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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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 citations represent the findings of a resurvey with complaint #85995 at the above named facility on 11-2-15, 11-3-15, 11-4-15, 11-5-15, 11-9-15, 11-10-15, 11-12-15, 11-16-15, and 11-17-15.	S 000		
S3028 SS=E	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	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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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 by: KAR 26-41-101(f)(3)(A)(B)(C) The facility identified a census of 65 residents. The sample included 6 residents. Based on record review, interviews and observations for 3 (#300, #200, #100) of 6 residents sampled, the administrator failed to report allegations of abuse/neglect to the department within 24 hours, start an investigation, and implement immediate measures to prevent further potential abuse/neglect. Findings included: - Record review for resident #300 revealed diagnoses of dementia, macular degeneration, chronic multiple sclerosis pain, breast cancer, lung cancer and arthritis. The annual functional capacity screen (FCS) dated 1-20-14 recorded resident independent with transfer, walking/mobility, communication, required supervision for toileting, bladder incontinence, and experienced short-term memory loss, impaired memory recall, and impaired decision making. Current or recent problems were identified as impaired vision and falls/unsteadiness. The negotiated service agreement (NSA) dated 1-20-14 recorded resident required reminders for meals and activities. Reorientation as needed. Activities per cognitive level. Resident service plan (HCS) dated 1-20-14 recorded resident assist with bathing, and assist as needed for incontinence, resident ambulated with walker, and remind resident of activity times.	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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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 Interdisciplinary Progress Notes recorded falls on the following dates: 3-14-14 at 8:00 p.m., resident had unwitnessed fall with a laceration to right upper forehead. The laceration was treated with steri-strips. 8-10-14 at 8:45 a.m., resident fell in dining room and hit his/her head. The back of the head documented as " pink in color " and resident complained of pain in the head. 9-1-14 at 12:35 p.m., " This nurse called to the resident room by certified staff who reported resident was on the floor. Upon arrival resident was lying near end of bed by corner of bed frame. Resident stated I was trying to go to the restroom. Resident alert and oriented to name and location. Blood found near resident ' s head. Laceration to back of head, held pressure with clean wash cloth. . . Orders received to send resident to the emergency room for further evaluations. Emergency medical services (EMS) arrived at approximately 11:50 a.m. Resident left facility at 12:15 p.m. " Signed licensed nurse T. The annual Functional Capacity Screen (FCS) dated 1-19-15 recorded resident now required supervision transfer and experienced short-term memory loss, impaired memory recall, and impaired decision making. Current or recent problems continued to include impaired vision and falls/unsteadiness. The Negotiated Service Agreement (NSA) dated 1-19-15 recorded no change in services from 1-20-14.	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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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 Interdisciplinary Progress notes documented falls the following dates: 2-24-15 at 9:00 a.m., resident fell in dining room and noted to hematoma on right side of head with a skin tear. 3-1-15 at 6:55 p.m.,"resident was found on the floor in the bedroom with abrasions to knee and elbow. " 7-17-15 at 10:30 a.m., resident found on the floor in the bathroom when staff responded to a noise. Resident stated he/she hit the back of his/her head. 7-24-15 at 1:17 p.m., resident found on floor in room next to chair and table with no injury and stated he/she missed the chair when attempting to sit and hit his/her head on the table. 7-25-15 at 10:00 a.m., resident found on floor in dining room with blood coming from the back of his/her head and complaint of pain to the left hip and was sent to the hospital via ambulance. The record lacked additional documentation of an investigation to rule out abuse and neglect. Interview on 11-5-15 at 1:27 p.m. with licensed nurse K stated and confirmed these falls were not reported to the department and had no record on an investigation. For resident #300, the administrator failed to report allegations of abuse/neglect to the department within 24 hours, start an investigation, and implement immediate measures to prevent	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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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 further potential abuse/neglect. - Record review for resident #200 revealed diagnoses of dementia, Parkinson ' s disease, atrial fibrillation, coronary artery disease, and depression. The Functional Capacity Screen (FCS) dated 1-15-14 recorded resident required supervision for transfer, walking/mobility, communication, required physical assistance with bladder incontinence, management of medications/treatments, experienced short-term memory loss, and impaired memory recall. Current/recent problems identified as impaired vision and falls/unsteadiness. The Negotiated Service Agreement (NSA) dated 1-15-14 recorded resident required assistance with incontinence as needed, stand by assist with transfer, toileting, remind times for activities per cognitive level, and use call light for assistance. The Resident Service Plan (HCS) dated 1-14-15 recorded administer medications, assist with toileting, incontinent of bladder assist as needed, use walker and monitor for change in gait with stand by assist. The Interdisciplinary Progress Notes and Fall/Incident notes recorded unwitnessed falls on the following dates: 1-31-14 (no time) fell in room in front of closet. 3-1-14 at 2:30 p.m. fell in bathroom. 3-4-14 at 7:32 p.m. fell in room on floor in kitchen.	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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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 5 Found lying on left side. Resident stated hit head and complained of a headache. 3-6-14 at 6:20 p.m. fell in room. 4-6-14 at 11:57 a.m. fell and was found on floor on right side near closet. 6-6-14 (no time) resident fell on floor. 6-28-14 at 12:00 noon resident fell backwards in dining room and landed on right side. 8-10-14 at 8:00 p.m. fell on floor by recliner. 8-19-14 at 12:16 a.m. fell on floor in front of closet. 1-14-15 at 7:45 a.m. fell in bathroom. 2-1-15 at 7:40 a.m. fell in kitchen in room. 2-16-15 at 9:00 p.m. fell in front doorway. Scabbed area on right cheek bone. 3-29-15 at 3:11 p.m. fell in kitchen area. Redness to back and bottom. 4-4-15 at 4:50 p.m. fell in doorway of room. 8-2-15 at 1:55 a.m. fell, no injury noted. 8-4-15 at 7:45 p.m. resident found on floor on right side in living room. Was in recliner at 7:00 p.m. 10-19-15 at 7:55 p.m. resident had a non-injury fall while in dining room. 11-3-15 at 9:55 a.m. observed certified	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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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 6	S3028		

