tube used for draining urine from the bladder and having an inflatable part at the bladder end that allows the tube to be kept in place for variable time periods), was always incontinent of bowel, and had a urinary tract infection (an infection in any part of the urinary system) in the last 30 days.

The "Quarterly MDS," dated 03/02/23, documented R33 had intact cognition and required extensive assistance of two staff for transfers, toileting, and extensive assistance of one staff for bed mobility. The MDS further documented R33 had an indwelling Foley catheter and was frequently incontinent of bowel.

The "Urinary Cather Care Plan," dated 03/16/23, initiated on 2/13/22, directed staff to ensure catheter care was performed every shift and as needed, if staff notice R33's urine turning darker in color, encourage good fluid intake. The plan directed if she was experiencing burning, cloudy or foul odor from the urine, let her physician know

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 _____	04/05/2023

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 690	Continued From page 48	F 690		

right away, and replace her catheter as ordered by the physician. Monitor urine output each shift, if staff notice a low urine output, sediment in her urine, abnormal urine color, notify the physician. The update dated 03/16/23 further directed staff to apply a urinary catheter leg drainage bag to her catheter when she was out of her bed or up ambulating.

The "Physician Order," dated 11/15/22, directed staff to administer cranberry plus probiotic (promotes a healthy urinary tract), one tablet, by mouth, in the morning, for a supplement.

The "Physician Order," dated 12/02/22, directed staff to insert a 16 French x 30 (cc) cubic centimeters Foley catheter monthly and document urine output every shift for the diagnosis of urinary retention.

The "Physician Order," dated 01/14/23, directed staff to administer Macrobid (an antibiotic to treat and prevent urinary tract infections), 100 milligrams (mg), by mouth, twice a day, for 10 days for a diagnosis of urinary tract infections (uti).

The "Nurse's Note," dated 01/13/23 at 07:44 AM, documented R33's catheter was patent and draining, urine was clear and noted sediment, yellow in color.

The "Nurse's Note," dated 01/13/23 at 11:49 AM, documented staff collected a urinalysis (examination of urine) from R33.

The "Urinalysis Report," dated 01/13/23, documented R33 had increased protein, and blood in her urine.

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 _____	04/05/2023

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 690	Continued From page 49	F 690		

On 04/04/23 at 08:15 AM, observation revealed R33 laid in bed. Certified Nurse Aide (CNA) O and CNA P applied gloves and pulled down the resident's incontinence brief and pants. CNA O took R33's catheter bag, still full of urine, and guided the bag up the inside of the right pant leg and out the top of R33's pants. Further observation revealed CNA O and CNA P stood there as R33 was exposed from the waist down and discussed who would complete the catheter care and who would drain the catheter bag. Continued observation revealed CNA P took an incontinence wipe, performed incontinence care, and ran out of wipes before she could do catheter care. CNA P opened R33's nightstand drawer with soiled hands and was unable to find gloves. CNA O looked for more incontinence wipes in R33's dresser drawer and stated "Well, I guess we need to stock these rooms" and took R33's roommates' s incontinence wipes. Observation revealed R33 continued to be exposed from the waist down as the CNAs looked for incontinence wipes. CNA P took an incontinence wipe and wiped around the catheter tubing at the insertion site but did not cleanse the catheter tubing. With the same soiled gloves, CNA P and CNA O pulled up R33's incontinence brief and pants. Further observation revealed CNA O sat a container on the floor to drain the catheter bag, and spilled urine on the floor. CNA O stated, "how did it get spilled onto the floor?" CNA O failed to cleanse the port of the catheter tubing before clamping the tubing, took the catheter bag and down the top of R33's pants, down the inside of the right pant leg and held onto it as he assisted R33 into her recliner and asked her where she wanted him to place the catheter bag. R33 instructed CNA O to put the catheter bag in the dignity bag and lay it

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 _____	04/05/2023

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 690	Continued From page 50 on top on her trash can. On 04/04/23 at 12:20 PM, CNA P stated she knew she had not changed her gloves after incontinence care because she forgot and verified they had not covered R33 up when looking for extra gloves. On 04/05/23 at 11:56 AM, Administrative Nurse D stated staff should not leave residents exposed if they are not providing cares. Administrative Nurse D said the CNA should have removed her soiled gloves before touching other surfaces or the resident. The facility, "Urinary Catheter Care" undated competency checklist, directed staff to with a clean cloth between the thumb and forefinger of the dominant hand, clean the catheter at point of insertion into urethra using a pen roll to cleanse the entire circumference of the catheter. With the non-dominant hand, hold the catheter in place as the dominant hand cleanses the extension of the catheter tubing. Fold the cloth and repeat cleansing at least twice, continuing if any soilage observed after second wipe. The facility failed to provide appropriate catheter care for R33, who had a history of UTIs. This placed the resident at risk for infections.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		

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 _____	04/05/2023

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 695	Continued From page 51	F 695		

care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to replace Resident (R) 4's bilevel positive airway pressure (BiPaP -a machine that normalizes breathing by delivering pressurized air) mask, placing R4 at risk for respiratory infection.

Findings included:

- The Electronic Medical Record (EMR) for R4 documented diagnosis of chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dependence on other enabling machines and devices, dependence on supplemental oxygen, and obstructive sleep apnea (intermittent airflow blockage during sleep).

R4's "Annual Minimum Data Set" (MDS), dated 02/09/23, documented R4 had intact cognition and required extensive assistance of one staff for bed mobility, dressing, toileting, and personal hygiene. The MDS further documented R4 received oxygen and required non-invasive mechanical ventilator.

