STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175191	A. BUILDING _____ B. WING _____	07/29/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0695 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 42 residents. The sample included one resident reviewed for [MEDICAL CONDITION] (a surgical procedure in which a cut or opening is made in the windpipe) care. Based on record review and interview, the facility failed to provide Resident (R) 1 necessary [MEDICAL CONDITION] (trach) care and/or suctioning when he became short of breath, suctioning equipment was unavailable, and staff lacked current [MEDICAL CONDITION] education, which led to R1's hospitalization . Two days later the resident became short of breath, pulled out his [MEDICAL CONDITION], staff reinserted [MEDICAL CONDITION], and suctioned the airway. A few hours later staff found the resident unresponsive and he later died from airway obstruction and [MEDICAL CONDITION] (inadequate supply of oxygen). This deficient practice placed R1 in immediate jeopardy. Findings included: - The Hospital Referral Note, dated [DATE], documented R1 had [DIAGNOSES REDACTED]. The Admission Assessment, dated [DATE] at 10:04 AM, recorded the resident was alert and oriented to person, place, time, and situation, required limited assistance for Activities of Daily Living (ADLs), and had a [MEDICAL CONDITION]. R1's respiratory assessment noted he had a regular rate, clear breath sounds on right and left lungs, and no cough. The assessment lacked type or size of [MEDICAL CONDITION]. The assessment recorded the resident received oxygen at ,[DATE] liters (L) but lacked documentation of mode of delivery of the oxygen. The Baseline Care Plan, dated [DATE] at 10:46 AM, recorded R1 required one-person physical assistance with personal hygiene, received oxygen therapy, and [MEDICAL CONDITION] care. The care plan lacked specifics [MEDICAL CONDITION], suctioning needs, the type [MEDICAL CONDITION], delivery device for oxygen, or what [MEDICAL CONDITION] care the resident performed independently. The Hospital Discharge Physician Order, dated [DATE] (untimed), recorded the resident received oxygen [MEDICAL CONDITION] with humidity at 2 LPM (liters per minute) at rest and 3 LPM with activity. The note recorded the resident's expected stay at the nursing facility was 30 days or less. The Physician Order, dated [DATE] at 11:50 AM, directed staff to administer oxygen per nasal cannula, change the tubing weekly, check the resident's oxygen level daily, and notify the physician of oxygen (O2) saturation (sats) below 90%. The Physician order [REDACTED]. The Physician Order, dated [DATE] (untimed), directed staff to administer oxygen [MEDICAL CONDITION] at 3 LPM with activity and 2 LPM when at rest, change tubing weekly, and monitor oxygen saturation every shift. The Progress Note, dated [DATE] at 02:25 PM, recorded the resident arrived at the facility per facility van, seated in a wheelchair. The note recorded the resident was alert and oriented x 3 (person, place, and time), made his needs known, understood what was being said, and voiced no complaints of pain or discomfort. The note recorded the resident had a [MEDICAL CONDITION] with oxygen at 3 L with activity and required two-person assistance with all transfers and bed mobility. The Progress Note, dated [DATE] at 03:00 PM, recorded the resident reported an obstruction to his [MEDICAL CONDITION], coughed, and started to turn red. The note recorded staff sent the resident to the local hospital emergency room (ER) at that time. The emergency room Notes, dated [DATE] (untimed), recorded EMS (Emergency Medical Services) transferred R1 to the ER after he became short of breath and felt like he needed to clear his airway with suctioning. However, R1 did not have suctioning set up. EMS cleared some of the airway and placed R1 on oxygen as his O2 sats were in the low 80%s.The note recorded upon arrival to the ER R1 continued on oxygen until respiratory therapy was able to calm the resident and deep suction him. The note recorded R1 did have some blood clots and fresh blood. ER staff monitored the resident for over an hour until resections and bleeding stopped. Physician JJ [MEDICATION NAME](antibiotic) for tracheitis (infection of the trachea) and directed R1 to follow up with him the following week. The Hospital Patient Visit Information, form dated [DATE], recorded Physician JJ ordered [MEDICATION NAME] (Cipro) 500 milligrams (mg) twice daily, 14 tablets. The document recorded