medication aide H administer crushed medications in applesauce to resident #200. It took fifteen minutes to administer due to difficult time swallowing. Certified medication aide stated it took a long time to administer medications and feed resident as he/she had difficult time swallowing.

11-3-15 at 10:15 a.m. observed resident lying in bed on back. Licensed staff I assisted resident to turn on side and assisted up to sit on side of bed. Resident stated the staff walk with him/her to dining room. Resident speaks very soft and slowly.

The record lacked additional documentation of an investigation to rule out abuse and neglect.

Interview on 11-5-15 at 1:27 p.m. with licensed nurse K stated and confirmed these falls were not reported to the department and had no record on an investigation.

For resident #200, the administrator failed to report allegations of abuse/neglect to the department within 24 hours, start an investigation, and implement immediate measures to prevent further potential abuse/neglect.

- Record review for resident #100 revealed an admit date of 2-18-15 with diagnoses of Alzheimer ' s disease, dementia, and hypertension.

The functional capacity screen dated 2-11-15 (admit) recorded resident independent with toileting, transfer, walking/mobility, communication, experienced short-term memory loss, long-term memory loss, memory recall, decision making, and impaired decision making.

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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 7 The negotiated service agreement dated 2-11-15 (admit) recorded assist as needed for toileting, mobility, and incontinence. Encourage and remind activities. Resident will get on floor to do sit ups and push-ups with staff supervision. Activities per cognitive level. The Resident Service Plan (HCS) dated 2-11-15 recorded monitor of change in gait. Resident is alert, confused, forgetful, lethargic and has sundowners ' syndrome. Encourage and remind of activities. The nurses ' s notes recorded the following: 2-11-15 at 1:58 p.m. recorded resident #100 went outside to parking lot, stated was going to walk to Walmart to get strawberries. Staff redirected back into building. Resident in room at this time. Signed licensed nurse T. The record lacked documentation of an investigation to determine how the resident was able to exit the locked memory care unit and follow up actions to be implemented by staff. The facility failed to report elopement to the department, implement immediate measures to prevent further elopement, and conduct thorough investigation. Interview on 11-3-15 at 11:50 a.m. with certified staff L stated (resident #100) went out front door of the assisted living side and someone had to pick him/her up because he/she was going to go to Walmart to get strawberries. Interview on 11-3-15 at 11:55 a.m. with resident #100 stated he/she was hungry. Resident sitting in dining area. Resident looked a clock on wall	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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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 8 and stated, " Time to stir my tea, it has to be stirred every fifteen minutes. " Resident stated was in the army and is a pastor. Resident then got up and directed some residents to the dining room area. Resident alert, walked around the unit, steady gait. Interview on 11-4-15 at 9:40 a.m. with administrative staff A stated he/she remembered resident being out in parking lot in front of assisted living. He/she did not know how resident got their but did see resident in the front parking lot. A staff person talked resident into coming back in to the facility. Could not recall who the staff person was. Resident lived in the secured memory care unit. Interview on 11-5-15 at 12:45 p.m. with licensed nurse Z stated and confirmed the HCS lacked interventions for exit seeking behaviors, elopement risk for resident #100. For resident #100, the administrator failed to report elopement to the department within 24 hours, start an investigation, and implement immediate measures to prevent further potential abuse/neglect. For resident #300, #200, #100 the administrator failed to report allegations of abuse/neglect to the department within 24 hours, start an investigation, and implement immediate measures to prevent further potential abuse/neglect.	S3028		
