

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E589	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/02/2023
NAME OF PROVIDER OR SUPPLIER CUMBERNAULD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 716 TWEED STREET WINFIELD, KS 67156		
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F 000	<p>INITIAL COMMENTS</p> <p>A partial extended complaint survey for #178375, #178376, and #178104, was conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 03/01/23 and 03/02/23.</p> <p>On 03/01/23 at 05:57 PM, Administrative Nurse B was provided the Immediate Jeopardy (IJ) Template by email and notified the facility failed to ensure staff reported all alleged violations of abuse and mistreatment to administrative staff in a timely manner. On 02/03/23 Certified Nurse Aide (CNA) N and CNA O witnessed CNA M respond to the behaviors of R1 in a manner which alleged abuse or mistreatment. The staff failed to report to administration. On 02/10/23 CNA O and CNA N for the second time observed CNA M respond to behaviors of R 3 and R4 in a manner which alleged abuse or mistreatment. Neither CNA reported the witnessed incidents to the administration until 14 days after the first incident and 7 days after the second incident. This failure placed all resident in immediate jeopardy for the risk of potential ongoing abuse and mistreatment.</p> <p>This IJ also constituted Substandard Quality of Care. This Immediate Jeopardy was determined to first exist on 02/03/23 when two certified nursing staff witnessed another certified nursing staff member being abusive and mistreating R1. The abuse/mistreatment continued by the same certified nursing staff member when on 02/20/23, two certified nursing staff witnessed abuse/mistreatment by the same certified nursing staff member towards R 3 and also towards R4. The staff failure to report physical and verbal</p>	F 000			

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 000	<p>Continued From page 1</p> <p>abuse by the AP placed all residents at risk for verbal and physical abuse and psychosocial harm. The AP continued to work 14 days beyond the first observed and unreported occurrence.</p> <p>The facilities removal plan was accepted on 03/02/23 at 07:30 PM when the facility implemented the following:</p> <ol style="list-style-type: none"> On 03/01/23 at 06:30 PM, administrative staff educated all second shift staff present on information over the ANE policy. On 03/01/23 at 07:30 PM, administrative staff posted a sign on the time clock instructing all further direct care staff to stop and not clock in until they received the education over the ANE policy. It instructed the staff to read the information over ANE provided and then to sign the signature page prior to clocking in to start work. Direct care staff will not be allowed to work until this is completed. Mandatory in-service for ANE scheduled for all other facility employees to attend on 03/09/23. During the hiring process new employees will be required to sign the facility reporting policy for ANE in addition to watching the ANE video. Administration Nursing will monitor for effectiveness of ANE training by speaking to four employees and two residents, with intact cognition, weekly for three months. After three months by speaking to four employees and two residents with intact cognition biweekly for three months. After six months, by speaking to two employees and one resident with intact cognition monthly for 	F 000			

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F 000	Continued From page 2 three months. After nine months, by speaking to one employee monthly for three months then discontinue. 6. The nurse performing MDS assessments will ask residents with intact cognition if they themselves have been abused or witnessed abuse in the facility during the assessment. 7. During the resident's care plan meeting, we will discuss ANE questions. The staff will also ask family members and allow them to provide any observations/concerns with ANE and staff members. An onsite visit was completed on 03/02/23 at 09:00 AM to verify the removal of the Immediate Jeopardy. The scope and severity remain at an F. This 2567 was electronically sent to the facility on 03/07/2023.	F 000			
F 610 SS=L	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 610			

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F 610	<p>Continued From page 3</p> <p>designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>The facility reported a census of 35 residents, with four residents reviewed for abuse. Based on observation, interview, and record review the facility failed to ensure staff reported all alleged violations of abuse and mistreatment to administrative staff in a timely manner. On 02/03/23 Certified Nurse Aide (CNA) N and CNA O witnessed CNA M respond to the behaviors of R1 in a manner which alleged abuse or mistreatment, when CNA M shoved R1 roughly toward the wall, and the staff failed to report the incident. On 02/10/23 CNA O and CNA N again observed CNA M respond to the behaviors of R3 and R4 in a manner which alleged abuse or mistreatment when CNA M verbally threatened R3 and later yanked R4's walker and forcefully grabbed R4's wrist. Neither CNA reported the witnessed incidents to the administration until 14 days after the first incident and 7 days after the second incident. This failure placed all residents in immediate jeopardy for the risk of potential ongoing abuse and mistreatment.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Investigation of abuse during a complaint investigation revealed the following three abuse allegation incidents directly witnessed by facility staff involving CNA M and R1, R3 and R4, and were not reported: <p>1. On 02/03/23 an incident involving CNA M and</p>	F 610			

