STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0000	INITIAL COMMENTS A recertification survey was conducted on 05/12/26 to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The facility census on the first day of the survey was 38. The sample included 12 residents. Based on this survey, deficiencies were identified under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): §483.35(b)(1)-(3) §483.35(b) Registered Nurse §483.35(b)(1)Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide Registered Nurse (RN) coverage for eight consecutive hours a day, seven days a week. Findings included: - Review of the facility's "Nursing Schedule" lacked consecutive eight-hour RN coverage for the following dates:	F0727		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0727 SS = F	Continued from page 1 02/27/26 02/28/26 03/1/26 03/14/26 03/15/26 03/29/26 04/11/26 04/12/26 05/09/26 05/10/26 On 5/13/26 at 10:15 PM, Administrative Staff A stated they have a scheduler for nursing staff, and then Administrative Nurse D would look over the scheduler. They do have as-needed (PRN) staff and verified that they did not have RN coverage on the above dates. The facility's "Competent and Sufficient Staffing" dated 09/24, the facility would provide enough staff with the skill sets and competencies necessary to provide care/services for all residents in accordance with resident care plans and the facility assessment. A registered nurse provides services for at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled for more than eight (8) hours, depending on the acuity of the residents.	F0727		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0628 SS = D	Continued from page 2 responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0628 SS = D	Continued from page 3 section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0628 SS = D	Continued from page 4 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0628 SS = D	Continued from page 5 When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on the interview and record review, the facility failed to notify the Office of the Long-Term Care Ombudsman (LTCO- a public official who works to resolve resident issues in nursing facilities) when Resident (R) 17 was transferred and admitted to the hospital. Findings included: - R17's Electronic Medical Record (EMR) recorded a "Nurse's Note," dated 01/11/26 at 04:02 PM, that documented R17 admitted to the hospital. R17's clinical record lacked evidence of the LTCO notification for R17's 01/11/26 hospital transfer. The facility was unable to provide evidence the LTCO was notified. On 05/12/26 at 02:04 PM, observation revealed R17 sat in a wheelchair on the patio located by the dining room exit door. On 05/14/26 at 10:21 AM, Administrative Staff A stated she was responsible for notifying LTCO when R17 was transferred to the hospital. Administrative Staff verified she had not notified them. The facility's "Discharge Criteria Policy," revised 11/28/2017, documented when a resident was transferred or discharged from the facility, staff would send a copy of the discharge notice to a representative of the LTCO within 30 days.	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0656 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 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:	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0656 SS = D	Continued from page 7 Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for Resident (R)1 to address smoking safety. Findings included: - R1's diagnosis included chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dementia (a progressive mental disorder characterized by failing memory and confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R1's "Admission Minimum Data Set" (MDS), dated 05/09/26, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. The MDS documented R1 was independent with activities of daily living (ADLs), used a walker for mobility, required staff supervision in the facility, had an elopement alarm that was used daily, and smoked. R1's "Elopement Care Plan," dated 04/21/26, directed staff to remind the resident the facility is her home when she asks to leave the facility. The resident had an elopement bracelet, and staff should check to function properly. R1's" Care Plan" lacked evidence that R1 was a smoker, and the smoking practices included safe storage and smoking material. On 05/12/26 at 04:00 PM, observation revealed R1 sat at a table on the enclosed patio. Further observation revealed staff provided R1 with a cigarette and staff lit the cigarette. R1 smoked the cigarette and used a walker and independently walked back to her room. On 05/12/26 at 03:50 PM, Administrative Nurse D verified R1 smoked and had designated smoking times. Administrative Nurse D said the resident would go out with staff supervision and staff would store her cigarettes. Administrative Nurse D verified the facility lacked a smoking care plan in the resident's electronic health record for staff to view.	