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	175191	A. BUILDING _____ B. WING _____	C 11/14/2023

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 the findings of complaint investigation #KS00183676 and KS001837033. The 2567 was sent electronically on 11/17/23.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/17/2023

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.

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§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
F655 Tracy
The facility had a census of 39 residents. The sample included three residents reviewed for quality of care. Based on record review and interview, the facility failed to develop a baseline care plan for Resident (R) 1, which addressed his immediate health needs including his below the knee amputation (surgical removal of a body part), surgical incision, and daily dressing changes. This placed the resident at risk for inappropriate care due to uncommunicated care needs.

Findings included:

- The Electronic Medical Record (EMR) for R1 documented diagnoses of acquired absence of right leg below knee, acute kidney failure (the kidneys suddenly cannot filter waste from the blood), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following a cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood

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F 655	Continued From page 2	F 655		

vessels that supply it), and hypertension (high blood pressure).

The "Medicare 5 Day Minimum Data Set" (MDS), dated 10/25/23, documented R1 had moderately impaired cognition and required substantial to maximum assistance for upper and lower dressing, toileting, sit to stand, chair to bed, putting footwear on and off, and bathing. The MDS further documented R1 had no upper functional impairment, had lower functional impairment on one side, and had a surgical wound.

The "Baseline Care Plan," dated 10/19/23, documented R1 was alert, required assistance of two staff for transfers, toileting, and one staff for personal hygiene, dressing, bathing, and mobility. The care plan further documented R1 was alert and had no pain. The baseline care plan lacked mention of R1's amputation and/or the presence of a surgical incision and related treatments.

R1's hospital "Discharge Summary," dated 10/19/23, directed staff to keep the wound clean and dry, and continue with daily dressing changes, 4 x 4 gauze (an absorbent dressing for wounds), Kerlix (stretchy gauze bandage) and an ace wrap (provides moderate support to weak, sore muscles and joints) until seen at his follow-up appointment.

The "Nurse's Notes," dated 10/19/23 at 06:30 PM, documented R1's right knee skin was clean, dry and intact with sutures placed. R1 had a surgical incision, sutures were present, and the resident was on anticoagulants (blood thinner).

The "Nurse's Notes," dated 10/23/23 at 04:00

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F 655	Continued From page 3	F 655		

PM, documented R1's family member inquired about R1's dressing change to his incision and stated the surgeon requested a picture of the incision for review. The nurse's note further documented staff reviewed the "Discharge Summary" for dressing change orders, then removed the soiled dressing which had a moderate amount of dried blood. The note documented R1 had purplish discoloration surrounding the incision and had no odor or warmth to the incision. The dressing was changed as ordered, and staff reapplied the brace.

The "Treatment Administration Record," dated October 2023 lacked evidence staff provided R1's dressing changes until 10/23/23 (4 days after admission).

R1 was discharged from the facility on 10/27/23.

On 11/14/23 at 03:10 PM, Licensed Nurse (LN) G stated the nurse completed new admission paperwork and inputs all the orders from the physician into the computer and the following shift reviewed the admission packet to ensure no orders were missed.

On 11/16/23 at 10:30 AM, Administrative Nurse D stated the baseline care plan should address his surgical wound and treatments.

The facility's "Care Plan" policy, dated 11/28/17, documented the charge nurse was responsible for creating a baseline care plan within 48 hours after admission to be individualized to address the residents specific needs.

The facility failed to develop a baseline care plan

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F 655	Continued From page 4 for R1, who had a new below the knee amputation and required daily dressing changes. This placed R1 at risk for inappropriate care and services due to uncommunicated care needs.	F 655		
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 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 39 residents. The sample included three residents reviewed for quality of care. Based on record review and interview, the facility failed to ensure Resident (R) 1 received wound care as ordered for four days after a below the knee amputation (surgical removal of a body part). This placed the resident at risk for infection and decline. Findings included: - The Electronic Medical Record (EMR) for R1 documented diagnoses of acquired absence of right leg below knee, acute kidney failure (the kidneys suddenly cannot filter waste from the blood), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following a cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood	F 684		

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F 684	Continued From page 5	F 684		

vessels that supply it), and hypertension (high blood pressure).

The "Medicare 5 Day Minimum Data Set" (MDS), dated 10/25/23, documented R1 had moderately impaired cognition and required substantial to maximum assistance for upper and lower dressing, toileting, sit to stand, chair to bed, putting footwear on and off, and bathing. The MDS further documented R1 had no upper functional impairment, had lower functional impairment on one side, and had a surgical wound.

The "Baseline Care Plan," dated 10/19/23, documented R1 was alert, required assistance of two staff for transfers, toileting, and one staff for personal hygiene, dressing, bathing, and mobility. The care plan further documented R1 was alert and had no pain. The baseline care plan lacked mention of R1's amputation and/or the presence of a surgical incision and related treatment.

R1's hospital "Discharge Summary," dated 10/19/23, directed staff to keep the wound clean and dry, and continue with daily dressing changes, 4 x 4 gauze (an absorbent dressing for wounds), Kerlix (stretchy gauze bandage) and an ace wrap (provides moderate support to weak, sore muscles and joints) until seen at his follow-up appointment.

