STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175340	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens at Aldersgate	3220 SW Albright Drive Topeka, KS 66614

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39752 The facility identified a census of 160 residents. The sample included three residents with three residents reviewed for dementia (a progressive mental disorder characterized by failing memory and confusion) care. Based on observation, record review, and interview the facility failed to develop an individualized dementia treatment plan to address Resident (R)1's dementia-related behaviors to promote his highest practicable quality of life and well-being. This placed R1 at risk for impaired psychosocial well-being and impaired quality of life. Findings included: - R1's Electronic Medical Record (EMR) documented, under the Diagnosis tab, the following diagnoses: metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), Parkinsonism (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), restlessness, and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. R1 displayed no behaviors or mood concerns. R1 required substantial to maximum assistance with toileting, showering or bathing, and bed mobility. R1 was dependent on staff for transfers, personal hygiene, and wheelchair mobility. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/10/24 documented R1 had impaired cognitive function or impaired thought processes related to dementia. The Functional Abilities: Self-Care and Mobility CAA dated 12/10/24 documented R1 went to the emergency department for delirium (sudden severe confusion, disorientation, and restlessness) and increased weakness. R1's mobility was via wheelchair, and he was dependent on assistance with activities of daily living (ADL). R1's hospital documentation indicated he exhibited agitation and hallucinations (sensing things while awake that appear to be real, but the mind created). The Psychotropic CAA dated 12/10/24 documented R1 admitted from the hospital with agitation and hallucinations, but the hospital was unsure if this was related to R1's advancing Parkinson's disease or dementia. (continued on next page)

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

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Dementia Care Plan initiated on 12/05/24 directed staff to provide R1 with activities to keep R1 engaged throughout the day. R1's Memory Care Unit Care Plan initiated on 12/05/25 recorded R1 wandering within the secured unit regularly and R1 was an elopement risk related to poor safety judgment. R1's intervention initiated on 12/09/24 directed staff to visualize his whereabouts frequently. R1's Care Plan lacked any further information related to R1's dementia care or observed behaviors. The Skilled Note dated 12/15/24 at 01:28 PM documented R1 had exceptions with behaviors. R1 displayed disruptive behaviors and wandered. The skilled note lacked a description of what behaviors R1 had and what staff did in response to the behaviors and to prevent further episodes. The Skilled Note dated 12/16/24 at 04:25 AM documented R1 had exceptions with behaviors. R1 displayed disruptive behaviors and wandered. The skilled note lacked a description of what behaviors R1 had and what staff did in response to the behaviors and to prevent further episodes. The Behavior Note dated 12/16/24 at 05:07 AM documented R1 wandered into an unidentified resident's room at least once during that shift. R1 was redirected once without any further wandering that night. The Skilled Note dated 12/16/24 at 01:28 PM documented R1 had exceptions with behaviors. R1 had anxiety, and agitation, and displayed disruptive behaviors. R1 was agitated and or irritable. The skilled note lacked a description of what behaviors R1 had and what staff did in response to the behaviors and to prevent further episodes. The Skilled Note dated 12/18/24 at 03:17 AM documented R1 had exceptions with mood and behaviors. R1 was anxious, agitated, and displayed disruptive behaviors. R1 was agitated and or irritable. The skilled note lacked a description of what behaviors R1 had and what staff did in response to the behaviors and to prevent further episodes. The Skilled Note dated 12/18/24 at 11:38 AM documented R1 had exceptions with mood. R1 was anxious, had a flat affect, displayed disruptive behaviors, and had wandering behaviors. The skilled note lacked a description of what behaviors R1 had and what staff did in response to the behaviors and to prevent further episodes. The Behavior Note dated 12/18/24 at 02:44 PM documented R1 was observed in R2's room going through R2's things. R2 was unable to move from her bed and R1's actions made R2 uncomfortable. R1 was redirected multiple times from going into other resident rooms. The Skilled Note dated 12/19/24 at 03:13 AM documented R1 had exceptions with behaviors and was agitated and/or irritable. The skilled note lacked a description of what behaviors R1 had and what staff did in response to the behaviors and to prevent further episodes. The Skilled Note dated 12/19/24 at 01:37 PM documented R1 had exceptions with mood and was anxious. R1 had a flat affect and hallucinated. The skilled note lacked a description of what behaviors R1 had and what staff did in response to the behaviors and to prevent further episodes. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Skilled Note dated 12/20/24 at 01:48 PM documented R1 had exceptions with mood and behaviors and was anxious and hallucinated. The skilled note lacked a description of what behaviors R1 had and what staff did in response to the behaviors and to prevent further episodes. The Incident Note dated 12/21/24 at 04:58 PM documented R1 was found in the living room with his hand up R3's shirt. R1 was placed on one-to-one until further notice. On 12/31/24 at 02:55 PM, R1 sat in his wheelchair, clean and freshly shaven at the nurse's station. R1 reported that he was having a good day and he planned to stay busy. On 12/31/24 at 01:11 PM, Licensed Nurse (LN) G stated that the staff knew about R1 wandering and she had not told management about the event in R2's room on 12/18/24. LN G stated it was a busy day that day. LN G stated that the staff was aware of what the residents needed for care from the report that was given by the off-going staff each shift. On 12/31/24 at 01:18 PM, Certified Nurse Aide (CNA) M stated that she had answered R2's light and then proceeded to the front desk to help take a new admission to his room. When CNA M walked back by R2's room she saw R1 seated in his wheelchair, briefs, and clothes in his hand and the other hand was trying to pull up R2's dress. CNA M asked R1 what he was doing, to which R1 replied trying to change R2. CNA M stated she got R1 out of the room and took him up to the dining room so that CNA M could see him. CNA M also told LN G about the event and attempted to tell Social Services, but Social Services was out that day. CNA M stated that R1 would go in and out of different residents ' rooms and this was not a new behavior for him. CNA M stated that staff would redirect R1 and R1 was usually good about leaving the resident's rooms. CNA M stated R1 liked to roam into different rooms, especially when the residents were eating. On 12/31/24 at 02:53 PM, CNA M stated R2 seemed scared when R1 was in there. CNA M also revealed that R1 had previously [NAME] loudly in other residents' faces at mealtimes and R2 was one of those residents and R2 did not like that. CNA M stated staff would inform R1 that residents did not like it and attempt to redirect him, but R1 would continue to do it. On 12/31/24 at 03:00 PM, Administrative Nurse D stated that she expected staff to address resident behaviors and that the floor nurses as well as administrative staff could update the care plans. The facility's undated Dementia Care policy documented it was the facility's policy to provide the appropriate treatment and services to every resident who displayed signs of or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. The policy documented the facility would assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that included the resident, their family, and or resident representative, to the extent possible. The care plan goals would be achievable, and the facility would provide the resources necessary for the resident to be successful in meeting their goals. The care plan interventions would be related to each resident's symptomology and rate of dementia progression with the result being noted improvement or maintenance of the expected stable rate of decline associated with dementia. The policy directed that care plan goals and interventions would be monitored on an ongoing basis for effectiveness and would be reviewed and revised as necessary. (continued on next page)

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