R4's "BiPaP/Oxygen Care Plan," dated 02/23/23, documented R4 has a pulmonologist (a doctor who specialized diagnosing and treating diseases of the lungs) for the management of her BiPaP

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 _____	04/05/2023

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 695	Continued From page 52	F 695		

and oxygen, administer breathing treatments as ordered, check R4's oxygen saturation (a measure of how much oxygen the blood carried as a percentage of the maximum it could carry) according to the physician orders.

The "Physician Order," dated 06/20/19, documented R4 chose to wear her BiPaP at all times. it directed to check skin integrity under the mask every shift and ensure proper fit every shift.

The "Physician Order," dated 08/23/20, directed staff to change the BiPaP tubing weekly on Sundays. The order was discontinued on 09/13/20.

The "Treatment Administration Record" for March 2023 lacked documentation to direct staff when to change or clean R4's BiPaP mask or tubing.

On 04/02/23 at 08:55 AM, observation revealed R4 was in her room in bed with a visibly soiled BiPaP mask on her face. The bottom straps for the mask were also visibly soiled.

On 04/04/23 at 12:12 PM, observation revealed R4 was in her room in bed with the visibly soiled BiPaP mask as well as the bottom straps to the mask, on her face.

On 04/04/23 at 01:15 PM, R4 stated the mask should be changed every three months and should have a date on the mask. R4 stated she did not remember when staff had changed it last.

On 04/04/23 at 01:25 PM, Licensed Nurse (LN) H stated staff change R4's mask monthly but was unsure where they documented that information. LN H stated the mask can be changed at any

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 _____	04/05/2023

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 695	Continued From page 53 time for a new mask. On 04/0/23 at 03:00 PM, Administrative Nurse D stated the mask was changed every three months due to cost Administrative Nurse D stated R4 cannot get a new mask whenever she needs it but staff can take the mask off and clean it when needed. Administrative Nurse D further stated she was unaware there was not documentation of when to change and clean the mask and tubing. The facility's "CPAP and BiPaP Use" policy, dated 11/28/17, directed staff to check the seal of the mask to the face to ensure no air leaked, if so adjust the mask or remove and reseal. The policy further documented, clean the mask seal with soap and water, empty and clean the humidifier weekly with soap and water. The facility failed to ensure R4's BiPaP mask and tubing had been changed or cleaned, placing the resident at risk for infection.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 726		

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 _____	04/05/2023

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 726	Continued From page 54	F 726		

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to ensure the nurse possessed the skills and knowledge necessary to recognize and act upon Resident (R) 29's respiratory distress and elevated blood pressure. This placed R29 at risk for delayed treatment of medical concerns.

Findings included:

- R29's Electronic Medical Record (EMR) recorded diagnoses of degenerative (progressively worsening) disease of nervous system, essential hypertension (elevated blood pressure), memory deficit following cerebral infarction (stroke), personal history of COVID-19 (a very contagious respiratory virus capable of progressing to severe symptoms and in some

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 _____	04/05/2023

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 726	Continued From page 55	F 726		

cases death), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), morbid obesity, adult obstructive sleep apnea (absence of breathing), and major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The "Quarterly Minimum Data Set" (MDS), dated 01/12/23, documented R29 had intact cognition, was independent with set up assistance for activities of daily living (ADL). R29 was continent of urine and bowel and was steady at all times with transitions and walking. R29 received an antipsychotic (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions) routinely.

The "Continuous Positive Airway Pressure [CPAP -respiratory therapy in which air is pumped into the lungs through the nose and mouth]/Oxygen Care Plan" initiated on 05/11/22, documented R29 would keep oxygen saturation level above 90 percent (%), and directed staff to check oxygen saturation levels according to the doctor's orders or anytime R29 became short of breath or complained of feeling as if he could not catch his breath.

R29's EMR included "Special Instruction" on admission which directed staff to notify the physician if systolic blood pressure (SBP-maximum blood pressure during a contraction of the heart) of greater that 160 or less than 90, the diastolic blood pressure

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 _____	04/05/2023

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 726	Continued From page 56	F 726		

(DBP-measurement during pause before next heartbeat) greater than 100 or less than 60, resting pulse greater than 100 or less than 50, respirations greater than 28 or less than 10, and oxygen saturation less than 90%.

The "Physician Order Sheet" (POS), dated 03/08/23, directed staff to administer:
Diovan (medication used to treat high blood pressure and heart failure) 320 milligrams (mg) by mouth one time a day for hypertension.
Norvasc (medication used to treat high blood pressure and chest pain) 10 mg by mouth daily at bedtime.
Zebeta (medication used to treat high blood pressure) 10 mg by one time a day for hypertension; hold the medication and contact the physician for pulse less than 50.

Review of the March 2023 EMR revealed the following blood pressure results above physician ordered parameters:
03/06/23 blood pressure of 162/95 millimeters (mm) of Mercury (Hg)
03/20/23 blood pressure of 179/95 mmHg
03/21/23 blood pressure of 179/90 mm/Hg
03/22/23 blood pressure of 160/109 mm/Hg
03/23/23 blood pressure of 191/100 mm/Hg
03/27/23 blood pressure of 175/96 mm/Hg
03/29/23 blood pressure of 165/105 mm/Hg

Review of the April 2023 EMR revealed the following blood pressure results above physician ordered parameters:
04/01/23 blood pressure of 167/90 mm/Hg
04/03/23 blood pressure of 215/136 mm/Hg

The "Progress Note" dated 04/04/23 at 10:05 AM recorded R29 had shortness of breath and

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 _____	04/05/2023

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 726	Continued From page 57	F 726		

grunting respirations. R29 reported he felt poorly, had trouble breathing, and was having problems catching his breath. R29 had a blood pressure reading of 151/96 mm/Hg, oxygen saturation of 68%, a temperature of 98.0 Fahrenheit (F) and a pulse of 68. Staff called the physician and reported the vital signs, and the facility received a call back from the physician's office to send R29 to the hospital immediately per emergency medical services (EMS).

