

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2026
NAME OF PROVIDER OR SUPPLIER AVENTURA AT OVERLAND PARK, MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5951 W 107TH STREET OVERLAND PARK, KS 66207		
(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 complaint survey regarding allegations in the following complaints: 199672, 199653, and 199615 conducted on 09/03/26. The facility reported a census of 24 residents. The sample included 3 residents.	S 000		
S3026 SS=J	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) Based on interview and record review, the facility failed to protect Resident (R) 1 and other residents in the facility from neglect and implement interventions to avoid physical harm when R1's "Functional Capacity Screen" (FCS) and "Negotiated Service Agreement" (NSA) did not accurately reflect that the resident had inappropriate behaviors. On 08/18/26 R1, who had known behaviors directed toward other residents, shoved another resident to the ground and caused a laceration to their forehead. This placed R1 and the resident's of the facility in Immediate Jeopardy.	S3026		

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

TITLE

(X6) DATE

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2026
NAME OF PROVIDER OR SUPPLIER AVENTURA AT OVERLAND PARK, MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5951 W 107TH STREET OVERLAND PARK, KS 66207		
(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
S3026	Continued From page 1 Findings included: - Record review for R1 revealed an admission date of 11/26/25 with a diagnosis of dementia. - The 06/03/26 FCS documented R1 was independent with toileting, transferring, and walking/mobility. R1 had impaired short-term and long-term memory, impaired memory/recall, impaired decision-making, and was marked as a fall risk. - The FCS lacked identification the resident was at risk for inappropriate behaviors. - The 02/23/26 NSA identified R1 ambulated independently without an assistive device and staff were to keep her apartment free of clutter, ensure proper lighting, and to encourage the use of proper footwear. - The NSA lacked documentation of staff instructions for inappropriate behaviors. - The 02/23/26 at 09:27 PM "Progress Notes" by Certified Medication Aide (CMA) C documented R1 grabbed another resident's arm and bent her thumb back. - The 03/04/26 at 09:26 PM "Progress Notes" by CMA D documented R1 and R4 were witnessed slapping each other and arguing over a jacket. - The 08/18/26 at 10:14 PM "Progress Notes" by CMA C documented the resident was seen yelling at a resident, who was on the ground. Another resident reported R1 had pushed the resident down, which caused a laceration to the resident's forehead.	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2026
NAME OF PROVIDER OR SUPPLIER AVENTURA AT OVERLAND PARK, MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5951 W 107TH STREET OVERLAND PARK, KS 66207		
(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
S3026	Continued From page 2 The facility's investigation of the incident dated 08/18/26 revealed R1 admitted the resident came into her room and she pushed her out. During an interview on 09/03/26 at 03:00 PM with Administrative Staff B confirmed R1's FCS lacked documentation of the resident having inappropriate behaviors. Administrative Staff B continued to confirm R1's NSA lacked instructions on what staff were to do to prevent R1's inappropriate behaviors, which allowed R1 to harm another resident. The facility's "Resident Care Events/Incident Reporting & Investigation" policy documented after the incident investigation and short-term observation monitoring are finalized and the resident has either, returned to baseline or reached a new baseline; the director of nursing shall update the resident's care plan with the interventions identified during the investigation. The Immediate Jeopardy was removed on 09/03/26 when the following actions documented by the facility's Removal Plan were implemented and accepted by the department on 09/04/26 at 10:59 AM. 1) R1's FCS and NSA were updated to reflect the resident's behavior toward other residents, all interventions were put into place and the staff were informed of the changes through Care Stream. 2) By the end of the business day on 09/04/26 all resident- to- resident incidents were reviewed and updates to the FCS and NSA would reflect findings based on their review. 3) Incidents will be reviewed by the Director of Nursing/ Executive Director or appointee Monday	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/03/2026
NAME OF PROVIDER OR SUPPLIER AVENTURA AT OVERLAND PARK, MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5951 W 107TH STREET OVERLAND PARK, KS 66207		
(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	
S3026	Continued From page 3 through Friday to ensure the FCS and NSA of any/all residents are updated accordingly.	S3026			