S3105 SS=D	26-41-202 (j) Negotiated Service Agreement Outside Resource (j) If a resident's negotiated service agreement includes the use of outside resources, the	S3105		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3105	Continued From page 9 designated facility staff shall perform the following: (1) Provide the resident, the resident's legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice This REQUIREMENT is not met as evidenced by: KAR 26-41-202(j) The facility identified a census of 65 residents. The sample included 6 residents. Based on record review, interview, and observation for 1 (#200) of 6 residents sampled, the designated staff failed to monitor outside services provided by hospice. - Record review for resident #200 revealed a diagnoses of dementia, Parkinson ' s disease, atrial fibrillation, coronary artery disease, and depression. The Functional Capacity Screen dated 1-15-14 recorded resident independent with eating, required supervision for transfer, walking/mobility, communication, required physical assistance with bathing, dressing, bladder incontinence, management of medications/treatments, experienced short-term memory loss, and impaired memory recall. Current/recent problems identified as impaired vision and	S3105		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3105	Continued From page 10 falls/unsteadiness. The Negotiated Service Agreement dated 1-15-14 recorded resident required assistance with bathing, dressing, and incontinence as needed, stand by assist with transfer, toileting, remind times for activities per cognitive level, use call light for assistance, and hospice services provided. The Resident Service Plan dated 1-14-15 recorded assist with dressing, shower, administer medications, assist with toileting, incontinent of bladder assist as needed, use walker and monitor for change in gait with stand by assist. A written order dated 9-9-15 recorded wound to upper back: cleanse wound with wound cleanser, and apply duoderm dressing. Change dressing every three days and as needed. 11-3-15 at 10:15 a.m. observed resident lying in bed on back. Licensed nurse I assisted resident to turn on side and assisted up to sit on side of bed. Observed a duoderm dressing on upper left side of back dated 10-28-15. Licensed nurse I removed dressing and noted yellowish drainage in dressing and on wound. The wound was approximately a three centimeter circle red area that looked like top layer of skin opened. Licensed nurse I stated hospice nurses change the dressing every three days and confirmed the dressing was dated 10-28-15 and he/she changed the dressing on 11-3-15. The dressing to wound on back not changed every three days and as needed by hospice or facility staff. On 11-3-15 at 2:50 p.m. reviewed copy of	S3105		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3105	Continued From page 11 treatment record that identified last documented treatment was done on 10-28-15. Licensed nurse I confirmed hospice lacked documentation in the treatment record since 10-28-15. Interview on 11-5-15 at 1:27 p.m. with licensed nurse Z stated and confirmed the HCS lacked services provided by hospice and failed to monitor services provide by hospice for wound care. For resident #200, the designated staff failed to monitor outside services provided by hospice.	S3105		
S3155 SS=J	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility identified a census of 65 residents. The sample included 6 residents. Based on record review, interviews and observations for 2 (#300, #200) of 6 residents sampled with multiple falls, the administrator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services (HCS) to address the risk for falls and unsteadiness. For resident	S3155		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 12	S3155		

#300, this failure resulted in 12 falls between 3-13-14 and 7-25-15, including at least 8 falls with injury to the head, 2 of which required staples for head lacerations. This failure placed resident #300 in immediate jeopardy for harm, injury or death. Resident #300 experienced a fall on 10-6-15 which resulted in an acute subdural hematoma and was unresponsive until death on 10-13-15.