R29's EMR lacked evidence staff obtained an order and applied supplemental oxygen for R29's low oxygen saturation level of 68%.

On 04/03/23 at 08:15 AM observation revealed R29 walked through the dining room, slowly, with deep growling/grunting respirations and a moist cough. R29 ate only cereal for breakfast.

On 04/03/23 at 12:30 PM observation revealed R29 walked through the dining room with a slower gait and continued with growling/grunting respirations and a moist cough. R29 did not eat well again, took only a few bites, and left the table with a slow and slightly unsteady gait.

On 04/04/23 at 08:17 AM observation revealed R29 sat in the dining room, with a breakfast plate in front of him. R29 had obvious respiratory difficulties as evidenced by growling/grunting respirations, cough, and nasal congestion.

On 04/04/23 at 08:19 AM Licensed Nurse (LN) H stated that R29's blood pressure sometimes ran high, and she had not notified the physician of the out of parameter readings. LN H reported R29 had been tested for COVID-19 and result had been negative but did not know date of last test.

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 _____	04/05/2023

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 726	Continued From page 58	F 726		

On 04/04/23 at 04:08 PM, Administrative Nurse D reported R29 admitted to the hospital, and was positive for COVID 19. Administrative Nurse D reported facility staff initiated COVID-19 testing for all the residents.

On 04/05/23 at 08:19 AM, LN I reported there were no positive COVID-19 residents. LN I confirmed R29 was admitted to the hospital and was treated for COVID-19.

On 04/05/23 at 10:30 AM, Administrative Nurse D stated R29's elevated blood pressures should have been reported to the physician, and verified the record lack physician notifications. Administrative Nurse D stated the medical record also lacked documentation of oxygen administration when the resident had respiratory distress and had an oxygen saturation of 68%. Administrative Nurse D stated oxygen should have been administered.

The facility's "Competencies" policy, dated 11/28/17, documented competency validation will be completed for all nurses and nurse aides prior to independent care assignments for newly hired staff and annually thereafter. The follow-up for noncompliance with completion was the responsibility of the department head for the employee or the administrator.

The facility failed to ensure staff possessed the appropriate skilsl and knowledge necessary in order to provide assessment, ongoing monitoring, and physician involvement for R29 who had significantly high blood pressure, which were out of parameter set forth by the facility, and failure to identify R29's respiratory distress which

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 _____	04/05/2023

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 726	Continued From page 59 placed R29 at increased risk for physical complication, adverse outcomes, and delayed treatment.	F 726		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 14 residents, with six reviewed for behaviors. Based on observation, record review, and interview the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing for one sampled resident, Resident (R) 4, who had behaviors of refusing showers and personal hygiene assistance. This placed the resident at risk for poor hygiene, infection and increased behaviors. Findings included: - The Electronic Medical Record (EMR) for R4 recorded diagnoses of bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods),	F 740		

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 _____	04/05/2023

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 740	Continued From page 60	F 740		

depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

R4's "Quarterly Minimum Data Set" (MDS), dated 11/10/22, documented R4 had intact cognition and was dependent upon two staff for bathing and required extensive assistance of one staff for bed mobility, dressing, toileting, and personal hygiene. The MDS further documented R4 did not have any behaviors, and had no skin issues.

The "Annual MDS," dated 02/03/23, documented R4 had intact cognition and required extensive assistance of one staff for transfers, dressing, toileting, personal hygiene, and bathing. The MDS further documented R4 did not have any behaviors, had moisture associated skin damage, and received ointment other than to her feet.

The "Anxiety Care Plan," dated 03/13/23, initiated on 06/14/19, directed staff to conduct 1:1 visits with R4 as needed to help identify specific thoughts/ideas that cause anxiety or depression. The plan directed staff to encourage R4 to get out of bed more and get involved with activities and reassure R4 during periods of distress/anxiousness.

The "Activities of Daily Living (ADLs) Care Plan," dated 03/13/23, initiated on 06/14/19, documented R4 liked her hair in a braid and required staff assistance after every shower she took. The plan directed staff to encourage R4 to reposition in bed to allow air to flow freely to her backside decreasing the risk for moisture

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 _____	04/05/2023

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 740	Continued From page 61	F 740		

damage; help R4 keep her fingernails and toenails short. The plan directed to offer R4 a whirlpool or shower first before giving her a bed bath; R4 preferred to take a bed bath due to her anxiety of going into the shower room. The update, dated 08/20/19, documented R4 preferred to bathe around 10:00 AM on Monday, Wednesday, and Friday and would often refuse. The care plan documented R4 had been educated on the importance of proper bathing, however, continue to educate and encourage if she refused.

The "January 2023 Bathing Report" documented R4 refused a bath, shower, or bed bath 12 times with education provided to the resident.

The "February 2023 Bathing Report," documented R4 refused a bath, shower, or bed bath 9 times with education provided to the resident.

The "March 2023 Bathing Report," documented R4 refused a bath, shower, or bed bath 11 times with education provided to the resident.

