STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N018009	A. BUILDING: _____ B. WING _____	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERNAULD VILLAGE	716 TWEED STREET WINFIELD, KS 67156

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 12/30/24 and 12/31/24.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (a) The facility reported a census of 13 residents. The sample included 3 "Residents" (R)'s 1, 2, and 3. Based on record and interview the Administrator failed to ensure the "Negotiated Service Agreements'" (NSA)'s for R1, R2, and R3 were based on the "Functional Capacity Screening" (FCS), and the Administrator further failed to ensure the NSA's for R1, R2, and R3	S3085		

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

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S3085	Continued From page 1	S3085		

provided a description of services when R1, R2, and R3's FCS identified them at risk for falls.

Findings included:

- Record review for R1 revealed an admission date of 09/20/23 with diagnoses of acute kidney failure, muscle weakness, essential hypertension, postherpetic trigeminal neuralgia, pain, syncope and collapse, polyneuropathy, edema, unspecified hearing loss, wedge compression fracture of un thoracic (T) 11 and T12, dementia in other diseases classified elsewhere severe with anxiety, dizziness and giddiness, disorientation, and adjustment disorder.

Review of R1's "Functional Capacity Screen" (FCS) dated 09/20/24 revealed R1 required physical assistance with bathing, dressing, toileting, and transferring. R1 was independent with walking/mobility and eating. R1 lacked the ability to manage her own medications/medical treatments and was occasionally incontinent. R1 had impaired short-term memory, long-term memory and decision making. She was able to make herself understood and she understood others. R1 was marked at risk for falls and used a walker mobility device.

Review of R1's "Negotiated Service Agreement" (NSA) dated 09/20/24 identified the facility would provide the following health services; Under the section titled "Health Assessment and Wellness Monitoring" under the area indicated for "additional needs/preferences" was handwritten sitting and standing blood pressure daily. Under the section titled "Medications" it was marked "Injections" and handwritten was "Evnity 210 milligrams subcutaneous every month times 12

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S3085	Continued From page 2	S3085		

months. First injection given on 03/05/24". R1 was to have stand by assistance in and out of the shower/tub, staff to assist with the placement of R1's compression stockings, and for transferring one staff was to assist as needed. Under the section titled "Fall prevention/Risk" it was marked that R1 had a history of falls prior to admission and a "fall risk" assessment had been completed. Handwritten was "high risk for falls", "last fall on 05/11/24".

- Record review on 12/30/24 for R2 revealed an admission date of 05/16/2013 with diagnoses of melanocytic nevi, obesity, dementia in other diseases classified with other behavioral disturbances, major depressive disorder, unspecified psychosis not due to a substance and anxiety.

Review of R2's FCS dated 01/30/24 revealed R2 required supervision with bathing. She was independent with dressing, toileting, transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and medical treatments. R2 was able to maker herself understood and she understood others. R2 was marked at risk for impaired decision making and falls and used a walker mobility device.

Review of R2's NSA instructed the facility staff to provide the following health service of obtaining a daily blood pressure, and in the area indicated for "additional needs/preferences" it was handwritten "as ordered and as needed". Under the Section titled "VI. Medications" the only item marked read "Injections/Diabetic Care" and handwritten was Monthly Cyanocobalamin" IM (intramuscular) injection. Under the section titled "Bathing/Showering" it was marked that R2

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required no assistance and "stand by assistance" in and out of the shower/tub. Under the section titled "Dressing/Undressing" it was marked R2 could dress/undress without assistance and "needed supervision to dress appropriately". Under the section titled "Fall Prevention/Risk" it was marked that a "Fall Risk" assessment had been completed and R2 was a "high fall risk", it was written that R2 had three non-injury falls "in the past 4 months".

- Record review for R3 revealed an admission date of 07/28/23 with diagnoses of essential hypertension, presence of urogenital implants, pain, osteoarthritis of knee, primary generalized arthritis, peripheral vascular disease, and difficulty in walking.

Review of R3's FCS dated 07/26/24 revealed R3 required physical assistance with bathing, dressing and toileting. He was independent with transferring, walking/mobility and eating. He lacked the ability to manage his own medications/medical treatments, and R3's cognition was intact. R3 was able to make himself understood and he understood others. He was marked with impaired hearing, and he used a walker in his room and a wheelchair for mobility.