R1 was seen in the ER for tracheal obstruction and tracheitis. The Progress Note, dated [DATE] at 06:00 PM, recorded R1 returned from the local hospital. The Infection Note, dated [DATE] at 01:50 PM, recorded R1 continued to receive an antibiotic for tracheitis. The resident had been suctioning [MEDICAL CONDITION] bloody drainage and had no signs or symptoms of adverse reaction to the medication. Review of R1's medical record lacked information regarding staff supervision of the resident independently suctioning his trach, observation of his suctioning technique, or if the resident needed further education related [MEDICAL CONDITION]. The Infection Progress Note, dated [DATE] at 01:17 AM, recorded R1 continued on an antibiotic for tracheitis, the resident independently suctioned his trach,[MEDICAL CONDITION] blood tinged sputum (mucous secretion from the bronchi and lungs) when suctioned, no adverse reactions from medication, and remained without fever. The Physical Therapy Treatment Note, dated [DATE] (untimed), recorded R1 was lying in bed at the start of therapy, with O2 at 3L with saturations at 64%. R1 was unable to speak, reported his stoma was obstructed, and he couldn't breathe. The note recorded R1 stuck his finger down the stoma (opening of the [MEDICAL CONDITION] in the neck) and staff provided education not to do that. The note recorded Therapy Staff (TS) HH notified Licensed Nurse (LN) H that R1 stated he could not breathe with an obstructed stoma. LN H was unable to clear stoma, so TS HH notified Administrative Nurse E, and Administrative Nurse E took over. The Occupational Therapy Daily Treatment Note, dated [DATE] (untimed), recorded R1 was lying on his back in bed, he complained of difficulty breathing, and reported his stoma was blocked. R1 reported he was too short of breath and fatigued to participate in standing or transfers. R1 was incontinent of urine and needed his brief and bedding changed. TS GG notified LN H about R1's breathing difficulties. LN H turned up R1's oxygen to attempt to clear stoma. The resident's O2 sats were 64%. The Progress Note, dated [DATE] at 02:45 PM, recorded staff called Administrative Nurse E to R1's room. LN H was at R1's bedside. The resident's O2 sat was at 60%. The note recorded R1 had some shortness of air noted and reported R1 pulled out his soft inner canula (tube used to keep airway open) of the trach. Administrative Nurse E reinserted the soft inner canula into R1'[MEDICAL CONDITION] difficulty, then suctioned [MEDICAL CONDITION] times using sterile technique. The note recorded R1 had bloody tinged secretions per baseline and Administrative Nurse E administered a nebulizer treatment (medication to aide in breathing delivered by machine) [MEDICAL CONDITION]. His oxygen level increased to 95% and R1 was in no distress at that time, talked with staff, and communicated well. Staff paged Physician II to increase nebulizers to scheduled and educated staff to oversee R1's [MEDICAL CONDITION] care, frequently visualize R1, and alert the nurse with any changes. Review of R1's Electronic Medical Record (EMR) lacked documentation of frequent visual checks. The Progress Note, dated [DATE] at 04:35 PM, recorded staff called Administrative Nurse E to R1's room and observed R1 was unresponsive, without a pulse, and not breathing. Administrative Nurse E started Cardiopulmonary Resuscitation (CPR) and continued until EMS (Emergency Medical Services) arrived. At 04:42 PM, EMS arrived and took over doing CPR. At 05:20 PM, EMS left the facility with R1 with an obtainable blood pressure (number unknown), and pulse of 95 beats per minute (bpm, normal resting pulse 60 bpm). Administrative Nurse E notified R1's responsible party/significant other and Physician II of the transfer and R1's condition. The emergency room Note, dated [DATE] (untimed), recorded EMS arrived at the ER with R1 for evaluation CODE BLUE (a medical emergency). The note recorded the nursing facility called EMS after staff found R1 unresponsive after a breathing treatment. R1 reported difficulty breathing earlier that afternoon. The note recorded when EMS arrived at the nursing facility R1 was pulseless and apneic (without breath). EMS began CPR and noticed the resident was very difficult to bag (manual positive pressure ventilation to patients who are not breathing or not breathing adequately) through his trach. R1 received several rounds of CPR, [MEDICATION NAME] (medication to increase

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.