Findings included:

- Record review for resident #300 revealed diagnoses of dementia, macular degeneration, chronic multiple sclerosis pain, breast cancer, lung cancer and arthritis.

The annual functional capacity screen (FCS) dated 1-20-14 recorded resident independent with transfer, walking/mobility, eating, communication, required supervision for bathing dressing, toileting, bladder incontinence, required physical assistance with medications/treatments and experienced short-term memory loss, impaired memory recall, and impaired decision making. Current or recent problems were identified as impaired vision and falls/unsteadiness.

The negotiated service agreement (NSA) dated 1-20-14 recorded resident required stand by assist for bathing, reminders for meals and activities. Reorientation as needed. Activities per cognitive level.

Resident service plan (HCS) dated 1-20-14 recorded resident independent with dressing, assist with bathing, and assist as needed for incontinence, resident ambulated with walker, and remind resident of activity times.

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 13 The HCS lacked a description of services to address the resident ' s risk for falls. Interdisciplinary Progress Notes recorded falls on the following dates: 3-13-14 at unknown time (documented at 11:03 a.m.), resident fell leaving dining room after breakfast and hit his/her head on the floor; area to back of head red and discolored. 3-14-14 at 8:00 p.m., resident had unwitnessed fall with a laceration to right upper forehead. The laceration was treated with steri-strips. The HCS lacked interventions to address resident ' s risk for falls 8-10-14 at 8:45 a.m., resident fell in dining room and hit his/her head. The back of the head documented as " pink in color " and resident complained of pain in the head. New order for physical therapy (PT)/occupational therapy (OT) received on 8-11-14. (Physical therapy note 8-13-14 that PT/OT order discontinued) The HCS lacked interventions to address the resident ' s continued risk for falls. 9-1-14 at 12:35 p.m., " This nurse called to the resident room by certified staff who reported resident was on the floor. Upon arrival resident was lying near end of bed by corner of bed frame. Resident stated I was trying to go to the restroom. Resident alert and oriented to name and location. Blood found near resident ' s head. Laceration to back of head, held pressure with clean wash cloth. . . Orders received to send resident to the	S3155		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 14	S3155		

emergency room for further evaluations. Emergency medical services (EMS) arrived at approximately 11:50 a.m. Resident left facility at 12:15 p.m. " Signed licensed nurse T.

The record lacked documentation of the time the resident returned from the hospital or the treatment provided for the head injury.

Note written at 10:40 p.m. documents resident fell at approximately 5:25 p.m. and further documented resident had returned from hospital with six staples at back of head and complained of dizziness when standing.

The HCS lacked interventions to address dizziness and ongoing risk for falls

Amended NSA dated 9-4-14 recorded physical therapy and occupational therapy to evaluated and treat.

10-13-14 at 7:50 p.m. resident self-reported fall and denied hitting his/her head.

The annual FCS dated 1-19-15 recorded resident now required supervision transfer and experienced short-term memory loss, impaired memory recall, and impaired decision making. Current or recent problems continued to include impaired vision and falls/unsteadiness.

The NSA dated 1-19-15 recorded no change in services from 1-20-14.

The HCS dated 1-19-15 recorded resident now required cueing for dressing and continued to lack interventions to address resident #300 ' s risk for falls.

