STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175338	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Healthcare & Rehab Center, LLC	1223 Orchard Lane Baldwin City, KS 66006

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, record review, and interviews, the facility failed to appropriately store medications and biologicals when staff set up 11 residents' medication early and placed them in medication cups in the medication cart, labeled with resident's initials but lacking the required information regarding each medication (prescription and dosing information).Findings included:- On 04/13/26 at 07:42 AM, the medication carts were placed outside the dining room. Inspection of the medication carts revealed 11 medication cups marked with initials that contained medications. The medication cups were stored in the top left-hand drawer of the medication cart. The cups did not have names of the medications contained, the dose, or administration instructions.On 04/13/26 at 07:46 AM, Certified Medication Aide (CMA) S stated the facility's policy was to pop medication from bubble packs, right before administration of the medication to the residents. She stated medication should not be popped out of medication cards and placed into medication cups before a resident is ready to take the medication.On 04/15/26 at 09:20 AM, Administrative Nurse D stated medications should not be set up early. She stated the staff had been educated to set up medications only when the resident was ready to take medication.The facility's Medication Storage dated 01/01/20 documented all medications housed in the facility would be stored in the medication carts or medication rooms according to the manufacturer's recommendation and sufficient to ensure proper sanitation, temperature, light, moisture control, segregation, and security.

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 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, record review, and interview, the facility failed to ensure 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) were in place for Resident (R) 7 who had a Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) to the sacral (tailbone) area and failed to ensure staff used the appropriate personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) while providing wound care to R7. Findings included:- On 04/15/26 at 08:54 AM, Administrative Nurse E entered R7's room and washed her hands (no EBP sign was noted in the room or on R7's door) but did not wear a gown. Certified Nurse Aide (CNA) M was already in R7's room and had gloved hands but did not wear a gown. R7's bedside table had a barrier placed on top of it with the supplies needed for R7's wound dressing change on top of the barrier. CNA M raised R7's bed and pulled down his pants, and untabbed his brief. At this time, it was asked by the NFS why EBP were not being followed and why the appropriate PPE was not put on. Administrative Nurse E removed R7's dressing from his sacral wound and threw the dressing in the trash, then she removed her gloves and went to the sink to wash her hands. Administrative Nurse E applied clean gloves and grabbed the med cup that had gauze pads soaked in normal saline (NS- saline water solution for medical use) that she wiped the wound area with. Administrative Nurse E placed the used gauze in the trash, removed her gloves, and went to the sink to wash her hands and put on clean gloves. Administrative Nurse E applied the Santyl (prescription ointment is used to remove damaged tissue from skin ulcers) to the wound area, then applied the collagen particles (a treatment used for wounds with minimal to moderate drainage) to the wound bed. Administrative Nurse E removed her gloves and discarded them in the trash, washed her hands at the sink, and applied clean gloves. She then placed the new dressing on the wound area. During the wound dressing change, Administrative Nurse E did not wear a gown. On 04/15/26 at 08:56 AM, Administrative Nurse E stated that R7's wound was new and not chronic, so he did not require to be on EBP and a gown did not need to be worn. On 04/15/26 at 10:40 AM, Administrative Nurse E stated that the facility went by the most recent CDC guidelines for EBP. Administrative Nurse E could not state for certain what the facility policy regarding EBP said. Administrative Nurse E stated it was always her understanding that the use of EBP was only needed for chronic wounds and not any wound. On 04/15/26 at 11:03 AM, Administrative Nurse D stated she did not misquote what the facility policy was regarding the use EBP, but it was her understanding that unless a wound was chronic that full EBP including wearing a gown was not needed. The facility's Enhanced Barrier Precautions policy dated 04/01/24 documented the facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with multiple drug-resistant organisms (MDRO-common bacteria that have developed resistance to multiple types of antibiotics) that is not currently targeted by the Centers for Disease Control and Prevention (CDC). An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices, even if the resident is not known to be infected or colonized with a MDRO. The Implementation of Enhanced Barrier Precautions included making gowns and gloves available immediately near or outside of the resident's room.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on interviews, observation, and record review the facility failed to ensure Resident (R) 2's needs were met when staff failed to provide R2 with a call light in order to communicate her needs and wants to staff.Findings included:- R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and dysphagia (swallowing difficulty).The Quarterly Minimum Data Set (MDS) dated 11/25/25 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R1 had limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) to her upper and lower extremities on one side of her body. The MDS documented R2 was dependent on staff assistance with toileting, dressing, bathing, personal hygiene, and bed mobility. R2's Falls Care Area Assessment (CAA), dated 08/27/25, documented she was dependent on staff for assistance with activities of daily living which placed her at risk for falls.R2's Care Plan documented the following interventions:05/07/25, staff would ensure the call light was within reach and encourage her to use it for assistance as needed.On 04/14/26 at 12:49 PM, R2 laid on her bed with her eyes closed. The head of her bed was elevated, and her blankets were pulled up to her chest. The call light laid on the floor behind her recliner and bedside stand at the head of bed out of reach. Unable to view R2 from doorway of room, the privacy curtain was pulled from the wall to the foot of her bed.On 04/15/26 at 08:08 AM, Unable to view R2 from the doorway of her room. R2 laid on her bed awake. The call light laid on the floor behind her recliner and bedside stand out of reach of R2.On 04/15/26 at 08:10 AM, Certified Medication Aide (CMA) R stated R2 should always have a call light in her reach. CMA R stated R2 had a push button call light. CMA R pulled the call light out from behind the recliner and bedside stand and placed the call light on R2's abdomen.On 04/15/26 at 09:10 AM, Administrative Nurse D stated she expected every resident to have their call light within their reach when in their rooms.The facility's Accommodation of Needs policy dated 12/01/25 documented the facility would treat each resident with respect and dignity and would evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to submit complete and accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ).Findings included:- The PBJ Staffing Data Report CASPER Report 1705D provided by the Centers for Medicaid and Medicare (CMS) for Fiscal Year (FY) 2026 triggered during Quarter (Q) 1 for excessively low weekend staffing.On review of the facility's actual working schedule sheets from 10/01/25 to 01/01/26 revealed the facility maintained and had the same number of staff scheduled and worked as during the week: Two nurses for day and evening shift, and one nurse for night shift; four to five nurse aides both day and evening shift, three nurse aides on nights, and two medication aides on day and evening shiftsThe facility's Facility Assessment, revised on 11/11/25, documented the staffing needs and assignments were determined to promote continuity of care for residents within and across their assignments. Staffing needs and assignments vary based on the census and acuity level of the resident in the facility. The direct care staff was to have two licensed nurses for day and evening shift and one nurse for night shift, one medication aide on day and evenings, four to five nurse aids on days and evening shift, and three nurse aides on night shift.On 04/14/26 at 08:00 AM, Administrative Staff A stated she was unsure why the facility had triggered for low weekend staffing. She stated the New York office submits the PBJ from the hours the facility submits. Administrative Staff A stated she had reached out to the New York office. She stated there were as many staff working and scheduled on the weekend as there were on weekdays.The facility's Payroll Based Journal dated 02/05/25 documented it was the policy of the facility to electronically submit timey to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.