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 _____	07/22/2020

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 42 residents. Based on record review and interview, the facility failed to notify Resident (R) 1's physician of concerns following catheterization (insertion of a a flexible tube inserted through a narrow opening into a body cavity) and failed to notify R1's family in a timely manner of her emergency room transfer. Findings included: - Review of the medical records documented the facility admitted R1 on 07/05/20. R1's Physician order [REDACTED]. low moods), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin, disorder of electrolyte (minerals that help keep the body's fluid levels in balance, necessary to help the muscles, heart and other organs work properly), altered mental status, gastro [MEDICAL CONDITION] reflux disorder (GERD-backflow of stomach contents to the esophagus), and muscle weakness. The Admission Minimum Data Set (MDS), dated [DATE], recorded the resident had severe cognitive impairment, required supervision and assistance of one staff with eating, dressing and mobility. The MDS recorded the resident received scheduled pain, antipsychotic (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) medications. The Care Area Assessments (CAA) had not been completed related to the resident's short stay. The Initial Care Plan, dated 07/05/20, documented the resident required one staff assistance with toilet use, dressing, and mobility and was in room isolation for 14 days. The document directed staff to immediately notify the resident's family of care plan updates and changes. The Nursing Progress Note, dated 07/11/20 at 06:01 AM, documented at 05:15 AM the resident vomited watery, brown in color with coffee ground sediment liquid. The note documented staff notified the physician who directed staff to send the resident to the emergency room . The note documented the resident left the facility at 06:00 AM. The note lacked documentation the facility notified the resident's family of the resident's condition or transfer. On 07/22/20 at 02:13 PM, Licensed Nurse (LN) G reported the resident ate about half of her meals and had nausea and vomiting the evening before admission to the hospital. LN G reported the resident had not voided on her shift and LN G obtained a physician order [REDACTED]. LN G stated the catheter returned a small amount of dark colored urine and LN G stated she did not notify the physician. LN G reported she passed the information onto the following night shift staff who would pass the information to the day shift nurse to obtain orders for a urinalysis. On 07/22/20 at 03:17 PM, Administrative Nurse D stated she expected staff to notify the physician of abnormal resident assessments and conditions, and document physician communication and orders. Administrative Nurse D stated at 09:59 AM on 07/11/2020 she contacted R1's family to report the resident had been transferred to the emergency room (4 hours earlier). Administrative Nurse D stated when R1's transfer was reported to her, the family had not been notified of the transfer. Administrative Nurse D stated she called the family herself and the family should have been notified right away when the resident was transferred. The facility's Notification of Change policy, dated 04/27/2018, directs staff to immediately inform the resident's physician of any changes in the resident's status and promptly notify the resident's representative of decision to transfer or discharge the resident from the facility. The facility failed to notify R1's physician of concerns following catheterization and R1's representative of transfer to the emergency room in a timely manner, placing the resident at risk for continued decline and lack of representation during a hospital admission.
F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 42 residents. The sample included three residents reviewed for hydration. Based on interview and record review, the facility failed to provide one of three sampled residents, Resident (R) 1, assistance with hydration, failed to monitor her condition and continued nausea, dehydration, or notify the physician which caused the resident to hospitalized and placed in an Intensive Care Unit. Findings included: - Review of the medical records documented the facility admitted R1 on 07/05/20. R1's Physician order [REDACTED]. low moods), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin, disorder of electrolyte (minerals that help keep the body's fluid levels in balance, necessary to help the muscles, heart and other organs work properly), altered mental status, gastro [MEDICAL CONDITION] reflux disorder (GERD-backflow of stomach contents to the esophagus), and muscle weakness. The Admission Minimum Data Set (MDS), dated [DATE], recorded the resident had severe cognitive impairment, required supervision and assistance of one staff with eating, dressing and mobility. The MDS recorded the resident received scheduled pain, antipsychotic (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) medications. The Care Area Assessments (CAA) had not been completed related to the resident's short stay. The Initial Care Plan, dated 07/05/20, documented the resident required one staff assistance with toilet use, dressing, and mobility and was in room isolation for 14 days. The document directed staff to immediately notify the resident's family of care plan updates and changes. The Change in Condition Report, dated 07/06/20 at 04:45 AM, recorded the resident was not oriented to time, place, or situation. The assessment recorded the resident had short term memory impairment, confusion, hallucinations (sensing things while awake that appear to be real, but the mind created), and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The assessment recorded the resident required assistance with eating, had nausea without emesis, and the physician ordered a Basic Metabolic Panel (BMP- blood test that gives doctors information about the body's fluid balance and level of electrolytes) and [MEDICATION NAME] (a medication that can prevent nausea and vomiting). The Nursing Progress Note, dated 07/06/20 at 09:40 AM, recorded staff notified the on-call physician the resident felt nauseated and vomited a little orange juice. Review of the resident's July physician's orders [REDACTED]. The Dietary Assessment, dated 07/10/20 at 03:42 PM, documented the resident received a low concentrated sweet diet, ate independently in her room at that time, had a poor appetite, and nausea. The Nursing Progress Note, dated 07/10/20 at 08:50 PM, documented the resident vomited, had not voided during the shift, had a poor appetite, and poor fluid intake. The note documented the resident had increased confusion and staff notified the physician. The 07/10/20 Nutritional Summary and Plan recorded the resident was independent with meals in her room due to isolation restrictions, poor appetite, and nausea. The notes documented on 07/05/20 the resident's glucose was 116 milligrams/deciliter (mg/dl) (normal 70-130), BUN (blood, urea, nitrogen) 12 (normal 5-20 mg/dl), Creatinine 1.08 (normal 0.6-1.2 mg/dl), Sodium 139 (normal 135-145 milliequivalents per liter (mEq/L), and Potassium 3.4 (normal 3.5-5.1 mEq/L). The note documented nutritional risk factors - potential for poor intake, [DIAGNOSES