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 15 Interdisciplinary Progress notes documented falls the following dates: 2-24-15 at 9:00 a.m., resident fell in dining room and noted to hematoma on right side of head with a skin tear. 3-1-15 at 6:55 p.m., resident was found on the floor in the bedroom with abrasions to knee and elbow. " The HCS lacked interventions to address the resident ' s risk for falls. The Assisted Living Facility/Non-skilled Environment Fall Risk Assessment dated 4-9-15 recorded the following: - Resident has history of falls in last 6 months - Frequent (5 or more). - Mobility - Ambulation is steady with an assistive device. - Insight and Safety - Resident is unable to remember to ask for assistance and or is frequently impulsive with limited insight. The HCS continued to lack interventions to address fall risk The Interdisciplinary Progress notes documented additional falls the following dates: 7-17-15 at 10:30 a.m., resident found on the floor in the bathroom when staff responded to a noise. Resident stated he/she hit the back of his/her head. 7-24-15 at 1:17 p.m., resident found on floor in room next to chair and table with no injury and stated he/she missed the chair when attempting to sit and hit his/her head on the table.	S3155		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 16 7-25-15 at 10:00 a.m., resident found on floor in dining room with blood coming from the back of his/her head and complaint of pain the left hip and was sent to the hospital via ambulance. 7-25-15 at 1:30 p.m., resident returned from the hospital with seven staples to the scalp. 7-25-15 at 7:00 p.m. resident found on floor with no new injury and stated he/she fainted. Amended NSA dated 7-27-15 recorded facility supportive health services to provide home health aide from 8:00 a.m. to 8:00 p.m. for safety reasons until further notice. The NSA and HCS continued to lack interventions to address risk for falls from 8 p.m. to 8 a.m. and lacked a description of the services to be provided by the home health aide. Interdisciplinary Progress notes documented: On 10-6-15 at 11:28 p.m., " This nurse notified by aide that resident found on the floor with briefs pulled down on the ground with chair on top of resident. Baseball size knot noted to right eye. Resident has eyes open but does not respond to verbal stimulation. Resident would not track movement. Resident would not move extremities. Resident found at [approximately] 10:20 p.m. Physician notified and orders to send resident to hospital by EMS. Resident taken out of facility at 11:18 p.m. Statement on file from home health aide assigned to resident stated " at 7:55 p.m. [facility staff] came to give meds and was still giving meds when I left by 8 p.m. " Statement on file from direct care staff stated " about 20 after 10:00 I	S3155		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 17	S3155		

went to do hourly check and found him/her lying under a chair in his/her room... " (Direct care staff no longer employed by facility and unable to interview). The record lacked documentation of the last time the resident was checked prior to 10:20 p.m.

Hospital Trauma progress noted entered on 10-8-15 document resident admitted to hospital on 10-7-14 and at time of assessment on 10-8-15 resident " minimally responsive. Will arouse to voice and touch but does not open eyes. " The results of CAT Scan and hospital diagnoses recorded:
1.) Traumatic Subdural Hematoma
2.) Subarachnoid hemorrhage following injury
3.) Contusion of right orbital tissues
4.) Loss of consciousness
5.) Dementia

Neurosurgical progress note entered on 10-8-15 documented " no neurosurgical intervention recommended or needed. Family has opted for comfort care "

Transfer orders from hospital to long term care facility dated 10-8-15 recorded diagnoses of subdural hematoma, epidural hematoma and hypertension.

Admission notes for hospice care dated 10-8-15 recorded diagnosis acute subdural hematoma. Hospice notes from 10-9-15 to 10-13-15 documented resident continued to be unresponsive with progressive decline.

Interview on 11-4-15 at 12:00 p.m. with administrative assistant stated, " Resident passed away on 10-13-15 at the skilled facility. "

