

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

PRINTED: 07/26/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>175338</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BALDWIN HEALTHCARE &amp; REHAB CENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1223 ORCHARD LANE</b> <b>BALDWIN CITY, KS 66006</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 323 SS=D	<p>The following citations represent the findings of complaint investigation #103106.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents, with 3 residents sampled for accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision for resident #1 to prevent an elopement (a resident who left the facility without staff knowledge).</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The Physician's Order Sheet signed on 7/7/16 in resident #1's closed record included a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). Orders noted staff to apply a wander guard (a bracelet the resident wore to emit a signal when the resident came close to a door), and check the placement and function on every shift.</li> </ul> <p>The quarterly Minimum Data Set (MDS) dated 5/1/16 noted a Brief Interview for Mental Status</p>	F 323			

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 323	<p>Continued From page 1</p> <p>(BIMS) of 5 (less than 8 indicated severe cognition impairment). The resident was independent with locomotion, and did not exhibit wandering behaviors.</p> <p>The Care Area Assessment (CAA) dated 2/1/16 revealed the resident had dementia and required extensive staff assistance for Activities of Daily Living (ADLs).</p> <p>The care plan dated 5/5/16 documented the resident was at risk for an elopement, and staff were to redirect the resident when the security system sounded.</p> <p>The nurse's note dated 7/13/16 noted at 9:50 AM this morning, staff noticed the resident was outside of the facility in the west courtyard.</p> <p>In the facility's investigation of the incident, direct care staff O stated on July 13, 2016 at 9:40 AM or 9:45 AM, he/she sat at the nurse's station. The door alarm sounded for door #5, and he/she thought the dog exited the building, so he/she silenced the alarm.</p> <p>On 7/21/16 at 5:15 PM, the west courtyard door lacked a wander guard alarm system. The courtyard consisted of a sidewalk which ended in a grassy area. The area was enclosed with a chain-link fence and gate. There was a chain around the gate with a clasp latch.</p> <p>On 7/21/16 at 12:50 PM, administrative nursing staff D stated the door alarms produced a visual and audible signal at the nurse's station. When the alarm rang, he/she expected staff to check the panel for the door number, and then check the door which alarmed. Staff D further identified</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>the west courtyard door as door #5, which the resident exited. He/she stated the resident wore a wander guard bracelet.</p> <p>On 7/26/16 at 8:45 AM, direct care staff P stated all exit doors of the facility were alarmed. When the door alarm rang, staff checked the panel to see which door alarmed. Staff reset alarm and checked door. Staff P further stated the dog may set off the door alarm, but staff were expected to check the door. He/she stated the resident wore a wander guard bracelet.</p> <p>On 7/21/16 at 5:00 PM, licensed nursing staff H stated all exterior doors of the facility were alarmed. The system panel was at the nurse ' s station and showed a code for the door alarm. Staff checked the door and then reset the alarm. He/she said the resident was independently mobile in his/her wheelchair and wore a wander guard bracelet. Staff H further stated the only door in the facility with a wander guard alarm was the main entrance.</p> <p>The facility failed to provide a policy about door alarms and the expected response from staff, as requested.</p> <p>The facility failed to provide adequate supervision to prevent an elopement for this mobile and cognitively impaired resident.</p>	F 323			