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0656 SS = D	Continued from page 8 The "Smoking" policy, dated November 28, 2017, documented that the facility would offer a resident the opportunity to smoke in a safe environment withing the facility guidelines. Residents would have a smoking assessment completed. Residents requiring supervision while smoking may smoke at posted smoking times in designated areas. The facility would store all residents smoking materials at the nurses' station for residents who require supervised smoking. Smoking materials would be locked and identified with the resident's name. It would be the responsibility of the residents to notify staff if they wish to smoke at the designated smoking times. The Smoking Assessment would be completed quarterly and with any significant change in the residents' condition.	F0656		
F0677 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 by: Based on observation, record review, and interview, the facility failed to provide necessary activity of daily living services to maintain good personal hygiene, including bathing, for Resident (R)1 and R26. Findings included: - R1's diagnosis included chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dementia (a progressive mental disorder characterized by failing memory and confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R1's "Admission Minimum Data Set" (MDS), dated 05/09/26, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. The MDS documented R1 was independent with activities of daily living (ADLs) but required staff supervision for most ADL including bathing.	F0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0677 SS = D	Continued from page 9 R1's "Care Plan," dated 04/21/26, lacked documentation of R1's required assistance with ADL cares including bathing. R1's bathing/shower "Task" documentation in the Electronic Health Record (EHR) revealed the resident was scheduled to have a shower/bath twice a week. R1 was admitted to the facility 04/20/26 and received a shower on 04/24/26 and 05/12/26 (17 days with no shower). The bathing report lacked documentation the resident refused a shower or bath. On 05/12/26 at 03:30 PM, observation revealed R1 ambulated independently from her room to the dining room and got a cup of coffee. R1 had on a red T-shirt and black pants. Her hair was uncombed and greasy. On 05/12/26 at 04:00 PM, observation revealed R1 sat at a table on the enclosed patio smoking. Further observation revealed that R1 had a red T-shirt and black pants, and her hair was uncombed and greasy. On 05/14/26 at 10:30 AM, observation revealed R1 sat at a table on the enclosed patio smoking. Further observation revealed R1 had on a red T-shirt and black pants. Her hair remained uncombed and greasy. On 05/14/26 at 11:00 AM, Administrative Staff B verified the residents had scheduled shower days and the aides documented in the electronic health record, and on shower sheets. Administrative Staff B verified the dates the resident received a shower and verified R1 did not receive her twice a week showers. Administrative Staff B verified a few days ago they assigned an aide to give the residents showers, prior to that the aides taking care of the resident would shower the residents. 2. R26's diagnoses included (a progressive mental disorder characterized by failing memory and confusion), sleep apnea (a disorder of sleep characterized by periods without respirations), hemiplegia (paralysis of one side of the body and anxiety (mental or emotional reaction characterized	F0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0677 SS = D	Continued from page 10 by apprehension, uncertainty, and irrational fear). R26's "Significant Minimum Data Set" (MDS), dated 02/20/26, documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating cognitively intact. The MDS documented R26 was dependent on staff for all activities of daily living (ADLs), including bathing, and used a wheelchair for mobility. R26's "Care Plan," dated 02/19/26, lacked documentation of R26's required assistance with ADL cares, including bathing. R26's bathing/shower "Task" documentation in the Electronic Health Record (EHR) revealed the resident was scheduled to have a shower/bath twice a week on Mondays and Thursdays. R26 received a shower on the following dates: March: 03/05/26 and 03/19/26 (13 days, no shower) April 4/05/26 (16 days no shower) May: 05/10/26 (38 days no shower) 05/11/26 The bathing report lacked documentation, the resident refused a shower or bath. On 05/12/26 at 11:00 AM, observation revealed R26 sitting in a wheelchair in his room. He