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 18 Interview on 11-5-15 at 1:27 p.m. with licensed nurse Z stated and confirmed the HCS lacked interventions for falls and further stated home health aide was started due to increased falls. Licensed nurse Z further confirmed the record lacked interventions for falls and services home health aide provided. Interview on 11-5-15 at 1:45 p.m. with licensed nurse K stated and confirmed the HCS lacked interventions for falls and how often to monitor. Licensed nurse K also confirmed the HCS lacked documentation of services provided by the home health aide. For resident #300, the licensed nurse failed to provide or coordinate services necessary to address the resident ' s ongoing risk for falls. Resident #300 experienced 6 falls in the nine month period before revision of the FCS, NSA, and HCS in January 2015. Four of those falls resulted in injury to the head with 1 requiring 6 staples for a laceration to the back of the head. The HCS developed in January 2015 continued to lack interventions for falls/unsteadiness. Resident #300 experienced 6 additional falls (4 of which resulted in injury to the head) including 1 fall that required seven staples to the back of the head. The HCS plan was updated following the fall with head injury and laceration to include " facility supportive health services provided from 8:00 a.m. to 8:00 p.m. for safety reasons until further notice " but lacked interventions to address fall risk from 8 p.m. to 8 a.m. Resident #300 experienced a fall on 10-6-15 that resulted in a brain injury and passed away on 10-13-15.	S3155		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 19 - Record review for resident #200 revealed a diagnoses of dementia, Parkinson ' s disease, atrial fibrillation, coronary artery disease, and depression. The Functional Capacity Screen (FCS) dated 1-15-14 recorded resident independent with eating, required supervision for transfer, walking/mobility, communication, required physical assistance with bathing, dressing, bladder incontinence, management of medications/treatments, experienced short-term memory loss, and impaired memory recall. Current/recent problems identified as impaired vision and falls/unsteadiness. The Negotiated Service Agreement (NSA) dated 1-15-14 recorded resident required assistance with bathing, dressing, and incontinence as needed, stand by assist with transfer, toileting, remind times for activities per cognitive level, use call light for assistance, and hospice services provided. The Resident Service Plan (HCS) dated 1-14-15 recorded assist with dressing, shower, administer medications, assist with toileting, incontinent of bladder assist as needed, use walker and monitor for change in gait with stand by assist. The HCS lacked interventions to address falls and unsteadiness. The Interdisciplinary Progress Notes and Fall/Incident notes recorded unwitnessed falls on the following dates with no injury except where noted: 1-31-14 (no time) fell in room in front of closet.	S3155		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 20 3-1-14 at 2:30 p.m. fell in bathroom. 3-4-14 at 7:32 p.m. fell in room on floor in kitchen. Found lying on left side. Resident stated hit head and complained of a headache. 3-6-14 at 6:20 p.m. fell in room. 4-6-14 at 11:57 a.m. fell and was found on floor on right side near closet. 6-6-14 (no time) resident fell on floor. 6-28-14 at 12:00 noon resident fell backwards in dining room and landed on right side. 8-10-14 at 8:00 p.m. fell on floor by recliner. 8-19-14 at 12:16 a.m. fell on floor in front of closet. The NSA/HCS lacked interventions for falls/unsteadiness. The annual FCS, NSA and HCS dated 1-15-15 unchanged form 1-15-14 FCS and NSA. The HCS continued to lack interventions to address resident #200 ' s continued risk for falls. The Interdisciplinary Progress Notes and Fall/Incident notes recorded unwitnessed falls on the following dates with no injury except where noted: 1-14-15 at 7:45 a.m. fell in bathroom. 2-1-15 at 7:40 a.m. fell in kitchen in room.	S3155		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 21 2-16-15 at 9:00 p.m. fell in front doorway. Scabbed area on right cheek bone. 3-29-15 at 3:11 p.m. fell in kitchen area. Redness to back and bottom. 4-4-15 at 4:50 p.m. fell in doorway of room. 6-18-15 at 10:15 p.m. staff present with resident, turned to turn on shower light and resident was falling, lowered as best as could but resident was already almost to floor. Resident sustained small red abrasions to left and right mid back areas. Resident did not hit head. 8-2-15 at 1:55 a.m. fell, no injury noted. 8-3-15 at 7:56 a.m. fell in bathroom in front of toilet. Staff with resident when resident began to fall. Unsteady gait, lowered to floor on knees. 8-3-15 at 7:15 p.m., resident gait unsteady with walker. The HCS lacked interventions to address increased unsteadiness and risk for falls. 8-4-15 at 7:00 p.m. resident weak and unstable. Staff used hospice wheel chair to transport resident to meals and activities. Resident confused. 8-4-15 at 7:45 p.m. resident found on floor on right side in living room. Was in recliner at 7:00 p.m. 10-19-15 at 7:55 p.m. resident had a non-injury fall while in dining room.	S3155		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 22 The HCS continued to lack a description of services to address the resident ' s risk for falls. 