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F 0695 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) blood pressure, heart rate, and cardiac output), and [MEDICATION NAME] (used in resuscitation to improve acidotic state). R1 had a pulse and EMS transferred him to the ER. Upon arrival, R1 was pulseless and very difficult to bag, pupils fixed and dilated (flat and widened), and no heart sounds heard. ER staff resumed CPR,[MEDICAL CONDITION] and replaced with an Endotracheal Tube (ET tube-a flexible plastic tube that is placed through the mouth into the trachea (windpipe) to help a patient breathe). R1 was again very difficult to bag and Respiratory Therapy suctioned out some bloody secretions and clots. The note recorded ER staff needle decompressed (a life-saving maneuver performed to relieve excess air in the chest cavity) R1's right chest wall with a rush of air to the right side, needle decompression of the left side without rush of air. R1 continued to be difficult to bag after tracheal suctioning and decompression. ER staff attempted further maneuvers for relieving the obstruction without much success, and the code was called (meaning discontinuation of CPR). The Progress Note dated [DATE] at 06:35 PM, recorded Administrative Nurse E received a call from the hospital ER nurse who stated R1 passed away at 05:27 PM, shortly after arrival at the ER. Review of [MEDICAL CONDITION] and Suctioning Competency Checklist, dated [DATE], documented five of the eleven licensed nursing staff completed the competency checklist consisting of how to gather [MEDICAL CONDITION] supplies, properly perform [MEDICAL CONDITION] suctioning, cleaning the [MEDICAL CONDITION], and assessing cardiopulmonary status and oxygen saturations. LN G's Witness Statement, signed [DATE], documented on [DATE] she was informed of R1's admission to the facility, but not informed he had a trach. Immediately prior to R1's admission, the hospital nurse informed LN G the resident had [MEDICAL CONDITION] he took care of himself. LN G documented she informed Administrative Nurse D and Social Services (SS) X that R1 had a trach. Five minutes later R1 arrived at the facility. LN G obtained his vital signs and weight, then gave him a shower. R1 was alert and talked to the nurse with no complaints of breathing problems during the admission assessment. LN G documented she set R1's oxygen concentrator at 2 L per nasal cannula, then left his room to document her assessments. LN G documented she [MEDICAL CONDITION] review about ,[DATE] weeks prior due to the possibility of receiving a different resident with a trach, but that resident did not come to the facility. LN G documented the last time she performed a hands-on with [MEDICAL CONDITION] test, or took care of a resident with a trach, was two years earlier. LN G documented she watched videos [MEDICAL CONDITION] to educate herself. The witness statement further revealed that LN G documented on [DATE] she did not set up a suction machine in R1's room before his admission or during her shift. LN H's Witness Statement, signed [DATE], documented on [DATE] the facility admitted R1 on the previous shift and informed her in report that R1 had [MEDICAL CONDITION] managed by himself. Shortly after completion of shift report staff notified LN H that R1 was having a hard time breathing with obstruction of his trach. LN H entered R1's room and observed the resident was breathing and able to talk with O2 sats of 96% on oxygen [MEDICAL CONDITION]. LN H documented she could not find a suction machine in R1's room, so she left R1's room to retrieve a suction machine and supplies. LN H documented when she could not find the supplies, she went to Administrative Nurse D informing her the resident had [MEDICAL CONDITION] R1 complained he had an obstruction. Administrative Nurse D gave instructions to call 911 and send R1 to the hospital. After R1 left with EMS, Administrative Nurse D found keys to the supply room and brought a suction machine and [MEDICAL CONDITION] supplies to R1's room. LN H documented R1 returned later that shift without difficulties. On [DATE], TS HH alerted LN H that R1'[MEDICAL CONDITION] an obstruction, LN H entered R1's room and attempted to suction him and was able to bring up a small amount of bloody sputum. R1 was breathing with an O2 sat of 90% on O2 [MEDICAL CONDITION] and was able to talk. LN H left R1's room and informed Administrative Nurse E she was going to send R1 to the hospital. Administrative Nurse E entered R1's room with LN H and found R1's O2 sat dropped to 88% on oxygen. LN H documented staff turned up the oxygen and Administrative Nurse E suctioned R1. After suctioning R1's O2 sat was 92% and he denied obstruction. LN H documented that 40 minutes later Certified Nurse Aide (CNA) R notified LN H