STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087077	A. BUILDING: _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK ROAD WICHITA, KS 67226

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citation represent the findings of the resurvey at the above named facility on 6/5/19, 6/6/19, 6/1019, 6/11/19, and 6/12/19.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S3028		

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
	N087077	A. BUILDING: _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK ROAD WICHITA, KS 67226

(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) COMPLETE DATE
S3028	Continued From page 1 KAR 26-41-101 (f)(3)(E) The facility identified a census of 74 residents. The sample included 6 residents and 1 closed record review. Based on record review, interview, and observation for 1 (#333) of 6 residents sampled, the administrator failed to report allegation of abuse to the department within 24 hours and complete/submit the Department's investigation report within five working days of the initial report of resident to resident altercation. Findings included: - Record review for resident #333 revealed an admit date of 5/16/18 with diagnoses alzheimer's disease, bipolar, and hypertension. The annual Functional Capacity Screen dated 5/16/18 recorded resident independent with bathing, dressing, toileting, transfer, walking/mobility, experienced decision making, and impaired decision making. The annual Negotiated Service Agreement dated 5/16/18 recorded resident independent with activities of daily living and staff to monitor resident for agitation. The annual Resident Service Plan dated 5/16/18 recorded resident independent with bathing, dressing, toileting, ambulation, alert, oriented, agitated, and behaviors managed with medication. The Interdisciplinary Notes (nurses notes) recorded the following: 1/1/19 at 11:00 a.m. "This nurse was in the hallway, when loud screaming noises were noted	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087077	A. BUILDING: _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK ROAD WICHITA, KS 67226

(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) COMPLETE DATE
S3028	Continued From page 2	S3028		

coming from the dining room. This nurse walked into the dining room and noted resident (#333) standing in the dining room. This nurse was notified that resident was in an altercation with resident #888 at dining room table. Witnesses stated resident #333's table mate #888 pointed at resident #333's orange and stated, 'That's a big orange'. Resident #333 then grabbed resident #888's arm and stated, 'Don't touch my food.' Resident #333 then got in resident #888's face and started yelling curse words at him. Resident #333 then stood up and grabbed resident #888 by his shirt, pinning him against the wall in the dining room. Another resident nearby came up to resident and asked him to step away from the situation. Resident #333 then started to yell at the other resident. Other residents stated that they do not feel safe. This nurse asked to talk to resident, this nurse explained to resident #333 that his behaviors were not appropriate, resident then stated, 'I didn't touch him' and started laughing. This nurse asked resident to go up to his apartment and take some time to himself, resident continued laughing and walked out to this nurses office. Resident #333 noted to be walking the hallways. Medical care provider notified and gave new order to increase depakote to 500 Milligrams (MG) two times a day. Informed resident is becoming unpredictable and lashes out suddenly without warning. Medical care provider agreed and gave order to send resident to behavioral health hospital for evaluation and treatment." Family notified and will take resident to the hospital. Signed licensed nurse C.

Written statement from licensed nurse C recorded resident #900 notified this nurse that resident #888 pointed to resident #333's orange stating, "That is a big orange" and resident #333

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087077	A. BUILDING: _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK ROAD WICHITA, KS 67226

(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) COMPLETE DATE
S3028	Continued From page 3	S3028		

became agitated, grabbed resident #888's wrist stating, "Don't touch my food." Resident #333 then got into resident #888's face and began cursing. Resident #333 then grabbed #888 by the shirt, stood up and from resident #888 and #900's perspective pinned resident #888 against the wall in the dining room. Another resident #911 then came up to resident #333 and asked him to stop. Resident #333 then started yelling at resident #911. This nurse asked to speak with resident #333 and he came into my office. This nurse asked resident #333 what was going on and he stated, "I didn't touch him" and then began laughing. This nurse asked resident to go to his apartment to cool down because his actions were not appropriate. Resident continued to laugh and left the nurse station. Resident began to pace the hallways and staff notified to monitor the situation. This nurse contacted administrator and family. This nurse talked with all residents involved and comforted resident #888 and assured resident he was safe and staff are monitoring the situation. Signed licensed nurse C.

Typed statement on 1/4/19 from administrator recorded visited with residents involved; stories were consistent from two witnesses. Her assessment of resident #888 showed no apparent injury. Appropriate and immediate action was taken by removing resident #333 from the area. Resident was monitored by staff.

Resident was sent to behavior hospital that day of incident.

Interview with administrator on 6/10/19 at 4:00 p.m. stated he/she made decision about the altercation between resident #333 and #888 was not abuse or neglect because no one was hurt. Administrator determined it was not reportable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087077	A. BUILDING: _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK ROAD WICHITA, KS 67226

(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) COMPLETE DATE
S3028	Continued From page 4 and no harm done. Surveyor asked administrator if he/she reported the altercation to the Department and he/she stated no and had not completed the Department's complaint investigation report or submit within five working days because he/she did not feel it was abuse or neglect. For resident #333, the administrator failed to report allegation of abuse to the department within 24 hours and complete/submit the Department's investigation report within five working days of the initial report of resident to resident altercation.	S3028		