The "Physician Order," dated 02/07/23, directed Social Service and Nursing staff to assess strategies for a bathing routine as R4 told the physician she thinks she refused her baths while she was asleep and would like bath refusals in writing signed by R4.

The "Nurse's Note," dated 03/20/23 at 12:51 PM, documented R4 refused her bath due to being anxious and sick to her stomach. The note further documented R4 was offered medication to help with her nausea, R4 refused and stated she does not ever want a bath. Staff reeducated R4 on skin

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 _____	04/05/2023

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 740	Continued From page 62	F 740		

care and hygiene, with the risk of infections, and R4 stated she did not care if she got any infection or sores and did not want to be out of her bed for any reason. The noted documented R4 was offered a bed bath and she refused.

The "Nurse's Note," dated 03/22/23 at 11:10 AM, documented R4 flatly refused to take a shower and stated she was afraid she would fall. The note further documented R4 was told that people normally perspire, get sweaty, develop body odor and yeast when they don't shower. R4 stated she doesn't care and refused to bathe at all.

On 04/02/23 at 08:55 AM, observation revealed R4, in bed. Her hair was braided, but was greasy and disheveled. Further observation revealed R4's toenails were long, some were grown above the tip of her toes.

On 04/04/23 at 09:10 AM, Certified Nurse Aide (CNA) Q stated at the beginning of the shift, staff checked the computer to see which residents were scheduled for bathing. CNA Q stated if the resident refused, the aides asked the resident twice and if the resident continued to refuse, the aides gave a refusal sheet for the nurse to document on and document the refusal.

On 04/04/23 at 01:25 PM, Licensed Nurse H stated R4 refused her baths for months; staff educated her and it does not make a difference.

On 04/04/23 at 03:00 PM, Administrative Nurse D stated they have tried and tried to get R4 to take a bath, shower, or bed bath and stated R4 refused to sign the refusal sheets. Administrative Nurse D further stated, they try different staff to encourage her and it works a couple times, then

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 _____	04/05/2023

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 740	Continued From page 63 she will refuse. Administrative Nurse D stated she did sit down hard on the shower chair, but that was a couple years ago and she still won't go to the shower. R4 used to have an anxiety pill they would give her prior to her shower but she would refuse to take it and she no longer has it. Administrative Nurse D stated Social Service staff should be involved with her and should talk with her about her anxiety and did not know if there was documentation of the resident refusing behavioral health care services or if it was offered. The facility's "Behavioral Health" policy, dated 11/28/17, documented, residents would receive the necessary behavioral health care and services to attain or maintain the highest practicable physicial, mental, and psychosocial well-being. The policy further documented the facility would ensure the services were person-centered and reflect the resident's goals for care while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. The facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being for R4 who refused bathing and hygiene related to her behavioral health needs and concerns. This placed the resident at risk for poor hygiene, infection and increased behaviors.	F 740		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or	F 745		

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 _____	04/05/2023

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 745	Continued From page 64	F 745		

maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:

The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to identify and provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of one sampled resident, Resident (R) 4, who had behaviors of refusing showers and personal hygiene assistance. This placed the residnet at risk for impaired quality of life.

Findings included:

- The Electronic Medical Record (EMR) for R4 recorded diagnoses of bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

R4's "Quarterly Minimum Data Set" (MDS), dated 11/10/22, documented R4 had intact cognition and was dependent upon two staff for bathing and required extensive assistance of one staff for bed mobility, dressing, toileting, and personal hygiene. The MDS further documented R4 did not have any behaviors, and had no skin issues.

The "Annual MDS," dated 02/03/23, documented R4 had intact cognition and required extensive

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 _____	04/05/2023

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 745	Continued From page 65	F 745		

assistance of one staff for transfers, dressing, toileting, personal hygiene, and bathing. The MDS further documented R4 did not have any behaviors, had moisture associated skin damage, and received ointment other than to her feet.

The "Anxiety Care Plan," dated 03/13/23, initiated on 06/14/19, directed staff to conduct 1:1 visits with R4 as needed to help identify specific thoughts/ideas that cause anxiety or depression. The plan directed staff to encourage R4 to get out of bed more and get involved with activities and reassure R4 during periods of distress/anxiousness.

The "Activities of Daily Living (ADLs) Care Plan," dated 03/13/23, initiated on 06/14/19, documented R4 liked her hair in a braid and required staff assistance after every shower she took. The plan directed staff to encourage R4 to reposition in bed to allow air to flow freely to her backside decreasing the risk for moisture damage; help R4 keep her fingernails and toenails short. The plan directed to offer R4 a whirlpool or shower first before giving her a bed bath; R4 preferred to take a bed bath due to her anxiety of going into the shower room. The update, dated 08/20/19, documented R4 preferred to bathe around 10:00 AM on Monday, Wednesday, and Friday and would often refuse. The care plan documented R4 had been educated on the importance of proper bathing, however, continue to educate and encourage if she refused.

The "January 2023 Bathing Report" documented R4 refused a bath, shower, or bed bath 12 times with education provided to the resident.

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 _____	04/05/2023

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 745	Continued From page 66	F 745		

The "February 2023 Bathing Report," documented R4 refused a bath, shower, or bed bath 9 times with education provided to the resident.

The "March 2023 Bathing Report," documented R4 refused a bath, shower, or bed bath 11 times with education provided to the resident.

The "Physician Order," dated 02/07/23, directed Social Service and Nursing staff to assess strategies for a bathing routine as R4 told the physician she thinks she refused her baths while she was asleep and would like bath refusals in writing signed by R4.