was dressed in street clothes. His hair was greasy and his beard and mustache were scraggly and appeared unkempt. On 05/14/26 at 11:00 AM, Administrative Staff B verified the residents had scheduled shower days, and the aides document in the electronic health record and on shower sheets. Administrative Staff B verified the dates the resident received a shower and verified R26 did not receive his twice a week showers. Administrative Staff B verified a few days ago they assigned an aide to give the residents showers, prior to that the aides taking care of the resident would shower the residents. The "Bath and Shower" policy, dated November 28, 2017, documented the facility would ensure	F0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0677 SS = D	Continued from page 11 residents' baths and showers are performed and documented as scheduled according to residents' preference to maintain each resident's hygiene and safety. The policy documented upon admission to the facility, the charge nurse would ask the resident what type of bath he/she preferred(showers/whirlpool) and what time of day he/she prefers to have a bath/shower. The charge nurse would add the residents name to the bath/shower schedule on the days resident prefers indicating the resident's preference of a shower or bath and on the shift that accommodates the time the resident prefers. The Director of Nursing or designated personnel would review the "Bathing Report" to ensure each resident is receiving a bath/shower and hair care as required.	F0677		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility nursing staff failed to provide adequate services to support nutrition when staff failed to consistently provide Resident (R) 5 her physician-ordered Boost Plus (nutritional drink). Findings included:	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0692 SS = D	Continued from page 12 - R5's Electronic Medical Record (EMR) documented R5 had a diagnosis of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R5's "Quarterly Minimum Data Set" (MDS), dated 02/19/26, documented that R5 had no swallowing disorders, a weight of 134 pounds, and had no weight loss or gain. R5's "Care Plan," revised on 04/19/26, documented that R5 was able to feed herself after her food was set up and was a picky eater. The plan documented R5 enjoyed milkshakes and preferred to drink up to five Boost Plus per day as part of her regular meal. The "Physician Order, “dated 11/14/25 at 05:00 PM, instructed staff to provide R5 with 240 milliliter (ml), of supplement with meals and at bedtime. Review of R5’s May 2026 “Medication Administration Record” (MAR) revealed documentation that R5 had not received her Boost on the following dates: 05/02/26 at 08:00 AM and 12:00 PM 05/05/26 at 08:00 AM and 12:00 PM 05/06/26 at 08:00 AM 05/07/26 at 08:00 AM and 12:00 PM 05/11/26-05/13/26 at 08:00 AM and 12:00 PM The MAR noted R5 refused the Boost on 05/07/26, 05/10/26-05/13/26 at 05:00 PM On 05/13/26 at 12:00 PM, observation revealed Licensed Nurse (LN) I brought R5 a meal tray, consisting of cooked cubed potatoes without a Boost drink. Further observation revealed R5 asked for her Boost. LN I looked in R5’s mini refrigerator for the drink, and stated there were none in the refrigerator. LN I stated she would report it to the dietary department. Further observation revealed R5 reported LN I that she had been out for about a week. 05/12/2026 at 12:07 PM R5 stated she knew she lost weight because she did not like the food in the facility, which was not her forte.	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0692 SS = D	Continued from page 13 05/12/2026 12:40 PM, LN I stated R5 only liked cubed potatoes and her chocolate shakes, but R5 was out of the shakes. LN I stated she would only drink chocolate Boost, and the facility had to special order them because the facility's food supplier did not carry them. On 05/13/26 at 01:00 PM, R5 stated she had not received her Boost with her noon meal. On 05/14/26 at 02:40 PM, R5 stated she had not received her Boost drink for about a week because she was out of it. R5 stated she never refused the Boost. On 05/14/26 at 02:45 PM, Dietary Manager (DM) BB stated she was unaware R5 was out of Boost. DM BB stated R5's Boost was not available through the facility's dietary food supplier. DM BB stated the medication aides were to keep track of R5's supply of Boost, and if she was out, report to the business office staff, who was responsible for obtaining it from the local grocery store. On 05/14/26 at 03:00 PM, Administrative Staff C stated she was unaware R5 was out of Boost. Administrative Staff C stated the medication aides were responsible for reporting to the business office when R5 runs out of it, and staff go to the local grocery store and buy it. On 06/14/26 at 10:39 AM, Nurse Consultant GG stated he expected staff to notify nursing when R5 was out of her supplement. Staff should follow the physician's orders because she had a diagnosis of malnutrition. The facilities "Physician Orders Policy," revised 09/21/2021, documented physician orders would be followed related to the care needs of individual residents.	