

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/20/2026
NAME OF PROVIDER OR SUPPLIER ANTIOCH VALLEY SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12700 ANTIOCH ROAD OVERLAND PARK, KS 66213		
(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 represents the findings of a resurvey with attached complaints 199452, 199005, 198736, 198263, 198255, 198148, 198076, 198078, 197777, 197300, 197265, 195958, 194675, and 194161 at the above named assisted living conducted on 08/17/26, 08/18/26, 08/19/26, 08/20/26.	S 000		
S3026 SS=G	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 83 residents with six residents included in the sample. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 9 was secured in her wheelchair during an outing in the facility's bus. This failure resulted in actual harm when R9 fell forward from her seat during an abrupt stop and suffered a fractured clavicle (collarbone). Findings included: - Record review for R9 revealed an admission	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3026	Continued From page 1 date of 08/15/25 with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and unsteadiness on feet. The 03/06/26 "Functional Capacity Screen" (FCS) identified R9 required physical assistance with bathing, dressing, toileting, and transfers. She was at risk for falls, had impaired decision-making, and required supervision for transportation. The 03/11/26 "Negotiated Service Agreement" identified R9 received assistance from facility staff for bathing, dressing, toileting, and transfers. She received assistance from facility staff to keep the area around her recliner and/or lift chair free of clutter and fall hazards, ensure her emergency call device was within reach, staff reminders to call for assistance when needed, increase lighting to prevent falls, and she would wear a seat belt while using her motorized wheelchair. R9 was independent with transportation or her family or an outside caregiver provided transportation. The 10/23/25 at 02:30 PM "Health Status" progress note documented R9 had a fall during a facility outing. Upon nursing assessment, R9 complained of pain when she lifted her left arm and the pain increased upon palpation (touching) of her left shoulder. The nurse recommended for R9 to be sent to the emergency department. The 10/23/25 at 07:12 PM "Health Status" progress note documented R9 admitted to the local hospital for fracture of her left clavicle. The 10/31/25 facility's "Investigation" documented R9 participated in a facility bus outing on 10/23/25. During the drive, R9 fell forward from	S3026		

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S3026	Continued From page 2 her seat when the bus driver had to apply the bus brakes firmly. R9's shoulder hit the seat in front of her and her wrist began to bleed from a small skin tear. R9 refused emergency medical transport and expressed her wish to continue the outing. Staff later confirmed the wheelchair brakes were properly secured but R9's seatbelt was not fastened before the incident. On 08/19/26 at 02:03 PM, Administrative Nurse C stated the staff member driving the facility bus received education after the incident to ensure residents were secured in the bus. There was a policy for staff driving company vehicles, but it did not address transporting residents. On 08/20/26 at 10:28 PM, Administrative Nurse C stated the staff member operating the bus the day of the incident with R9 did not usually drive the bus. The "NSAs" for R9 prior to the incident did not address ensuring her seatbelt was secured when riding in the bus. On 08/20/26 at approximately 11:09 AM, R9 sat in a motorized wheelchair in her apartment. She stated she had an accident during an outing when she fell forward in the facility bus. It was the driver's responsibility to make sure she was buckled but she should have "demanded" they made sure she was secured. She could buckle her own seatbelt if it was within reach. The 09/01/13 facility's "Motor Vehicles" policy did not address transporting residents. The 10/30/25 "Reeducation Memo" documented the driver of a motor vehicle would ensure that all residents were appropriately and safely strapped in prior to operating the vehicle.	S3026			

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S3216	Continued From page 3	S3216		
S3216 SS=D	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-41- 205(i) The facility reported a census of 83 residents with six included in the sample. Based on interview and record review, the facility failed to maintain records of controlled medications for accurate reconciliation. Findings included:	S3216		

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S3216	Continued From page 4 - Review of Resident (R) 3's record revealed an admission date of 04/05/21 with diagnoses of diabetes mellitus and osteoporosis. The 02/13/26 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with management of medications. The 02/18/26 "Negotiated Service Agreement" (NSA) identified R3 received administration of all medications by facility staff. The 06/07/26 "Order Summary Report" documented two active orders for oxycodone (opioid medication) ordered on 04/02/26 as follows: 10 milligrams (mg) one tablet by mouth two times a day for hip pain. 10 mg two tablets by mouth every morning and at bedtime for hip pain. The 06/11/26 facility's "Investigation" documented the following: On 06/07/26 R3 did not have her prescribed oxycodone available for administration and the narcotic count sheet associated with R3's oxycodone could not be located. 180 oxycodone 10 mg tablets were delivered to the facility on 05/14/26. Audits of all medication carts and medication storage areas and review of all available narcotic documentation including R3's medication administration record (MAR) revealed approximately 40 oxycodone tablets and their associated narcotic count sheets were unaccounted for.	S3216		

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S3216	Continued From page 5 On 08/19/26 at approximately 12:54 PM Administrative Nurse C confirmed some of R3's oxycodone tablets and their associated count sheets went missing. The revised 01/2024 facility's "Abuse, Prevention and Prohibition Policy" documented the facility prohibited misappropriation of residents' property. The facility failed to maintain records of controlled medications for accurate reconciliation.	S3216			
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3)	S3280			

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S3280	Continued From page 6 The facility reported a census of 83 residents. Based on interview and record review, the facility failed to provide evidence of documentation that residents and staff received routine quarterly reviews of the facility's emergency management plan. Findings included: - Review of the facility's emergency management plan lacked evidence of documentation residents and staff received quarterly reviews for the second, third, and fourth quarters of 2025. On 08/20/26 at approximately 04:48 PM, Administrative Staff A confirmed in an email the facility lacked documentation that residents and staff received for the second, third, and fourth quarters of 2025. On 08/20/26 at 11:27 AM, an emergency management plan policy was requested which the facility failed to provide. The facility failed to provide evidence of documentation that residents and staff received quarterly reviews of the facility's emergency management plan.	S3280		