The "Nurse's Note," dated 03/20/23 at 12:51 PM, documented R4 refused her bath due to being anxious and sick to her stomach. The note further documented R4 was offered medication to help with her nausea, R4 refused and stated she does not ever want a bath. Staff reeducated R4 on skin care and hygiene, with the risk of infections, and R4 stated she did not care if she got any infection or sores and did not want to be out of her bed for any reason. The noted documented R4 was offered a bed bath and she refused.

The "Nurse's Note," dated 03/22/23 at 11:10 AM, documented R4 flatly refused to take a shower and stated she was afraid she would fall. The note further documented R4 was told that people normally perspire, get sweaty, develop body odor and yeast when they don't shower. R4 stated she doesn't care and refused to bathe at all.

R4's clinical record lacked evidence of social service support provided to the resident.

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 _____	04/05/2023

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 745	Continued From page 67	F 745		

On 04/02/23 at 08:55 AM, observation revealed R4, in bed. Her hair was braided, but was greasy and disheveled. Further observation revealed R4's toenails were long, some were grown above the tip of her toes.

On 04/04/23 at 09:10 AM, Certified Nurse Aide (CNA) Q stated at the beginning of the shift, staff checked the computer to see which residents were scheduled for bathing. CNA Q stated if the resident refused, the aides asked the resident twice and if the resident continued to refuse, the aides gave a refusal sheet for the nurse to document on and document the refusal.

On 04/04/23 at 01:25 PM, Licensed Nurse H stated, R4 refused her baths for months; staff educated her and it does not make a difference.

On 04/04/23 at 03:00 PM, Administrative Nurse D stated Social Service staff should be involved with her and should talk with her about her anxiety and did not know if there was documentation of the resident refusing behavioral health care services or if it was offered.

The facility's "Social Services Designee" policy, dated 06/07/22, documented the social services designee assist in implementing and directing social service programs and assure that the residents physical, mental, emotional and social needs are met and maintained on an individual basis. The duties and responsibilities include, record and maintain regular social service progress notes indicating response to the treatment plan and/or adjustment to institutional life, make routine visits to residents and perform services as necessary, maintain contact with the resident's family, and involve them with

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 _____	04/05/2023

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

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F 745	Continued From page 68 non-medical progress reports as necessary, and assist in interpreting social, psychological and emotional needs of the resident/family to the medical staff, attending physician, and other resident care team members. The facility failed to identify provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of R4, who had behaviors of refusing showers and personal hygiene assistance. This placed the residnet at risk for impaired quality of life.	F 745		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		

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 _____	04/05/2023

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 761	Continued From page 69	F 761		

package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review, and interview the facility staff failed to assess and record temperatures in the medication refrigerators in the medication room. This placed the residents, who received medications from the refrigerators, at risk for receiving less potent or unintended effects from the medications.

Findings included:

- On 03/30/23 at 09:27 AM, observation in the medication room revealed a lack of evidence that staff assessed and maintained adequate refrigerator temperatures.

On 03/30/23 at 09:27 AM, Licensed Nurse (LN) J stated staff checked the temperature daily but did not document the reading.

On 04/04/23 at 12:53 PM, Administrative Nurse D verified staff had not been recording the two refrigerator temperatures in the medication room and stated staff should be recording the temperatures.

The facility's "Storage of Medications and Biologicals Policy," revised 01/21, documented medications requiring "refrigeration" or temperatures between 36 degrees Fahrenheit (F) and 46 degrees are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage "in a cool place"

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 _____	04/05/2023

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

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F 761	Continued From page 70 are refrigerated unless other wise directed on the label. The facility failed to ensure staff assessed and recorded the two refrigerator temperatures in the medication room. This placed the residents, who received medications from the refrigerators, at risk for receiving less potent or unintended effects from the medications.	F 761		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to	F 849		

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 _____	04/05/2023

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 849	Continued From page 71	F 849		

any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and

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 _____	04/05/2023

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 849	Continued From page 72	F 849		

bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone

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 _____	04/05/2023

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 849	Continued From page 73	F 849		

that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms,

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 _____	04/05/2023

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 849	Continued From page 74	F 849		

and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents in which two were reviewed for Hospice (specialized care to people who are near the end of life) services, Resident (R)1 and R30. Based on observation, record review, and interview, the facility failed to ensure communication and collaboration with the Hospice provider placing the residents at risk for uncommunicated and unmet end of life care needs.

Findings included:

- R1's Electronic Medical Record (EMR) recorded diagnoses of chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) with late onset, dementia (progressive mental disorder characterized by failing memory, confusion) with

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 _____	04/05/2023

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 849	Continued From page 75	F 849		

severe mood disturbance, chronic kidney disease, and personal history of malignant neoplasm (cancer) of the breast.

The "Significant Change Minimum Data Set" (MDS), dated 03/13/23, documented R1 had severe cognitive impairment, had verbal behaviors directed toward others which occurred on to three days of the look back period, required extensive assistance of one to two staff for activities of daily living. The MDS further documented R1 had pain, received routine pain medication and had hospice services.

The "Hospice Care Plan", dated 03/13/23, documented to coordinate R1's care with the hospice staff to assure all needs were being met. The hospice will consult with facility staff regarding needs being met, pain management, medication management, consulting doctors for new orders, supply healthcare supplies, communication with family, assist in nursing/bathing and companionship.

The "Progress Note", dated 03/06/23 at 10:51AM, documented the social service designee spoke with family about hospice service due to the resident's decline. Family called to inform the facility they would like to set up hospice services and chose a preferred hospice provider.

