STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175569	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumbernauld Village	716 Tweed Street Winfield, KS 67156

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure adequate infection control practices related to urinary catheter care (a tube inserted into the bladder to drain the urine into a collection bag), peri-hygiene, and shared mechanical lift use. Findings included:- On 04/07/26 at 08:14 AM, Certified Nurse Aide (CNA) M assisted Resident (R) 2 with morning cares. R2 received antibiotic treatment for a urinary tract infection (UTI- an infection in any part of the urinary system). CNA M donned clean gloves and provided a brief change due to urine incontinence. CNA M removed the soiled brief and provided peri-hygiene care. CNA M then placed a clean brief on R2, used a gait belt which CNA M wore around her shoulder, assisted R2 into her wheelchair, opened the clothing cabinet, and pulled out three different dresses for R2 to choose from to wear for the day. CNA M then assisted R2 into the bathroom before removing soiled gloves. On 04/07/26 at 01:26 PM, CNA M verified knowing R2 was currently being treated for a urinary tract infection. CNA M reported she should have changed gloves after providing per-hygiene care and placing a clean brief for R2. On 04/07/26 at 01:45 PM, Licensed Nurse (LN) G, who had been present in R2's room while CNA M was providing care, verified that CNA M should have changed gloves and washed hands after removing the soiled brief and providing peri-hygiene. On 04/07/26 at 01:37 PM, R3 sat in his room, in an electric wheelchair. R3 had Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) relating to the suprapubic catheter, which had been attached to a leg bag under his clothing. CNA N donned gloves and emptied the leg bag's urine contents into a urinal for measurement. CNA N then cleaned the drain spicket with an alcohol pad and flushed the urine in the bathroom. CNA N had not donned a gown during contact with R3's urinary catheter system. R3 reported staff usually wore gloves and gowns while caring for him. On 04/08/26 at 11:31 AM, Administrative Nurse E verified CNA N should have donned both gloves and gown while caring for R3's urinary catheter. 04/06/2026 11:01 AM, the mechanical lift was utilized for resident care and was transported from rooms H14, H11, and H6 without being sanitized. On 04/07/26 at 09:13 AM, Certified Nurse Aide (CNA) O stated she was uncertain when the mechanical lifts were cleaned; possibly the housekeeping staff or night shift staff cleaned the lifts. On 04/08/26 at 01:30 PM, Administrative Nurse E stated her expectation of the staff was to cleanse the mechanical lifts between each resident's use and has ordered a device to attach to the lifts so that staff can utilize cleaning products between residents. The facility's Infection Control Policy dated 08/2025, documented that the facility would facilitate safe care of all residents and staff with known or suspected communicable disease by establishing and maintaining 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. Contact Precaution will be used for specific residents known to be suspected of being infected or colonized with microorganisms that can be transmitted by direct contact with the resident (and or skin-to-skin contact that occurs when performing resident-care activities that require touching the resident's skin) or indirect contact (touching) with environmental surfaces or resident care items in the resident's environment. Clean non-sterile gloves when entering the room, remove soiled gloves, wash hands, and change gloves after having contact with infectious (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	material. If the common equipment or items are unavoidable, clean and disinfect them before use for another resident with a chemical agent approved for use on the identified microorganism.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident (R) 6 had a stop order for the use of as-needed (PRN) antianxiety (a class of medication that calms and relaxes people as required. Findings included: - R6's Electronic Medical Record (EMR) included diagnoses of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure) disease with late onset, pain, and anxiety (mental or emotional reaction characterized by apprehension. R6's admission Minimum Data Set (MDS), dated [DATE], documented that R6 had severe cognitive impairment, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and other behavioral symptoms not directed toward others, which occurred one to three days of the look-back period. R6 also received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antidepressant (a class of medications used to treat mood disorders), and opioids (a class of controlled drugs used to treat pain). The Behavioral Symptom Care Area Assessment (CAA), dated 02/03/26, documented that R6 had multiple episodes of behaviors indicating paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking regarding a family member and agitation. R6 had an increase in dose of Seroquel (an antipsychotic) and lorazepam (an antianxiety), one milligram (mg) as needed every four hours for anxiety.R6's Care Plan, dated 02/04/26, documented that R6 had severely impaired cognition, a diagnosis of depression, and took antidepressant therapy and antipsychotic medications for anxiety and paranoid thoughts. The plan directed staff to redirect focus to other topics to prevent distress, review Black Box Warnings (BBW-the highest safety-related warning that medications can have assigned by the Food and Drug Administration), and monitor for signs of worsening depression. The Physician Order, dated 01/30/26 directed staff to administer lorazepam 1 milligram (mg)every four hours PRN for restlessness/agitation. The order lacked a stop date. The Physician Order, dated 02/19/26, directed staff to administer lorazepam 1 mg in the afternoon related to anxiety disorder. The Physician Order, dated 03/27/26, directed staff to administer topical lorazepam 2 mg/milliliter (ml), to be applied as 1 milliliter (ml) to the inner wrist, only if R6 refused the oral dose, every 4 hours PRN for restlessness or agitation. The order lacked a stop date. The Consultant Pharmacist Review, dated 02/09/26, documented a recommendation to the physician for anxiolytic medication usage, and if the physician orders a stop date for this medication, or a gradual dose reduction (GDR). The physician responded, No, and documented that R6 was receiving hospice services and pursuing a palliative course (treatment designed to relieve or reduce the intensity of uncomfortable symptoms) of care, and the medication was necessary for adequate symptom management to keep the resident comfortable. The rationale lacked a specific duration. On 04/06/26 at 03:38 PM, R6 was sitting in the commons area, with an alarm attached to the back of the wheelchair, looking out the windows with staff seated near and talking with the resident. On 04/08/26 at 09:08 AM, Certified Medication Aide (CMA) R reported that R6 was cooperative with taking her medications and had not exhibited behaviors. CMA R stated the charge nurse was responsible for administering PRN medications like Lorazepam and opioid pain medications if the resident required them. On 04/08/26 at 11:31 AM, Administrative Nurse E reported she was responsible for monitoring the psychotropic medication use for the residents. Administrative Nurse E verified R6's physician had declined a stop date for the use of PRN lorazepam and was uncertain of the need for a stop order for palliative care residents. The facility's Unnecessary Drugs and Psychotropic Drugs policy, dated 05/2025, documented that psychotropic medications require limiting the timeframe of PRN psychotropic medications, which are not antipsychotic medications, to 14 days, unless a longer timeframe is deemed appropriate by the attending physician or the prescribing practitioner.