F0692		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by:	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0760 SS = D	Continued from page 14 Based on observation, interview, and record review, the facility failed to ensure Resident (R) 3's remained free from significant medication errors when staff administered seven units of insulin that had been discontinued. Findings included: - On 05/12/26 at 12:15 PM, observation revealed, after Licensed Nurse (LN) G took R3's blood sugar (the concentration of sugar present in the bloodstream), she stated that R3 did not need any sliding scale insulin (a hormone produced by the pancreas that regulates blood sugar) but did need his noon insulin. LN G's facility tablet showed R3 had an order for insulin aspart (rapid acting), seven units (u), subcutaneously, four times a day. LN G primed (the process of dialing a small, two unit does and expelling it into the air before it was injected) the insulin Flex Pen (a pre-filled, disposable insulin delivery device) and administered the insulin into his abdomen (the belly or midsection). On 05/12/26 at 12:30 PM, during record review and interview with staff, the order for the insulin was not on R3's Medication Administration Record (MAR) or Treatment Administration Record (TAR), or in the Physician Orders. Upon questioning, LN G was unable to find the active order on her desktop computer. Another nurse, LN I, stated that she never gave R3 any other insulin at noon, except for sliding scale insulin, and was unsure where LN G would have seen the order. After further investigation, looking throughout R3's EMR with Consultant GG, the inactive order was located in the Electronic Medical Record (EMR) under the "Supply" tab. Consultant GG researched the order and stated that R3 had an order for the seven units, along with the sliding scale insulin, but it had been discontinued on 09/30/25. Consultant GG further stated that the "Supply" tab was meant for the Pharmacy to document how much insulin was available for the resident at the time of that order. Consultant GG verified the order had not been removed from the EMR and that LN G should not have administered the seven units of insulin. LN G stated she would contact the physician for clarification of the order. The facility's "Medication Error and Drug Reactions" policy, dated 11/28/17, documented that all medication errors and drug reactions must be immediately reported to the physician, the DON, and the resident and/or their representative. A detailed account of the medication error must be recorded in	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0760 SS = D	Continued from page 15 the resident's clinical record. When a drug reaction or error in medication or dose occurs, the resident must be closely monitored. The vital signs are to be taken as follows: any change in the resident's vital signs, cognition, level of consciousness, or mobility must immediately be reported to the physician. The employee administering the medication error is to complete a risk watch occurrence report. The don and administrator are responsible for ensuring a thorough investigation is completed, and all med errors will be reviewed by the quality assurance committee.	F0760		
F0761 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 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: Based on observation, interview, and record review, the facility failed to properly store medications when staff failed to discard Resident (R)11 insulin (a hormone that lowers the level of glucose in the blood) outdated flex pen and failed to label R3 and R6s' insulin flex pens when initially opened for use.	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0761 SS = D	Continued from page 16 Findings included: - On 05/12/26 at 08:10 AM, observation of the Rapid Recovery and Purple Pride nurse medication cart revealed R11's Humalog (rapid-acting insulin) flex pen was labeled with an open date of 03/17/26. The insulin had a discard date of 04/14/26. R3 and R6's Novolog (fast acting insulin) flex pen was not labeled with an open date or a discard date. On 05/12/26 at 08:15 AM, License Nurse (LN) H verified the nurses should date the insulin when opened and discard the outdated insulin flex pens. On 05/14/26 at 01:00 PM, Administrative Nurse D verified the nurse should label and date the insulin flex pens with the date opened and check the insulin flex pens for out dates and discard if expired. Medlineplus.gov directs open, unrefrigerated Novolog and Humalog can be used within 28 days; after that time, they must be discarded. The facility's "Storage of Medications" policy dated January 21, 2021, documented medications and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are removed from the stock, disposed of accordingly to procedures for medication disposal, and recorded from the pharmacy, if a current order exists.	F0761		