R1's clinical record including the Hospice binder lacked nursing and other discipline notes related to R1's cares and needs.

On 04/04/23 at 09:18 AM, observation revealed R1 sat in the dining room, and called out for help several times though no staff responded to her.

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 _____	04/05/2023

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 849	Continued From page 76	F 849		

On 04/04/23 at 09:14 AM Licensed Nurse (LN) H reported the hospice staff gave the facility staff verbal report and discussed the resident's condition with the staff that was working. LN H stated the hospice staff had not been leaving a paper visit sheet of the visits.

On 04/04/23 at 09:17 AM Administrative Nurse D stated hospice was to document their visit and hospice should fax or e-mail the visit note to the facility. Administrative Nurse D stated she had expected the notes to be sent no later than 24 hours.

On 04/04/23 at 11:55 AM Consultant GG stated the hospice office would send all the paperwork that was required in the chart and reported there must have been a miscommunication because the visit logs should be in the resident's chart.

The facility's "Hospice/End of Life" policy, dated 11/28/17, documented hospice/end of life services will be provided according to resident's needs and preferences. Social Services will coordinate with hospice. A significant change in status assessment will be initiated and the plan of care will be updated to reflect coordination of care and services with hospice.

The facility failed ensure communication and collaboration with Hospice, placing the resident at risk for unmet end of life care needs.
- The Electronic Medical Record (EMR) documented R30 had diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), anxiety, mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and mood

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 _____	04/05/2023

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 849	Continued From page 77	F 849		

disorder category of mental health problems, feelings of sadness, helplessness, and guilt).

R30's "Significant Change Minimum Data Set" (MDS), dated 03/01/23, documented R30 had severely impaired cognition and required extensive assistance of one staff for toileting, personal hygiene, bathing, and independent with bed mobility and transfers. The MDS further documented R30 received hospice services.

The "Hospice Care Plan," dated 03/13/23, directed staff to coordinate care with the hospice staff to ensure all my needs are being met, inform her family of her condition and if she would like to see them, respect R30's advance directives, and provide her with mediations and other measures to maintain her comfort as hospice will provide medications.

Review of R30's clinical record lacked documentation a hospice care plan of coordination of care between hospice and the facility, nursing and other discipline visit notes, and hospice admission documentation.

On 04/03/23 at 08:56 AM, observation revealed R30 lying on her bed with eyes closed.

On 04/04/23 at 09:14 AM, Licensed Nurse (LN) H stated hospice gives a verbal report to staff on the resident's condition and did not think a paper copy was left at the facility.

On 04/04/23 at 09:17 AM, Administrative Nurse D stated hospice document when they visit the resident and expected the hospice documents to be in the resident's chart within 24 hours of the visit.

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 _____	04/05/2023

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 849	Continued From page 78 On 04/04/23 at 11:55 AM, Consultant GG stated there was a miscommunication and the documents were being provided to the facility and was aware the care plan, logs and visits should be in the resident's chart. The facility "Hospice/End of Life" policy, dated 11/28/17, documented Hospice/End of Life services would be provided according to resident's needs and preferences. Social Services would meet with the resident, family, and/or resident representative to discuss options for end of lice services including hospice. Upon decision to elect hospice services, the physician would be contacted to obtain orders, and social services would coordinate with hospice. A significant change in status assessment would be initiated and the plan of care would be updated to reflect coordination of care and services with hospice. The facility failed to coordinate care between themselves and hospice services, documentation of hospice visits, and admission documentation for R30, who received hospice services. This placed the resident at risk for inappropriate end of life care.	F 849		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility	F 865		

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 _____	04/05/2023

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 865	Continued From page 79	F 865		

must:

§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

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 _____	04/05/2023

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 865	Continued From page 80	F 865		

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in

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 _____	04/05/2023

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 865	Continued From page 81	F 865		

systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

§483.75(i) Sanctions.
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility's Quality Assessment and Assurance (QAA) program failed to make good faith efforts to identify multiple issues of concern for the 40 residents, who resided in the facility. This placed the residents at risk for decreased quality of care.

Findings included:

- Based on observation, record review, and interview, the facility failed to provide Resident (R) 30 and R20 care in a manner to maintain and enhance dignity and respect. Refer to F550.

Based on observation, record review, and interview, the facility failed to notify R29's physician of a change of condition. Refer to F580.

Based on record review, and interview, the facility

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 _____	04/05/2023

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 865	Continued From page 82	F 865		

failed to place estimated cost on the Medicare Beneficiary Notices for three residents. Refer to F582.

Based on observation, record review, and interview, the facility failed to address hypertension (elevated blood pressure) medication in the comprehensive care plan for R29. Refer to F656.

Based on observation, record review, and interview, the facility failed to provide routine bathing for R17, R38, and R2. Refer to F677.

Based on observation, record review, and interview, the facility failed to provide quality of care for R29 who had a condition change. Refer to F684.

Based on observation, record review, and interview, the facility failed to provide incontinent care for R20 and proper urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) care for R33. Refer to F690.

Based on observation, record review, and interview, the facility failed to provide clean and sanitary respiratory equipment for R4. Refer to F695.

Based on record review, and interview, the facility failed to provide competent nursing staff for R29 who had elevated blood pressure and respiratory distress. Refer to F726.

Based on observation, record review, and interview, the facility failed to provided physician ordered mental health support for R4. Refer to

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 _____	04/05/2023

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 865	Continued From page 83	F 865		

F740.

