

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/09/2024
NAME OF PROVIDER OR SUPPLIER  Orchard Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE  1600 S Woodlawn Blvd Wichita, KS 67218	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40801</p> <p>The facility reported a census of 69 residents, with five residents identified and reviewed for elopement. Based on interview, observation, and record review the facility failed to ensure a safe and secure environment to prevent the elopement of cognitively impaired Resident (R) 1, identified at high risk for elopement. On 05/06/24 at 07:09 PM the charge nurse let R1 out the front doors of the building not realizing he was not allowed out the front doors to smoke. When R 1 went out the doors his WanderGuard (a bracelet that sets off an alarm when a resident wearing one attempts to exit the building without an escort) caused the alarm to activate, and the charge nurse located a CNA to turn off the alarm. The CNA did not check which resident cause the alarm to activate before or after turning off the alarm. The facility was not aware of R1 missing from the building until three hours later when the certified medication aide (CMA) could not find R1 to administer his 10:00 PM medications. After staff conducted a search and could not locate R1, they notified administrative staff at 10:45 PM. The facility did not notify local law enforcement until 12:03 AM. R1 returned to the facility with local law enforcement almost five and half hours after he walked out. This deficient practice placed R1 in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Residents (R) 1's Physician Orders dated 05/05/24 revealed a diagnosis of dementia (a progressive disorder characterized by failing memory, confusion).</li> </ul> <p>The Quarterly Minimum Data Set, dated dated dated [DATE] revealed a Brief Interview for Mental Status score of seven, indicating severely impaired cognition. No behaviors of wandering or elopement were noted on the assessment.</p> <p>The Care Plan dated 05/07/24 identified R1 as an elopement risk with a history of wandering and attempts to leave facility unattended. The resident had a WanderGuard in place with the functioning to be checked each shift and documented in R1's treatment record.</p> <p>The Elopement assessment dated [DATE] revealed a score of 18, which indicated a high risk.</p> <p>The Physicians Orders dated 11/06/23 instructed staff to ensure placement and function of the resident's WanderGuard each shift, document the location, and assess if working.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Nurses Notes dated 05/07/24 at 02:00 AM revealed R1 was last seen by the charge nurse who let R1 out of the building. The CMA on duty could not locate R1 and they conducted a search for the resident. The charge nurse initiated the facility missing person policy, notified administrative staff, and the resident's family. At 12:03 AM staff contacted local law enforcement three hours after R1 was first noted as missing. Law Enforcement located R1 and returned him to the facility at 12:35 AM. Staff completed a skin assessment, and no injuries were noted. Staff placed R1 on one-to-one supervision with every 15-minute visual checks.</p> <p>R1 located about 8 city block away/ equaling three and one fourth miles.</p> <p>Review of the Weather Underground online information revealed the weather report for the area indicated on 05/06/24 at 07:09 PM the temperature was 77 degrees Fahrenheit (F), and when R1 returned at 12:36 AM it was 64 degrees F.</p> <p>Review of the information on CommunityCrimeMaps.com revealed the area in which R1 traversed had numerous violent, narcotic, missing person, vandalism, burglary, and assault crimes.</p> <p>Observation on 05/07/24 revealed the front entrance had a locked door, which required a badge or code to open the door.</p> <p>Observation of the area in which the resident traversed revealed R1 traveled over high traffic streets with speed of 40 miles per hour, past a six-lane interstate with speeds of 60 miles per hours.</p> <p>An interview on 05/08/24 at 10:34 AM with Certified Medication Aide (CMA) R revealed on the day the resident eloped from the facility they could not locate R1 to give him is 10:00 PM medications. CMA R searched for the resident and after staff could not locate the resident, CMA R notified the charge nurse and started the elopement procedure.</p> <p>An interview on 05/08/24 at 10:45 AM with Administrative Nurse B revealed the expectation of staff were for them to know the difference between door alarms and the WanderGuard alarm and not to shut the alarm off without checking why it sounded. Administrative Nurse B stated staff would have known R1 was missing sooner if they had done their rounds.</p> <p>The facility policy Wandering and Elopement dated 2021 revealed residents who are at risk of unsafe wandering or high risk for elopement will have interventions put into place to address the risk. Residents who are identified as being at high risk will have a wander alert bracelet applied to wrist or ankle.</p> <p>On 05/08/24 at 03:11 PM Administrative Staff A and Administrative Nurse B were provided the Immediate Jeopardy template and notified the facility failure to provide adequate supervision to prevent cognitive impaired R1, with history of wandering, from leaving the facility after a staff member let him out of the front doors to smoke and did not react to the WanderGuard alarm and R1 was outside the facility for 5.5 hours. to leave the facility by exiting out the front doors to the parking lot unsupervised.</p> <p>The facility identified and implemented the following corrective action on 05/07/24, which included:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> <li>1. All staff were re-educated starting on 05/07/24 at 12:40 AM and completed on 05/08/24 at 03:00 PM regarding the elopement policy, missing person policy, and resident sign out policy.</li> <li>2. Elopement drills were completed on each shift.</li> <li>3. All residents at risk for elopement received a WanderGuard bracelet and they were checked for function and placement.</li> <li>4. All residents had updated wandering assessments completed.</li> <li>5. The Risk for Elopement Book was reviewed and updated.</li> <li>6. All residents identified as being at risk for elopement had care plans updated as needed.</li> <li>7. Agency staff would be educated on the audible wander alarm sounds prior to working a shift.</li> </ol> <p>The surveyor verified the facility implemented the above corrective actions on 05/08/24 at 4:00 PM. Due to the facility corrective actions completed prior to the onsite survey, deemed the deficient practice past noncompliance and existed at a J scope and severity.</p>		