F0880 SS = D	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.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0880 SS = D	Continued from page 17 §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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, 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.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0880 SS = D	Continued from page 18 §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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to keep Resident (R) 3's urinary catheter tubing (thin, flexible, hollow medical tube designed to be inserted into the bladder to drain, collect, or monitor urine) from dragging on the floor underneath his wheelchair. Staff also failed to disinfect a multi-use glucometer (an instrument used to calculate blood glucose) after using it to obtain a blood sugar reading for R3. Findings included: 1. On 05/12/2026 at 12:13 PM, observation revealed Linese Nurse (LN) G checked R3's blood sugar with a glucometer. Further observation revealed LN G placed the glucometer back into the bag and put it on the medication cart without disinfecting it. On 05/12/23 at 12:13 PM, LN G verified the glucometer was a multi-use glucometer and stated she thought maybe the night shift was responsible for disinfecting it. She said she was not sure what she should use to disinfect it. On 05/12/26 at 3:30 PM, Nurse Consultant (NC) GG stated all the residents should have their own glucometer, and LN G was a new nurse at the facility. Consultant GG said LN G should have disinfected the glucometer with a Sani-wipe (disinfectant wipe) before putting it away. 2. On 05/13/26 at 11:00 AM, observation revealed R3 sat in a wheelchair in the dining room with his	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0880 SS = D	Continued from page 19 catheter tubing underneath the seat of the wheelchair, touching the floor carpet. He propelled himself out the patio exit door with the tubing dragging on the carpeted floor and the patio cement floor. On 05/13/26 at 12:00 PM, observation revealed R3 sat in a wheelchair with his urinary catheter tubing underneath his wheelchair seat, touching the carpet floor. On 05/13/26 at 12:02 PM, LN H verified R3's tubing was touching the carpeted floor and stated it should not be. On 05/13/26 at 12:30 PM, Administrative Nurse D stated that staff should position R3's urinary catheter tubing under his wheelchair, off the floor. Upon request, the facility did not provide a urinary catheter policy regarding the placement of urinary catheter tubing or the cleaning of shared equipment.	F0880		
F0908 SS = C	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that essential equipment in the kitchen was maintained in a safe operating condition, with the ice machine's top panel held on with duct tape. Findings included: - On 05/12/26 at 08:00 AM, observation in the facility kitchen revealed the ice machine's top panel lying on top of the ice machine. The ice machine's motor and internal components were exposed. On 05/12/26 at 08:10 AM, Dietary BB stated that they use duct tape to hold the panel in place due to the holes where the screws go being stripped. Dietary BB stated it had been that way for a month or two.	F0908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEYBROOK RETIREMENT COMMUNITY	**2025 LITTLE KITTEN AVENUE , MANHATTAN, Kansas, 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
F0908 SS = C	Continued from page 20 On 05/12/26 at 10:30 AM, Maintenance U stated that the screws were stripped, and he needed to fix them. Staff had been holding the panel in place for a couple of months, and he just needed to find the right screws to fix it. On 5/13/26 at 11:50 AM, Dietary CC stated she had to unscrew the top panel of the ice machine to clean it every month, and the holes where the screw went were stripped, so they held it on with duct tape. On 5/13/26 at 12:45 PM, Administrative Staff A stated that when there is equipment that needs maintenance, it goes into the Tel's system (a web-based building management software designed to track, assign, and manage maintenance requests) so Maintenance U could fix it. Administrative Staff A stated that the panel was usually in place, but I had just been there when the duct tape had not held it in place. Upon request, a policy for maintenance of the facility was not provided.	F0908		