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 _____	02/24/2025

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 represent the findings of a resurvey for the above named assisted living conducted on 02/20/25 and 02/24/25.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or 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. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 67 residents with six residents included in the sample. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreements" (NSA) for Resident (R) 3, R4, and R6 described the services they received based	S3085		

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

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S3085	Continued From page 1 on their "Functional Capacity Screens" (FCS) for falls. Findings included: - Record review for R3 revealed an admission date of 06/25/24 with diagnoses of mild cognitive impairment and polyosteroarthritis. The 01/29/25 "FCS" identified R3 was marked at risk for falls. The 01/29/25 "NSA" failed to describe services R3 received to prevent injury from falls. The 02/10/25 "Fall Risk Data Collection Tool" documented R3 scored 34.0 which was high risk for falls. On 02/24/25 at 11:06 AM Administrative Nurse B confirmed R3's "NSA" failed to describe the services she received for falls. The administrator failed to ensure the "NSA" for R3 described the services she received for falls. - Record review for R4 revealed an admission date of 07/19/24 with a diagnosis of repeated falls. The 07/19/24 "FCS" identified R4 was marked at risk for falls. The 07/19/24 "NSA" failed to describe services R4 received to prevent injury from falls. The 02/09/25 "Fall Risk Data Collection Tool" documented R4 scored 36.0 which was high risk	S3085		

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LARKSFIELD PLACE ASSISTED LIVING	2727 N ROCK ROAD WICHITA, KS 67226

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S3085	Continued From page 2 for falls. On 02/24/25 at 11:15 AM Administrative Nurse B confirmed R4's "NSA" failed to describe the services she received for falls. The administrator failed to ensure the "NSA" for R4 described the services she received for falls. - Record review for R6 revealed an admission date of 02/12/25 with diagnoses of hypertension and chronic pain. The 02/12/25 "FCS" identified R6 was marked at risk for falls. The 02/12/25 "NSA" failed to describe services R6 received to prevent injury from falls. The 02/12/25 "Fall Risk Data Collection Tool" documented R6 scored 9.0 which was low risk for falls. On 02/24/25 at 11:36 AM Administrative Nurse B confirmed R6's "NSA" failed to describe the services she received for falls. The administrator failed to ensure the "NSA" for R6 described the services she received for falls. The 07/06/23 facility's "Negotiated Service Agreement" policy documented the "NSA" was based on the resident's "FCS," service needs, and preferences and would contain a description of the services the resident would receive. The administrator failed to ensure the "NSA's for R3, R4, and R6 described the services they	S3085		

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S3085	Continued From page 3 received based on their "FCS's" for falls.	S3085		
S3155 SS=E	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 reported a census of 67 residents with six residents included in the sample. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse included descriptions of bed assist devices, their purpose, and instructions for their use and monitoring in the "Negotiated Service Agreements" for Residents (R) 3, R7, and R8. Findings included: - Record review for R3 revealed an admission date of 06/25/24 with diagnoses of mild cognitive impairment and polyosteroarthritis. The 01/29/25 "Functional Capacity Screen" (FCS) identified R3 was independent with	S3155		

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S3155	Continued From page 4	S3155		

transfers.

The 01/29/25 "Negotiated Service Agreement" (NSA) identified R3 was independent with transfers. The "NSA" lacked a description of a bed assist device, its purpose, and instructions for its use and monitoring.

The 02/20/25 "Resident Roster" provided during the survey documented R3 was one of six residents marked for use of bed assist devices.

On 02/24/25 at 11:06 AM Administrative Nurse B confirmed R3 had a bed assist device attached to her bed. She stated the bed assist device was in place because most of R3's falls happened when she transferred in or out of bed.

Observation on 02/24/25 at approximately 11:52 AM revealed a bed assist device attached to the side of R3's bed fit tight against the mattress with no gaps greater than 4.75 inches.

The administrator failed to ensure a licensed nurse included a description of a bed assist device, its purpose, and instructions for its use and monitoring in R3's "NSA."

- Record review for R7 revealed an admission date of 10/15/21 with diagnoses of cognitive communication deficit and type two diabetes mellitus.

The 02/11/25 "FCS" identified R7 was independent with transfers.