that R1 was nonresponsive, LN H started CPR, and notified EMS. LN H documented the last time she performed [MEDICAL CONDITION] suctioning and care was in [DATE], and in [DATE] she verbalized to the Director of Nursing (DON) the steps [MEDICAL CONDITION] and suctioning. On [DATE] at 07:45 PM, CNA M stated the facility admitted R1 on [DATE] and later transferred R1 back to the hospital by ambulance due to the facility not having suction machine and tubes available in the resident's room. On [DATE] after 02:00 PM shift change, LN H told CNA M to go clean up R1 from being incontinent, TS HH was in R1's room and told CNA M that R1 was having difficulty breathing, like he had a blockage in his trach. CNA M told LN H that R1 was having difficulty breathing and had a blockage. LN H told CNA M, You are the third person who told me this and if he can talk, he can breathe, then instructed CNA M to go change R1 and obtain a set of vital signs. CNA M stated LN H eventually went to R1's room, attempted to suction R1, and stated, Oh yea, he is definitely blocked. LN H left the room and Administrative Nurse E came running in. Administrative Nurse E realized R1'[MEDICAL CONDITION] was out, cleaned it, then reinserted it, and started suctioning R1. CNA M stated R1's O2 sat was at 60% when suctioning started, after Administrative Nurse E finished, R1's oxygen sat was between 96% and 98%. R1 said he felt somewhat better, staff gave him the call light, left the room, and checked on him every 15 minutes. CNA M stated approximately an hour or so later R1 was found unresponsive. Administrative Nurse E performed CPR until EMS arrived. On [DATE] at 09:54 AM, Administrative Nurse E stated she reviewed the hospital referral documentation for R1 and accepted him for admittance into the facility, but missed R1 had a history of [REDACTED]. Administrative Nurse E stated normally staff would [MEDICAL CONDITION] that included an oxygen concentrator, suction machine with canister, suction kits, [MEDICAL CONDITION] kits set up in the resident's room prior to the resident's arrival. Administrative Nurse E stated on [DATE], when R1 arrived at the facility, she had left for the day, around 03:30 PM staff called her [MEDICAL CONDITION]. Administrative Nurse E stated staff had to send R1 to the emergency room and he returned the same day. Administrative Nurse E stated on [DATE] around 02:45 PM TS HH notified her that R1's O2 sat was 64%. Administrative Staff E entered R1's room and observed R1 having difficulty breathing and R1 had removed his [MEDICAL CONDITION]. Administrative Nurse E stated she cleaned [MEDICAL CONDITION], applied lubricant, and reinserted the tube back into R1's trach. Administrative Nurse E then suctioned large amounts of clear to pink colored sputum out of R1's trach, after suctioning R1's trach, his O2 sats went up to 97%. Administrative Nurse E instructed nursing staff to monitor R1's O2 sat every 10 minutes and she checked on him every 20 minutes. At 04:10 PM, staff observed R1 in his room doing very well. At 04:27 PM staff notified Administrative Nurse E the resident was unresponsive and not breathing, Administrative Nurse entered R1's room, observed R1 was not breathing and did not have a pulse, so she started CPR. Staff notified EMS, they arrived and took over CPR on R1 before leaving for the hospital. On [DATE] at 12:59 PM, Administrative Staff A stated there was not a facility policy on [MEDICAL CONDITION] care or suctioning, they only had a competency form. On [DATE] at 08:22 AM, Administrative Nurse D stated SS X emailed resident admission referrals to her. Administrative Nurse D stated if she knew the resident had a trach, she expected nursing staff to have suction equipment and supplies set up in the resident's room before the resident arrived. In [DATE] she handed out competency forms [MEDICAL CONDITIONS] to the licensed nurses, it was not a hands-on with demonstration competency, just a paper review. Administrative Nurse D stated [MEDICAL CONDITION] and suctioning training, LN I reviewed the competency form with the other licensed nurses. Administrative Nurse D did not follow up on the [MEDICAL CONDITION] training because the facility did not accept the potential resident with [MEDICAL CONDITION] June. Administrative Nurse D stated it had been a long time since she had a resident with a trach. Administrative Nurse D did not know the facility'[MEDICAL CONDITION] and suctioning policy or protocol. On [DATE] Administrative Nurse E approved R1's admission and was not informed R1 had a trach. On [DATE] in the afternoon, LN H came in the conference room yelling that she needed suction supplies to take care of R1's because he was turning red. Administrative Nurse D stated she told LN H they needed to send R1 out to the emergency room if he was turning