Based on observation, record review, and observation, the facility failed to provide medically related social service support for R4. Refer to F745

Based on observation, record review, and interview, the facility failed to document medication room refrigerator temperatures. Refer to F761.

Based on observation, record review, and interview, the facility failed to obtain hospice (special care to people who are near the end of life) documentation for coordination of care for R1 and R30.

Based on observation, record review, and interview, the facility failed to conduct waterborne pathogen test, isolate R26 who had been exposed to COVID (a highly infectious respiratory disease) positive roommate and provide proper urinary catheter care for R33. Refer to F880.

On 04/05/23 at 12:45 PM, Administrative Staff A reported she collected data from the interdisciplinary team and other sources of information for the quality assessment and assurance program that meets on a monthly basis to formulate plans of improvement.

The facility's "QAPI Plan", dated 06/21/22, documented the QAPI program will aim for safety and high quality with all clinical interventions and service delivery while emphasizing autonomy, choice, and quality of daily life for residents and family by ensuring our data collection tools and monitoring systems are in place and are

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 _____	04/05/2023

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 865	Continued From page 84 consistent for proactive analysis, system failure analysis, and corrective action. We utilize the best available evidence (e.g. data, national benchmarks, published best practices, clinical guidelines) to define and measure our goals. The facility failed to identify multiple issues of concern for the 40 residents who reside in the facility placing the residents at risk for lack of quality care.	F 865		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		

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 _____	04/05/2023

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 880	Continued From page 85	F 880		

but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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 _____	04/05/2023

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 880	Continued From page 86	F 880		

This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review, and interview the facility failed to provide a sanitary environment to help prevent the development and transmission of communicable disease and infections when the facility failed to develop a water management plan to minimize the risk for development of Legionella (type of bacteria that can cause serious lung infections) or other waterborne pathogens (agents that cause disease or infection) from entering the facility water system. The facility staff further failed to assess and document washing machine temperatures. Staff failed to isolate Resident (R) 36 after exposure to his roommate's symptomatic COVID (highly contagious, potentially fatal respiratory infection). Staff failed to perform appropriate hand hygiene when providing R33's cathter (tube inserted into the bladder to drain urine) cares. These deficient practices placed all residents at increased risk for developing an infection.

Findings included:

- On 04/04/23 at 08:39 AM, observation of the laundry room revealed a lack of evidence staff assessed and documented the washing machine temperatures.

On 04/04/23 at 08:39 AM, Laundry Staff (LS) V stated he checked the washing machine temperature every morning but did not document it.

On 04/04/23 at 11:09 AM, Maintenance Staff (MS) U stated he checked the washing machine

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 _____	04/05/2023

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 880	Continued From page 87	F 880		

temperature daily but did not document it. MS U stated he was unaware he needed to document them.

On 04/04/23 at 12:42 PM, when asked to see the facility's water management plan, MS U was unaware of a plan and stated the facility did not have one.

On 04/04/23 at 02:09 PM, Administrative Staff A stated the facility had a plan but had not been following it.

The facility's "Legionella Policy," revised 04/27/18, documented the facility would conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system. The policy stated annual testing would be completed at least once a year and with any new construction, equipment changes, changes in treatment products(disinfectants), change in water usage, changes in water usage or one or more cases of disease thought to be associated with the system.

The facility failed to develop a water management plan for detecting Legionella and other waterborne pathogens in the water system and failed to monitor and record washing machine temperatures. This placed the 40 residents at risk for developing an infection.
- The Electronic Medical Record for R33 documented diagnoses of type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), hyperlipidemia (condition of elevated blood lipid levels), congestive heart failure (a condition with low heart output and the

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 _____	04/05/2023

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 880	Continued From page 88	F 880		

body becomes congested with fluid), obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), urinary retention (a lack of ability to urinate and empty the bladder).

R33's "Admission Minimum Data Set" (MDS), dated 12/04/22, documented R33 had intact cognition and required extensive assistance of one staff for transfers, dressing, toileting, and personal hygiene. The MDS further documented R33 required the use of an indwelling Foley catheter (tube used for draining urine from the bladder and having an inflatable part at the bladder end that allows the tube to be kept in place for variable time periods), was always incontinent of bowel, and had a urinary tract infection (an infection in any part of the urinary system) in the last 30 days.

The "Quarterly MDS," dated 03/02/23, documented R33 had intact cognition and required extensive assistance of two staff for transfers, toileting, and extensive assistance of one staff for bed mobility. The MDS further documented R33 had an indwelling Foley catheter and was frequently incontinent of bowel.

The "Urinary Catheter Care Plan," dated 03/16/23, initiated on 2/13/22, directed staff to ensure catheter care was performed every shift and as needed, if staff notice R33's urine turning darker in color, encourage good fluid intake. The plan directed if she was experiencing burning, cloudy or foul odor from the urine, let her physician know right away, and replace her catheter as ordered by the physician. Monitor urine output each shift, if staff notice a low urine output, sediment in her urine, abnormal urine

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 _____	04/05/2023

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 880	Continued From page 89	F 880		

color, notify the physician. The update dated 03/16/23 further directed staff to apply a urinary catheter leg drainage bag to her catheter when she was out of her bed or up ambulating.

The "Physician Order," dated 11/15/22, directed staff to administer cranberry plus probiotic (promotes a healthy urinary tract), one tablet, by mouth, in the morning, for a supplement.

The "Physician Order," dated 12/02/22, directed staff to insert a 16 French x 30 (cc) cubic centimeters Foley catheter monthly and document urine output every shift for the diagnosis of urinary retention.