11-3-15 at 9:55 a.m. observed certified medication aide H administer crushed medications in applesauce to resident #200. It took fifteen minutes to administer due to difficult time swallowing. Certified medication aide stated it took a long time to administer medications and feed resident as he/she had difficult time swallowing. The HCS lacked interventions to address difficulty swallowing. 11-3-15 at 10:15 a.m. observed resident lying in bed on back. Licensed staff I assisted resident to turn on side and assisted up to sit on side of bed. Resident stated the staff walk with him/her to dining room. Resident speaks very soft and slowly. On 11-5-15 at 12:15 p.m. observed resident in dining room eating very small portions and eating very slow. At 1:45 p.m. resident continued to eat very slow with encouragement. Staff came by and offered or administered small bites. For resident #200 who experienced multiple falls and unsteadiness, the licensed nurse failed to provide or coordinate services necessary to address the resident ' s ongoing risk for falls. For residents #300 and #200, the administrator failed to ensure a licensed nurse provided and coordinated the provision of necessary Health Care Services (HCS) to address the risk for falls and unsteadiness. This failure placed resident#300 who experienced 12 falls between	S3155		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3155	Continued From page 23 3-13-14 and 7-25-15, including at least 8 falls with injury to the head, in immediate jeopardy for harm, injury or death. Resident #300 experienced a fall on 10-6-15 that resulted in a subdural hematoma, leaving him/her unresponsive until death on 10-13-15. The jeopardy was removed when resident #300 was transferred to the hospital in 10-6-15.	S3155		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility identified a census of 65 residents. The sample included 6 residents. Based on record review, interview, and observation for 6 (#100, #200, #300, #400, #500, #600) of 6 residents sampled, the administrator failed to ensure the Negotiated Service Agreement (NSA)/health care services (HCS) contained the name of the licensed nurse responsible for implementation and supervision of the plan. Findings included: - Record review for resident #100 revealed an admit date of 2-18-15 with diagnoses of alzheimer ' s disease, dementia, and hypertension.	S3165		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3165	Continued From page 24 The NSA dated 2-11-15 (admit) recorded assist as needed for bathing, toileting, mobility, dressing and incontinence. Orientation to facility and shower. Encourage and remind activities. Resident will get on floor to do sit ups and push-ups with staff supervision. Activities per cognitive level. The HCS dated 2-11-15 recorded independent with bathing, toileting, mobility, monitor of change in gait, assist as needed for dressing and shower. Resident is alert, confused, forgetful, lethargic and has sundowners ' syndrome. Encourage and remind of activities. The NSA/HCS lacked the name of the licensed nurse responsible for implementation of HCS. - Record review for resident #200 revealed a diagnoses of dementia, Parkinson ' s disease, atrial fibrillation, coronary artery disease, and depression. The NSA dated 1-15-14 recorded resident required assistance with bathing, dressing, and incontinence as needed, stand by assist with transfer, toileting, remind times for activities per cognitive level, use call light for assistance, and hospice services provided. The HCS dated 1-14-15 recorded assist with dressing, shower, administer medications, assist with toileting, incontinent of bladder assist as needed, use walker and monitor for change in gait with stand by assist. The NSA/HCS lacked the name of the licensed nurse responsible for implementation of HCS.	S3165		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3165	Continued From page 25 - Record review for resident #300 revealed diagnoses of dementia, macular degeneration, chronic multiple sclerosis pain, breast cancer, lung cancer and arthritis. The NSA dated 1-20-14 recorded resident required stand by assist for bathing, reminders for meals and activities. Reorientation as needed. Activities per cognitive level. The HCS dated 1-20-14 recorded resident independent with dressing, assist with bathing, and assist as needed for incontinence, resident ambulated with walker, and remind resident of activity times. The NSA/HCS lacked the name of the licensed nurse responsible for the implementation of HCS. - Record review for resident #400 revealed diagnoses of chronic obstructive pulmonary disease, bronchitis, and breast cancer. The NSA dated 3-9-15 recorded resident independent with dressing toileting, transfer, walking/mobility, eating, bladder incontinence, communication, required supervision with bathing, medication administration, and experienced falls/unsteadiness and impaired vision. The HCS dated 3-9-15 recorded stand by assist with bathing, weekly medication planner prefilled and resident at risk for falls/unsteadiness. The NSA/HCS lacked the name of the licensed nurse responsible for implementation of HCS. - Record review for resident #500 revealed an admit date of 11-19-14 with diagnosis of	S3165		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3165	Continued From page 26	S3165		