Review of R3's NSA dated 07/28/24 identified the facility would provide the following health services of monitory monthly R3's vital signs and weight, qualified staff to administer his medications, stand by assistance in and out of the shower/tub, application of compression stockings and bilateral knee braces, and under the section titled "Fall Prevention and Risk" the following was marked: "History of falls before admission" and "Fall risk assessment completed". Handwritten was the

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S3085	Continued From page 4 following "High Risk", "falls occurred on 01/24/24 and 02/12/24". Record review of R3's electronic "Medical Record" under the "Miscellaneous" tab revealed a document from R3's primary care provider for an office visit dated 07/21/24. Under the section titled "Problem History" a diagnosis of History of falling" was made on 03/24/22. Interview on 12/31/24 at approximately 02:30 PM with Registered Nurse C confirmed the NSA's for R's 1, 2, and 3 lacked health services to reduce the risk for falls, she further confirmd the interventions are on the health service plan to address fall interventions when they occured. The Administrator failed to ensure the NSA's for R1, R2, and R3 were based on the (FCS), and the Administrator further failed to ensure the NSA's for R1, R2, and R3 provided a description of services when R1, R2, and R3's FCS identified them at risk for falls.	S3085		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.	S3186		

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S3186	Continued From page 5 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (b) The facility reported a census of 13 residents. The sample included 3 "Residents" (R)'s 1, 2, and 3. Based on record and interview the Administrator failed to ensure R2's "Negotiated Service Agreement" (NSA) identified who was responsible for the administration for select medications. Findings included: - Record review on 12/30/24 for R2 revealed an admission date of 05/16/2013 with diagnoses of melanocytic nevi, obesity, dementia in other diseases classified with other behavioral disturbances, major depressive disorder, unspecified psychosis not due to a substance and anxiety. Review of R2's "Functional Capacity Screen" (FCS) dated 01/30/24 revealed R2 required supervision with bathing. She was independent with dressing, toileting, transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and medical treatments. R2 was able to make herself understood and she understood others. R2 was marked at risk for impaired decision making and falls and used a walker mobility device. Review of R2's NSA instructed the facility staff to provide the following health service of obtaining a daily blood pressure. Under the Section titled "VI. Medications" the only item marked read	S3186		

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S3186	Continued From page 6 "Injections/Diabetic Care" and handwritten was Monthly Cyanocobalamin" IM (intramuscular) injection. Review of R2's "Health Service Plan" (HSP) lacked documentation of R2 self-administering medications/over the counter medications. Review of the facility provided document titled "Independent With Medication Self - Administration Evaluation Form" dated 01/30/24 and signed by Registered Nurse C, revealed under the section titled "Medication Ordering and Delivery" the following was marked "Facility staff orders medications" and hand written was "as resident request" with the following hand written medications/Over the Counter medications; Vaseline gel, Albuterol inhaler, Clinpro toothpaste, Biotene, Debrorx, Premarin Cream, Voltaren Gel and Lantiseptic". Under the section titled "Medication Storage" it was marked that the medications were stored in a safe place away from the other residents, and handwritten was the following" "Resident stores in bathroom/drawers in private room". Under the section titled "Self-Administration of Medications" it was marked with the following; "Able to self-administer accurately", "Understands medications use(s)", and "Mediations taken at the correct time at the right dose". Observation on 12/31/24 at approximately 01:00 PM of R2's bathroom sink, there laid a tube of Voltaren Gel, and a tube of Clinpro Toothpaste. Interview on 12/31/24 at approximately 02:30 PM with Registered Nurse C confirmed R2's NSA lacked identification of who was responsible for administering select medications/over the counter medications.	S3186		

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S3186	Continued From page 7 The Administrator failed to ensure R2's NSA identified who was responsible for the administration for select medications.	S3186		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (g) (3) The facility reported a census of 13 residents. Based on observation and interview the Administrator failed to ensure the" Licensed Nurse" (LN) or the Licensed Pharmacist placed the full name of the resident on bottles of Over-the-Counter (OTC) medications. Findings included: - Observation on 12/30/24 at approximately	S3211		

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S3211	Continued From page 8 09:30 AM with "Certified Medication Aide" (CMA) A and LN B of the assisted living medication cart located in the front common area of the assisted living. In the bottom drawer of the cart there were the following OTC medications which lacked the full name of the resident: 1 bottle of Acetaminophen 325 "milligram" (mg) tablets 1 bottle of Geri Care Tylenol 500 mg tablets 1 bottle of Goodneighbor Nausea Relief Interview on 12/30/24 at approximately 09:30 AM with CMA A confirmed the unlabeled bottles of OTC's in the bottom drawer of the assisted living medication cart were "stock" medications. Interview on 12/31/24 at approximately 02:30 PM with Registered Nurse C and LN B confirmed all OTC medications should be labeled with the resident's full name. The Administrator failed to ensure the LN or the Licensed Pharmacist placed the full name of the resident on bottles of OTC medications.	S3211		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency	S3280		

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S3280	Continued From page 9	S3280		

management plan with employees and residents; and
(4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-104 (d) (3)

The facility reported a census of 13 residents. Based on record and interview the Administrator failed to ensure a review of the facility's emergency management plan was reviewed with all employees at least quarterly.

Findings included:

- Record review on 12/31/24 of the facility provided document titled "Annual Emergency Preparedness Training" and was dated 02/29/24.

Interview on 12/31/24 at approximately 02:30 PM with Registered Nurse C confirmed the facility lacked documentation of the Emergency Preparedness training being provided to all staff at least quarterly.

The Administrator failed to ensure a review of the facility's emergency management plan was reviewed with all employees at least quarterly.