red, and we will get the supplies while he was gone. LN H sent R1 to the hospital. Administrative Nurse D stated while R1 was gone she called Administrative Staff A to ask where the suction [MEDICAL CONDITION] were located. Administrative Nurse D had to get into the medical records office to retrieve the key to the central supply room. Administrative Nurse D and the SS X went to the central supply room to get [MEDICAL CONDITION] and gave them to LN H to set up in R1's room before he returned from the emergency room . Administrative Nurse D stated on [DATE] Administrative Nurse E entered R1's room to suction R1 due to his oxygen level of 60%. After suctioning the resident his oxygen sat increased to 97%. Administrative Nurse D stated LN H wanted to send R1 to the emergency room again, but Administrative Nurse E told her no because R1 was doing better and staff were checking on him every 10 minutes. Administrative Nurse D stated she was later told the nurses started CPR, she grabbed the ambu bag (device used to inflate lungs during CPR) and called 911. EMS arrived and took over CPR, then transported R1 to the emergency room . On [DATE] at 09:09 AM, TS HH stated on [DATE] R1 was lying flat in bed when therapy started. TS HH stated R1 was difficult to understand and stated he could not breathe, with an obstruction of his trach. TS HH left the room to get a pen and paper to communicate with the resident and went back into his room. TS HH stated the resident started sticking his finger in his throat and saying he had an obstruction. TS HH told LN H R1 was incontinent, needed changed,

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F 0695 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) [MEDICAL CONDITION] obstructed, and he could not breath per his report. TS HH stated LN H said she would be right there. TS HH stated she took sheets into R1's room and waited for the CNA's to come change R1. TS HH stated the CNAs (names unknown) said LN H sent them down to change R1 and obtain his O2 sat. TS HH left the room to get LN H who was walking down the hall. LN H tried to suction R1's trach, but could not and said she was going to call the ambulance. TS HH ran to get Administrative Nurse E and told her what was happening with the resident and Administrative Nurse E immediately ran to R1's room. C GG stated she did not return to R1's room. On [DATE] at 10:24 AM, Administrative Staff A confirmed the facility had notice R1 had [MEDICAL CONDITION] the initial hospital referral papers (received [DATE]). On [DATE] at 01:22 PM, Physician II stated he would come see a resident only if they would be in the facility long term and he did not know if he wrote instructions on how to take care of the resident's trach. Physician II stated there might have been a communication problem, he did not see R1 in the facility, and he expected the discharging hospital to write orders [MEDICAL CONDITION]. The staff should have contacted him if a resident had a [MEDICAL CONDITION] and he would have agreed with the discharging hospital's orders or given new orders. Physician II stated he did not give orders for suctioning and was not aware the resident would need it. Physician II stated he signed R1's death certificate and cause of death was trachea obstruction and [MEDICAL CONDITION]. The facility failed to properly screen R1who had a [MEDICAL CONDITION] before admission. The facility admitted R1 and failed to have proper suctioning equipment [MEDICAL CONDITION] supplies readily available, and failed to provide staff current [MEDICAL CONDITION] education . Within hours of arriving at the facility R1 became short of breath and complained of tracheal obstruction. There was no suctioning machine [MEDICAL CONDITION] set up and R1 had to be transferred to the ER. He returned to the facility later that day. Two days later the resident's airway became obstructed again, R1 became short of breath and pulled out his [MEDICAL CONDITION]. Staff reinserted the tube. Approximately an hour and a half later, staff found the resident unresponsive, started CPR, called EMS and transported the resident to the ER where he later died . This deficient practice placed R1 in immediate jeopardy. The facility removed the immediate jeopardy on [DATE] at 05:55 PM, when the facility educated all nursing staff on reviewing all aspects of resident care needs prior to admission and communicating with the hospital regarding any special needs in order to ensure all equipment and education to nursing staff was completed prior to admission to the facility, completed [MEDICAL CONDITION] care competencies, educated nursing staff on scope of practice, and educated and moved all [MEDICAL CONDITION] supplies to the nurse's station medication room. The deficient practice remained at a scope and severity of a G.