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 _____	11/07/2023

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 citations represent the findings of an abbreviated survey for complaints #183727 of the above named facility conducted on 11/07/2023.	S 000		
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: K.A.R. 26-41-204 (a) The facility reported a census of 66 residents. The sample included 1 "Resident" (R) closed record review. Based on record review and interview the administrator failed to ensure "Licensed Nurse" (LN) B provided/coordinated the provisions of necessary health care services at the time of her admission to the facility, in accordance with the cognitive impairment noted on R1 "Functional Capacity Screen" (FCS) and not identified on R1 "Negotiated Service Agreement" (NSA). This failure allowed R1 to exit the facility at 06:02 PM without facility staff knowledge. Facility staff were unaware R1 was	S3155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S3155	Continued From page 1 not in the facility until 09:20 PM, when the local police department called the facility to inquire if they had a resident with R1's name. R1 was out of the facility for a total of 3 hours and 18 minutes without staff knowledge placing her in jeopardy. Findings included: - Review of R1 records revealed an admission date of 10/25/23 with diagnoses of arthritis, cardiac murmur, chest pain, chest tightness, cognitive impairment, dementia, hypertension, and vasospastic angina. The FCS dated 10/25/23 revealed R1 required supervision with bathing and managing her medications. She was independent with dressing, toileting, transferring, walking, and eating. She was continent of bladder and had impaired short-term memory and impaired memory recall. She did not use a walking mobility device. The signed NSA dated 10/25/23 identified the facility would provide the following health services: bathing, activity of daily living (ADL) assistance, and medication management. The NSA lacked identification of health services to assist R1 with her cognitive impairment. The "Health Service Plan" (HSP) dated 10/25/23, under the Cognition heading revealed R1 "Requires reminders: has mild to moderate disorientation or difficulty recalling/retaining information. Staff to cue/remind as needed".	S3155		

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S3155	Continued From page 2 Review of R1's electronic medical record under the "Progress Notes" tab revealed the following entries: 10/25/23 at 01:23 PM, R1 arrived at the assisted living community at 10:05 AM. R1 was alert and orientated to person, place, and time. R1 had forgetfulness, short-term and long-term memory loss. 10/25/23 at 01:47 PM, Per R1 son, R1 is noted with increasing forgetfulness at home. He was becoming concerned with R1 being alone in the home. R1 noted with poor short-term memory. R1 ambulated with a steady gait without an assistive device. R1 family reported she was not taking showers at home and request staff to remind and set up the shower for R1 and monitor R1 for routine changing of her clothes. 10/27/23 at 10:11 AM and noted as a "Late Entry" for 10/26/23: The facility nurse was notified by the facility "Certified Medication Aide" (CMA), that R1 was out of the facility. R1 had been observed throughout the "evening" and had been "happy and content". The local police department reported resident was picked up approximately 1.9 miles from the facility, and R1 was complaining of having stroke symptoms. R1 was taken to a local emergency room, where the hospital nurse reported R1 was medically stable and very confused. 10/30/23 at 4:28 PM R1 did not return to the facility, and the family made arrangements to pick up R1 belongings.	S3155		

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S3155	Continued From page 3 Review of facility provided document titled "Elopement Risk Screening" dated 10/25/23 revealed a score of "6" "Not at risk for elopement". If the resident scored 10 or greater then 10, they would have been considered a risk for elopement. Review of facility provided document titled "Brief Interview for Mental Status" (BIMS), revealed a score of 6, "Severe Impairment". Review of facility provided "History and Physical" (H and P) dated 09/15/23 revealed R1 needed a referral back to the neurologist for re-evaluation of mild cognitive impairment that was diagnosed in 2019. R1 had not been re-evaluated since that time and she was not taking the Donepezil that was prescribed by the neurologist in 2019. Review of the facility provided signed document titled "Transitional Care Agreement for Assisted Living" stated the facility would provide individualized care plans, assistance with ADLs, and three meals per day. Review of the facility provided signed and notarized "Witness Statements" revealed the following: Facility staff CC wrote he saw "a person" approach the door to exit. He saw her attempt to open the door and he then hit the button at his desk to release the door to allow the person to exit the building. He "did not at the time realize she was a resident" and he knew the person was not "someone indicated in the front desk book as an elopement risk".	S3155		

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S3155	Continued From page 4	S3155		

CMA DD wrote that she saw R1 "go to dinner around 05:40 PM" and she then received the call from the local police department at approximately 09:20 PM. The police revealed that R1 was with them, and she was found 1.9 miles from the facility.

LN EE wrote that she received the call from CMA DD that R1 was "reported out of the facility per the local police department". LN EE wrote that CMA DD reported to her that she had seen R1 earlier in the evening and R1 was happy and content. LN EE located R1 at the local hospital and was told by the hospital nurse that R1 had no medical issues and "was only confused".

LN B wrote she performed the initial assessment on R1 prior to her admission to the facility. LN B further revealed that R1 lived alone in her home and per her son took frequent walks through the neighborhood and around the golf course she lived nearby. LN B continued to write that there were no nursing concerns noted for elopement upon admission.