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F 610	<p>Continued From page 4</p> <p>R1:</p> <p>In the 02/17/23 "Complaint Investigation Witness Statement," CNA N, stated while working as a float on 02/03/23. "I heard yelling coming from [R1's] room. I opened the door and asked [CNA M] and [CNA O] if they needed help, they declined the help." CNA N's statement included CNA O reported to him that CNA M started yelling at R1 on 02/03/23 and shoved R1 roughly towards the wall to change the resident.</p> <p>On 03/01/23 at 01:50 PM, regarding R1 and the incident on 02/03/23, CNA N reported he only heard the yelling as he walked down the hall, and he did not hear what was said. CNA N stated he did not report the incident to the administrative staff.</p> <p>On 03/01/23 at 12:36 PM, regarding the incident on 02/03/23, CNA O reported "I did not report [CNA M] to the administrative staff due to [CNA M] can be intimidating and take it out on me."</p> <p>Following the abuse incident to R1 on 02/03/23, CNA M continued to work with the residents in the facility, for 14 more days, since these staff members did not report the abuse incident.</p> <p>2. On 02/10/23 an incident involving CNA M and R3:</p> <p>In the 02/17/23 "Complaint Investigation Witness Statement," revealed on 02/10/23 CNA O and CNA R were in the process of laying R3 down when CNA M came into the room and yelled and cussed at R3. R3 yelled back at CNA M, which caused CNA M to become upset, and she stated, "You are lucky [CNA O] is right here or I would</p>	F 610			

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F 610	<p>Continued From page 5</p> <p>pull you up in that chair with your [expletive] pig tails." CNA M left the room and no other issues occurred.</p> <p>An interview on 03/01/23 at 11:25 AM, revealed R3 in her room where R3 stated if a staff member cussed at her, she would cuss right back to them.</p> <p>On 03/01/23 at 05:00 PM, CNA R explained she did not remember the date of the incident but remembered CNA M came into the room and was verbally abusive and stated CNA M said something about pulling R3 up in bed by her ponytails. CNA R reported the staff were so busy it just slipped her mind to report the incident.</p> <p>On 03/01/23 at 12:36 PM, CNA O reported she did not report this abuse incident to administrative staff, due to CNA M would be hateful and hard to work with.</p> <p>3. On 02/20/23 an incident involving CNA M and R4:</p> <p>In the 02/17/23 "Complaint Investigation Witness Statement" CNA N reported on 02/10/23, CNA M came to help with R4 due to an issue of the resident being combative with the staff. As CNA N and CNA M were walking R4 to her room, CNA M grabbed R4's walker and attempted to yank on it. CNA M also placed her hand on R4's wrist forcefully at the same time. CNA N told CNA M to stop in which CNA M then did stop.</p> <p>On 03/01/23 at 01:50 PM, CNA N explained he did not report the incident to the nurse because it happened in the hallway, in sight of the nurse's station. CNA N explained he did not know if the nurses saw the incident but felt they could hear</p>	F 610			

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F 610	<p>Continued From page 6 the commotion in the hallway.</p> <p>On 03/01/23 at 05:00 PM, administrative Nurse B explained that her expectation was for the staff to report any ANE immediately.</p> <p>The facility policy undated "Abuse, Neglect and Exploitation [ANE] Policy" it was the policy of the facility to prohibit and prevent abuse, neglect, and exploitation of residents. The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention.</p> <p>The facility failed to ensure the direct staff members immediately reported each of three incidents of abuse to the facility. Due to this failure, CNA M continued to work in the facility with the residents for 14 days following the first incident, placing the residents in immediate jeopardy for continued instances of verbal and physical abuse by CNA M.</p> <p>On 03/01/23 at 05:57 PM, Administrative Nurse B was provided the IJ template and notified the facility failed to ensure the residents were kept free of verbal/physical abuse, when on 02/03/23 and 02/10/23, CNA M verbally and physically abused R1, R3, and R4. The CNA's failed to report the three witnessed incidents of abuse to the administration until 14 after the first incident. This failure placed all resident at risk for potential ongoing abuse and mistreatment, placing them in immediate jeopardy.</p> <p>The facility implemented a plan to remove the immediacy of the deficient practice on 03/01/23 at 07:30 PM with the following actions:</p>	F 610			

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F 610	<p>Continued From page 7</p> <ol style="list-style-type: none"> On 03/01/23 at 06:30 PM, administrative staff educated all second shift staff present on information over the ANE policy. On 03/01/23 at 07:30 PM, administrative staff posted a sign on the time clock instructing all further direct care staff to stop and not clock in until they received the education over the ANE policy. It instructed the staff to read the information over ANE provided and then sign the signature page prior to clocking in, and direct care staff would not be allowed to work until completion. The facility scheduled a mandatory in-service on ANE for all other facility employees to attend on 03/09/23. During the hiring process new employees would be required to sign the facility reporting policy for ANE in addition to watching the ANE video. Administration Nursing would monitor for effectiveness of ANE training by speaking to four employees and two residents, with intact cognition, weekly for three months. After three months by speaking to four employees and two residents with intact cognition biweekly for three months. After six months, by speaking to two employees and one resident with intact cognition monthly for three months. After nine months, by speaking to one employee monthly for three months, then discontinue. The nurse performing MDS assessments will ask residents with intact cognition if they themselves have been abused or witnessed abuse in the facility during the assessment. 	F 610			

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F 610	Continued From page 8 7. During the resident's care plan meeting, we will discuss ANE questions. The staff will also ask family members and allow them to provide any observations/concerns with ANE and staff members. On 03/02/23 at 09:00 AM, the surveyor verified onsite the implementation of the IJ removal plan. The deficient practice remained at a scope and severity of "F."	F 610		