The "Nurse's Notes," dated 10/19/23 at 06:30 PM, documented R1's right knee skin was clean, dry and intact with sutures placed. R1 had a surgical incision, sutures were present and the resident was on anticoagulants (blood thinner).

The "Nurse's Notes," dated 10/23/23 at 04:00

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F 684	Continued From page 6	F 684		

PM, documented R1's family member inquired about R1's dressing change to his incision and stated the surgeon requested a picture of the incision for review. The nurse's note further documented staff reviewed the "Discharge Summary" for dressing change orders, then removed the soiled dressing which had a moderate amount of dried blood. The note documented R1 had purplish discoloration surrounding the incision, and had no odor or warmth to the incision. The dressing was changed as ordered, and staff reapplied the brace.

The "Treatment Administration Record," dated October 2023 lacked evidence staff provided R1's dressing changes until 10/23/23 (4 days after admission).

R1 was discharged from the facility on 10/27/23.

On 11/14/23 at 03:10 PM, Licensed Nurse (LN) G stated the nurse completed new admission paperwork and inputs all the orders from the physician into the computer and the following shift reviewed the admission packet to ensure no orders were missed.

On 11/14/23 at 03:45 PM, Administrative Nurse D stated the dressing change order was missed upon admission and when the family member told the facility, the dressing change was immediately done and placed on the treatment record. Administrative Nurse D further stated education was provided to all the nurses and she expected each nurse to read the admission paperwork thoroughly, so orders were correct and not missed.

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F 684	Continued From page 7 Upon request a policy for dressing change, following physician orders, was not provided by the facility. The facility failed to ensure R1's dressing change to his surgical wound was changed daily as physician ordered. This placed the resident at risk for infection and decline.	F 684		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: The facility had a census of 39 residents. The sample included three residents, with two reviewed for footcare. Based on observation, record review, and interview, the facility failed to provide footcare to two sampled resident, Resident (R) 2 and R3, who had diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and required foot care from a licensed nurse. This placed the residents at risk for complications including poor hygiene, discomfort, and injuries.	F 687		

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Findings included:

- The Electronic Medical Record (EMR) for R2 recorded diagnoses of diabetes mellitus type 2, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), end stage renal disease (kidneys are damaged and cannot filter blood the way they should), and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain).

The "Medicare 5 Day Minimum Data Set" (MDS), dated 11/07/23, documented R2 had intact cognition and required some assistance with self-care, dependent upon staff for toileting, substantial to maximum assistance with showers, lower body dressing, putting on footwear, and partial or moderate assistance with upper body dressing assistance.

R2's "Care Plan," dated 11/13/23 directed staff to assess her skin for any impairment during bathing, dressing, toileting. The plan directed staff to have a licensed nurse provide nailcare.

On 11/14/23 at 11:30 AM, during wound care, R2 stated she had two sore toes, and she was prone to ingrown nails. Upon request, Licensed Nurse (LN) G removed R2's socks and looked at her feet. Observation revealed R2's toe nails were very thick, brown in color, and were grown over the tips of her toes.

On 11/14/23 at 11:30 AM, LN G stated she would have R2 take a whirlpool bath the next day so that R2's toes could soak, and then she would provide R2 toenail care. LN G further stated she

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would have the podiatrist check R2's toenails on his next visit.

On 11/14/23 at 03:34 PM, Administrative Nurse D stated she would make sure R2 was seen the next time the podiatrist came. Administrative Nurse D said she expected a LN to provide toenail care between the podiatrist visits.

The facility's "Foot Care" policy, dated 04/27/18, documented foot care would be provided to residents to ensure they receive proper treatment and care to maintain mobility and good foot health.

The facility failed to provide foot care to R2, who had overgrown toenails on both feet, This placed the resident at risk for complications and injury.

- The Electronic Medical Record (EMR) for R3 documented diagnoses of diabetes mellitus type 2, candidiasis of nails (yeast infection which caused nails to separate from the finger or toes), and hypertension (high blood pressure).

The "Quarterly Minimum Data Set" (MDS), dated 11/02/23, documented R3 was cognitively intact, and dependent upon staff for toileting, showers, putting on footwear, and substantial to maximum assistance or personal hygiene.

R3's "Care Plan," dated 08/24/23, initiated on 06/14/19, directed staff to help keep her fingernails and toenails short as she had trouble trimming them herself, and the care of the nails was to be done by a nurse.

On 11/14/23 at 10:30 AM, observation revealed

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R3's feet were very dry with large flakes of skin coming off of the top and bottoms of her feet. R3's toenails were thick, brown, and grown over the tops of her toes. R3 asked Licensed Nurse (LN) H to put lotion on her feet for her.

On 11/14/23 at 10:30 AM, LN H stated R3 received nailcare from the podiatrist that came to the facility, so staff did not do any nail care for her. LN H was unsure when the last time the podiatrist had been to the facility or when he was coming back.

On 11/14/23 at 03:45 PM, Administrative Nurse D stated the podiatrist was at the facility the beginning of October but further stated she expected the nurse to provide toenail care between podiatry visits.

The facility's "Foot Care" policy, dated 04/27/18, documented foot care would be provided to residents to ensure they receive proper treatment and care to maintain mobility and good foot health.

The facility failed to provide foot care to R3, who had overgrown toenails on both feet, This placed the resident at risk for complications and injury.