dementia.

The NSA dated 7-5-14 recorded resident independent with bathing, dressing, toileting, bladder incontinence communication, required supervision with walking/mobility, eating, physical assistance with management of medications/treatments, experienced poor memory recall, impaired decision making, falls/unsteadiness and impaired vision.

The HCS dated 7-5-15 recorded resident required supervision with bathing, eating, staff to administer medications/treatments, assist with bladder incontinence, encourage to go to activities and at risk for falls/unsteadiness.

The NSA/HCS lacked the name of the licensed nurse responsible for implementation of HCS.

- Record review for resident #600 revealed an admit date of 9-26-14 with diagnoses of dementia, hypertension, and congestive heart failure.

The NSA dated 6-20-15 recorded resident independent with toileting, required supervision with transfer, walking/mobility, eating, bladder incontinence, required physical assistance with bathing, dressing, management of medications/treatments, experienced memory recall, short-term memory, long term memory, impaired decision making, falls/unsteadiness.

The HCS dated 6-20-15 recorded resident required physical assistance with bathing two times a week, assist with dressing, stand-by assist with transfer, walking/mobility, bladder incontinence, remind to come to meals, facility staff to administer medications, encourage to

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3165	Continued From page 27 participate in activities. Resident is very hard of hearing. The NSA/HCS lacked the name of the licensed nurse responsible for implementation of HCS. Interview on 11-5-15 at 1:27 p.m. with licensed nurse Z stated and confirmed the NSA/HCS lacked the name of the licensed nurse responsible for implementing and supervising health care services provided. Interview on 11-5-15 at 1:30 p.m. with licensed nurse K stated and confirmed the NSA/HCS lacked the name of the licensed nurse responsible for implementing and supervising health care services provided. For residents #100, #200, #300. #400, #500, and #600, the administrator failed to ensure the NSA/HCS contained the name of the licensed nurse responsible for implementation and supervision of the plan.	S3165		
S3201 SS=F	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately	S3201		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3201	Continued From page 28 before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(3)(D) The facility identified a census of 65 residents. The sample included 6 residents. Based on record review, interview, and observations for 5 (#100, #200, #300, #500, #600) of 5 residents with facility management of medications, the licensed nurse or Certified Medication Aide (CMA) failed to document actual clock time medication administered. Findings included: - Record review for resident #100 revealed an admit date of 2-18-15 with diagnoses of alzheimer ' s disease, dementia, and hypertension. The functional capacity screen dated 2-11-15 recorded resident unable to manage own medications. The negotiated service agreement dated 2-11-15 recorded facility staff to administer medications. The medications administered lacked an acutal clock time. The Medication Administration Record (MAR) recorded, "AM (morning), PM (evening), HS (bedtime)."	S3201		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3201	Continued From page 29 - Record review for resident #200 revealed a diagnoses of dementia, Parkinson ' s disease, atrial fibrillation, coronary artery disease, and depression. The FCS dated 1-14-15 recorded resident unable to manage medications. The NSA dated 1-15-15 recorded facility staff to administer medications. The medications administered lacked an acutal clock time. The Medication Administration Record (MAR) recorded, "AM (morning), PM (evening), HS (bedtime)." - Record review for resident #300 revealed diagnoses of dementia, macular degeneration, chronic multiple sclerosis pain, breast cancer, lung cancer and arthritis. The FCS dated 1-19-15 recorded resident unable to manage medications. The NSA dated 1-19-15 recorded facility staff to administer medications. The medications administered lacked an acutal clock time. The Medication Administration Record (MAR) recorded, "AM (morning), PM (evening), HS (bedtime)." - Record review for resident #500 revealed an admit date of 11-19-14 with diagnosis of dementia. The FCS dated 6-29-15 recorded resident unable to manage medications.	S3201		

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 _____	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK RD 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
S3201	Continued From page 30 The NSA dated 7-5-14 recorded facility staff to administer medications. The medications administered lacked an acutal clock time. The Medication Administration Record (MAR) recorded, "AM (morning), PM (evening), HS (bedtime)." - Record review for resident #600 revealed an admit date of 9-26-14 with diagnoses of dementia, hypertension, and congestive heart failure. The FCS dated 6-20-15 recorded resident unable to manage medications. The NSA dated 6-20-15 recorded facility staff to administer medications. The medications administered lacked an acutal clock time. The Medication Administration Record (MAR) recorded, "AM (morning), PM (evening), HS (bedtime)." Interview on 11-5-15 at 1:27 p.m. with licensed nurse Z stated and confirmed all the resident MAR ' s lacked actual clock times medications administered. Interview on 11-5-15 at 1:30 p.m. with licensed nurse K stated and confirmed all the resident MAR ' s lacked actual clock times medications administered. For residents #100, #200, #300, #500, and #600, the licensed nurse or CMA failed document actual clock time medication administered.	S3201		