The "Physician Order," dated 01/14/23, directed staff to administer Macrobid (an antibiotic to treat and prevent urinary tract infections), 100 milligrams (mg), by mouth, twice a day, for 10 days for a diagnosis of urinary tract infections (uti).

The "Nurse's Note," dated 01/13/23 at 07:44 AM, documented R33's catheter was patent and draining, urine was clear and noted sediment, yellow in color.

The "Nurse's Note," dated 01/13/23 at 11:49 AM, documented staff collected a urinalysis (examination of urine) from R33.

The "Urinalysis Report," dated 01/13/23, documented R33 had increased protein, and blood in her urine.

On 04/04/23 at 08:15 AM, observation revealed R33 laid in bed. Certified Nurse Aide (CNA) O and CNA P applied gloves and pulled down the

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 _____	04/05/2023

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 880	Continued From page 90	F 880		

resident's incontinence brief and pants. CNA O took R33's catheter bag, still full of urine, and guided the bag up the inside of the right pant leg and out the top of R33's pants. Further observation revealed CNA O and CNA P stood there as R33 was exposed from the waist down and discussed who would complete the catheter care and who would drain the catheter bag. Continued observation revealed CNA P took an incontinence wipe, performed incontinence care, and ran out of wipes before she could do catheter care. CNA P opened R33's nightstand drawer with soiled hands and was unable to find gloves. CNA O looked for more incontinence wipes in R33's dresser drawer and stated "Well, I guess we need to stock these rooms" and took R33's roommates' s incontinence wipes. Observation revealed R33 continued to be exposed from the waist down as the CNAs looked for incontinence wipes. CNA P took an incontinence wipe and wiped around the catheter tubing at the insertion site but did not cleanse the catheter tubing. With the same soiled gloves, CNA P and CNA O pulled up R33's incontinence brief and pants. Further observation revealed CNA O sat a container on the floor to drain the catheter bag, and spilled urine on the floor. CNA O stated, "how did it get spilled onto the floor?" CNA O failed to cleanse the port of the catheter tubing before clamping the tubing, took the catheter bag and down the top of R33's pants, down the inside of the right pant leg and held onto it as he assisted R33 into her recliner and asked her where she wanted him to place the catheter bag. R33 instructed CNA O to put the catheter bag in the dignity bag and lay it on top on her trash can.

On 04/04/23 at 12:20 PM, CNA P stated she knew she had not changed her gloves after

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 _____	04/05/2023

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 880	Continued From page 91	F 880		

incontinence care because she forgot and verified they had not covered R33 up when looking for extra gloves.

On 04/05/23 at 11:56 AM, Administrative Nurse D stated staff should not leave residents exposed if they are not providing cares. Administrative Nurse D said the CNA should have removed her soiled gloves before touching other surfaces or the resident.

Upon request, a policy for hand hygiene was not provided by the facility.

The facility failed perform appropriate hand hygiene when providing incontinence care for R33. This placed the resident at risk for infections.

- On 04/05/23 at 10:00 AM observation revealed R26's room, which he shared with COVID positive R29, lacked personal protective equipment and signage on the door for isolation precautions and a variety of staff entering and exiting the room.

On 04/04/23 at 04:08 PM, Administrative Nurse D reported R29 admitted to the hospital, and was positive for COVID 19. Administrative Nurse D reported facility staff initiated COVID-19 testing for all the residents

On 04/05/23 at 08:19 AM, LN I reported the facility had no positive COVID residents. LN I confirmed R29 had been admitted to the hospital and was being treated for COVID.

On 04/05/23 at 10:30 AM Administrative Nurse D stated R26 did not come out of his room, but staff went in and out of the room. Administrative Nurse

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 _____	04/05/2023

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(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 880	Continued From page 92 D verified R26 should be isolated due to exposure to R29's symptomatic COVID condition and subsequent positive test. The facility's "COVID 19 Isolation" policy, dated 10/06/22, documented isolation precautions will be utilized when there is a COVID-19 risk. Residents determined to be at risk for COVID-19 will be placed on droplet isolation. Droplet precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. The facility will post a notice at the door indicating the resident is on droplet isolation. Employees caring for residents on droplet precautions are to wear a gown, gloves, N-95 face mask, and googles/face shield. The facility failed to isolate R26 after exposure to his symptomatic, COVID positive room mate which increased the risk for internal transmission of COVID.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification;	F 882		

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 _____	04/05/2023

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F 882	Continued From page 93	F 882		

§483.80(b)(3) Work at least part-time at the facility; and

§483.80(b)(4) Have completed specialized training in infection prevention and control.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents. Based on interview and record review the facility failed to provide an Infection Preventionist (IP) designated to manage and monitor the facility's Infection Prevention and Control Program (IPCP) for the 40 residents who resided in the facility. This placed the residents at risk for infections and health problems.

Findings included:

- On 04/04/23 at 10:05 AM, Administrative Nurse D stated she was enrolled in the IP program but had not completed it. Administrative Nurse D said the nurse consultant monitored the IPCP remotely, but the facility had no certified IP to provide oversight and monitor the facility's IPCP at least part-time in the facility.

The facility's "Infection Preventionist Policy," undated, documented the facility would designate an IP who would be responsible for oversight of the infection IPCP. The IP would have primary professional training in nursing or another related field. This person would work at least part time at the facility and would have completed specialized training in IPCP.

The facility failed to provide an IP who held the required certification to manage and monitor the facility's Infection Prevention and Control Program for the 40 residents who reside in the

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F 882	Continued From page 94 facility. This placed the residents at risk for infections and health problems.	F 882		