The 02/11/25 "NSA" identified R7 was independent with transfers. The "NSA" lacked a

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S3155	Continued From page 5 description of a bed assist device, its purpose, and instructions for its use and monitoring. The 02/20/25 "Resident Roster" provided during the survey documented R7 was one of six residents marked for use of bed assist devices. On 02/24/25 at 10:53 AM Administrative Nurse B confirmed R7 had a bed assist device and "NSA" lacked a description of a bed assist device, its purpose, and instructions for its use and monitoring. Observation on 02/24/25 at approximately 12:18 PM revealed a bed assist device attached to the left side of R7's bed covered with a mesh cover and had no gaps greater than 4.75 inches. The administrator failed to ensure a licensed nurse included a description of a bed assist device, its purpose, and instructions for its use and monitoring in R7's "NSA." - Record review for R8 revealed an admission date of 09/05/24 with diagnoses of hypertension and restless leg syndrome. The 09/05/24 "FCS" identified R8 was independent with transfers and required supervision for walking/mobility and used a wheelchair mobility device. The 09/05/24 "NSA" identified R8 was independent with transfers and walking/mobility. The "NSA" lacked a description of a bed assist device, its purpose, and instructions for its use and monitoring.	S3155		

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S3155	Continued From page 6 The 02/20/25 "Resident Roster" provided during the survey documented R8 was one of six residents marked for use of bed assist devices. On 02/24/25 at 10:53 AM Administrative Nurse B confirmed R7 had a bed assist device and "NSA" lacked a description of a bed assist device, its purpose, and instructions for its use and monitoring. The administrator failed to ensure a licensed nurse included a description of a bed assist device, its purpose, and instructions for its use and monitoring in R8's "NSA." On 02/24/25 at 10:53 AM Administrative Nurse B stated R3, R7, and R8 used their bed assist devices "mostly to get in and out of bed." On 02/24/25 at 01:40 PM Administrative Staff A stated the facility did not have a bed assist device policy. The administrator failed to ensure a licensed nurse included descriptions of bed assist devices, their purpose, and instructions for their use and monitoring in the "NSA's" for R3, R7, and R8.	S3155		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.	S3171		

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S3171	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility reported a census of 67 residents with six residents included in the sample. Based on observation, interview, and record review the administrator failed to ensure designated staff completed assessments for Residents (R) 3, R7, and R8 to confirm their bed assist devices were not a restraint, to determine the purposes of the bed assist devices, to assess the residents' ability to use the bed assist devices safely, that the bed assist devices were securely attached to the bed or bedframe, and they posed no risk for entrapment. Findings included: - Record review for R3 revealed an admission date of 06/25/24 with diagnoses of mild cognitive impairment and polyosteroarthritis. The 01/29/25 "Functional Capacity Screen" (FCS) identified R3 was independent with transfers. The 01/29/25 "Negotiated Service Agreement" (NSA) identified R3 was independent with transfers. The 02/20/25 "Resident Roster" provided during the survey documented R3 was one of six residents marked for use of bed assist devices. On 02/24/25 at 11:06 AM Administrative Nurse B confirmed R3 used a bed assist device attached to her bed. She stated the bed assist device was	S3171		

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S3171	Continued From page 8 in place because most of R3's falls happened when she transferred in or out of bed. Observation on 02/24/25 at approximately 11:52 AM revealed a bed assist device attached to the side of R3's bed fit tight against the mattress with no gaps greater than 4.75 inches. The administrator failed to ensure designated staff completed a bed device assessment for R3. - Record review for R7 revealed an admission date of 10/15/21 with diagnoses of cognitive communication deficit and type two diabetes mellitus. The 02/11/25 "FCS" identified R7 was independent with transfers. The 02/11/25 "NSA" identified R7 was independent with transfers. The 02/20/25 "Resident Roster" provided during the survey documented R7 was one of six residents marked for use of bed assist devices. On 02/24/25 at 10:53 AM Administrative Nurse B confirmed R7 used a bed assist device and cofirmed an assessment was not completed. Observation on 02/24/25 at approximately 12:18 PM revealed a bed assist device attached to the left side of R7's bed covered with a mesh cover and had no gaps greater than 4.75 inches. The administrator failed to ensure designated staff completed a bed device assessment for R7.	S3171		

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S3171	Continued From page 9 - Record review for R8 revealed an admission date of 09/05/24 with diagnoses of hypertension and restless leg syndrome. The 09/05/24 "FCS" identified R8 was independent with transfers and required supervision for walking/mobility and used a wheelchair mobility device. The 09/05/24 "NSA" identified R8 was independent with transfers and walking mobility. The 02/20/25 "Resident Roster" provided during the survey documented R8 was one of six residents marked for use of bed assist devices. On 02/24/25 at 10:53 AM Administrative Nurse B confirmed R8 used a bed assist device and cofirmed an assessment was not completed. The administrator failed to ensure designated staff completed a bed device assessment for R8. On 02/24/25 at 01:40 PM Administrative Staff A stated the facility did not have a bed assist device policy. The administrator failed to ensure designated staff completed assessments for R3, R7, and R8 to confirm their bed assist devices were not a restraint, to determine the purposes of the bed assist devices, to assess the residents' ability to use the bed assist devices safely, that the bed assist devices were securely attached to the bed or bedframe, and they posed no risk for entrapment.	S3171		