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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stoneybrook Retirement Community	2025 Little Kitten Avenue Manhattan, KS 66503

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 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:02/27/2602/28/2603/1/2603/14/2603/15/2603/29/2604/11/2604/12/2605/09/2605/10/26 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.

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.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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. 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.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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. 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 by apprehension, uncertainty, and irrational fear). R26's Significant Minimum Data Set (MDS), dated [DATE], 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) April4/05/26 (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 residents' baths and showers are performed and documented as (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for 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** 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:- 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 [DATE], 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 PM05/05/26 at 08:00 AM and 12:00 PM05/06/26 at 08:00 AM05/07/26 at 08:00 AM and 12:00 PM05/11/26-05/13/26 at 08:00 AM and 12:00 PMThe MAR noted R5 refused the Boost on 05/07/26, 05/10/26-05/13/26 at 05:00 PMOn 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. 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.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 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 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings included:- On [DATE] 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 [DATE]. The insulin had a discard date of [DATE]. R3 and R6's Novolog (fast acting insulin) flex pen was not labeled with an open date or a discard date. On [DATE] 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 [DATE] 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 [DATE], 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 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 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.

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F 0908 Level of Harm - Potential for minimal harm Residents Affected - Many	Keep all essential equipment working safely. 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.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.