Facility staff FF wrote on 10/16/23 the family's primary concern was R1's increased need for cues and reminders, bathing, dressing, meal preparation, and socialization. On 10/25/23 the daughter "was concerned the next morning that her mother was not adjusting well and noted that R1 stated she did not feel that she needed to be here".

Review of the facility provided investigation revealed administrator A looked at the video footage for the facility dated 10/26/23, and discovered the following:

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S3155	Continued From page 5 At 06:02 PM R1 was visualized on camera exiting the building At 06:05 PM R1 was visualized on camera walking north towards the exit gate At 06:30 PM R1 was visualized on camera heading south on the public sidewalk on a busy four lane street. Review of the video footage revealed on 10/26/23 at 06:02 PM R1 approached the double front doors of the facility. R1 pushed on the bar on the right side first and it did not open, she then tried the left side and the door opened and she exited the facility. Interview on 11/07/23 at approximately 04:00 PM with Dietary Manager C and dietary server D, they stated the expectation is that the dietary staff will let the nursing staff know when the resident has not come down for a meal. She explained the facility used a card system and the facility used a restaurant model serving system. She stated that when the residents are in the dining room their meal order is placed on a ticket, the ticket is given to the cook and when the plate is served the card is pulled by dietary staff and the ticket is placed in the box for the dietary manager. She stated if the residents' do not come to the dining room for a meal, and they are delivered a room tray then the "nursing staff" pull the cards when they deliver the meal to the resident room. The ticket with the resident menu choice is given to dietary staff to put in the box for the dietary manager. Dietary server D stated that on 10/26/23 she attempted to call the "nursing staff" thirty minutes prior to the evening meal ending to let them know that R1 had not	S3155		

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been served a meal, the phone was not answered. She continued that when she "looked later" R1's card had been pulled and she did not inquire any further.

Interview on 11/07/23 at approximately 04:30 PM with CMA E, she stated that on 10/26/23 at a time she could not remember she directed R1 to go to the dining room when she was observed going down the hall by the library. She stated that at approximately 04:40 PM she will start assisting residents to the dining room for their evening meal. She stated during the meal process she stays in the dining room and monitors the residents, and those who need assistance after the meal she will assist them back to their rooms. She stated she was not concerned when she did not see R1 in the dining room, she thought she ate and went back to her room. She stated she did not pull the dietary card to take a meal back to R1 room.

Interview on 11/07/23 at approximately 04:45 PM with administrator A, LN B and dietary manager C, it was discovered the phones to the qualified facility staff do not rollover to the next phone. It was confirmed that dietary server D did attempt to call the nursing staff with no answer of the phone to report R1 not having come to the dining room for her evening meal.

Interview on 11/7/23 at approximately 05:00 PM with administrator A and LN B, they confirmed R1 was out of the facility without staff knowledge until 09:20 PM when the local police department called the facility to inquire if R1 lived at the facility. They confirmed there was not a policy in place for new residents to the facility that

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included frequent checks on the new resident, and further confirmed that they could not confirm if R1 ate her evening meal. LN B confirmed the cognition portion of R1 NSA did not have a health service plan in place for her impaired cognition, and per the health service plan staff were instructed to remind/cue R1 as needed.

On 10/26/23 at 08:27 PM R1 was found by the local police department wearing slacks, a long-sleeved blouse, and shoes. The temperature was 72 degrees Fahrenheit. The road the facility is located on has a speed limit of 40 miles per hour and was a busy, heavily traveled four lane street with additional turning lanes at the intersections. R1 walked along this street and was found 1.9 miles away from the facility.

On 11/07/23 at 05:10 PM administrator A was informed of jeopardy for the resident elopement and was asked for the abatement plan.

The administrator failed to ensure the LN provided/coordinated the provisions of necessary health care services at the time of R1 admission to the facility. This failure allowed R1 to exit the facility at 06:02 PM without facility staff knowledge. Facility staff were unaware R1 was not in the facility until 09:20 PM, when the local police department called the facility to inquire if they had a resident with R1's name. R1 was out of the facility for a total of 3 hours and 18 minutes without staff knowledge placing her in jeopardy.

The abatement plan was accepted by the

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S3155	Continued From page 8 department on 11/07/23 at 05:44 PM. The plan included the following actions: On 10/29/23.Facility concierge and front desk personnel were retrained on front desk operations and resident's wanting to leave the facility. On 10/30/23 Implementation of new 72-hour monitoring for new residents which included walking them all the way to the dining room chair at all mealtimes for the first three days, putting their picture in the elopement binder at the front desk until the resident routine is learned by staff, and having all leaders talk to new residents at different times during the first 72 hours of admission. On 11/07/23 ticket to "Information Technology" (IT) was placed to have phones roll over instead of going to voice mail. To be completed by 11/08/23 a full review by the LN of all residents for their risk of elopement. To be completed by 11/08/23 a review of the dining card system for opportunities for improvement.	S3155		