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

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) REDACTED]. The note lacked the recommended 24 hours fluid intake for the resident. The Nursing Progress Note, dated 07/11/20 at 06:01 AM, documented at 05:15 AM the resident vomited watery, brown in color with coffee ground sediment liquid. The note documented staff notified the physician who directed staff to send the resident to the emergency room . The note documented the resident left the facility at 06:00 AM. R1's July Fluid Intake Record recorded the following daily intakes: 07/05/20 - 240 (ml) milliliters 07/06/20 - 720 ml 07/07/20 - 720 ml 07/08/20 - 480 ml 07/09/20 - 720 ml 07/10/20 - 380 ml R1's July Amount Eaten Record recorded the following daily intakes: 07/05/20 - 100% of supper meal 07/06/20 - 0-25% of all three meals 07/07/20 - 75-100% of all three meals 07/08/20 - refused breakfast, 0-25% of lunch and supper 07/09/20 - 100% of breakfast and lunch, 25% of supper 07/10/20 - 51-75 % of breakfast, refused lunch, 0-25% of supper 07/11/20 - 76-100 % of breakfast. Review of R1's Hospital History and Physical, dated 07/11/20 recorded the follow lab results obtained 07/11/20 at 06:37 AM: Sodium 130 mEq/L, Potassium 6.4 mEq/L, Creatinine 8.23 mg/dl. Review of R1's Hospital Record, dated 07/11/20 at 01:05 PM, recorded the resident admitted to the hospital with [REDACTED]. The resident stated she was thirsty/wanting to drink, had not been drinking well because no one brought her fluid, alert, and could follow simple commands. On 07/22/20 at 12:45 PM, Certified Medication Aide (CMA) R stated the resident was very lethargic, vomited, and had trouble taking her medications. CMA R reported she informed the nurse and thought the nurse gave the resident something for nausea before the resident went to the hospital. On 07/22/20 at 01:30 PM Certified Nurse (CNA) M stated when she cared for R1 the resident was unsteady and spilled her drinks, but CNA M did not help R1 eat or drink due to being the only aide working that hall and did not know the resident required assistance. On 07/22/20 at 02:13 PM, Licensed Nurse (LN) G reported the resident ate about half of her meals and had nausea and vomiting the evening before admission to the hospital. LN G reported the resident had not voided on her shift and LN G obtained a physician order [REDACTED]. LN G stated the catheter returned a small amount of dark colored urine and LN G stated she did not notify the physician. On 07/22/20 at 03:17 PM, Administrative Nurse D stated she expected nursing staff to notify the physician of abnormal resident assessments and conditions, and document physician communication and orders. On 07/22/20 at 04:55 PM, Administrative Nurse E reported on 07/06/20 the resident had a tele-med visit with the physician and at that time the physician gave orders for a BMP and [MEDICATION NAME]. Administrative Nurse E stated the order was not sent to the facility, the facility did not follow up on the order, there was no record of the tele-visit, or physician progress notes [REDACTED]. The facility failed to provide R1 assistance with hydration, failed to monitor her condition and continued nausea, dehydration, or notify the physician which caused the resident to hospitalized and placed in an Intensive Care Unit.