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	06/29/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on observation, record review, and interview, the facility failed to ensure residents remained free from abuse when Resident (R) 1 and R2's medications were misappropriated. Findings included:- The facility's investigation report 3047869 dated 06/17/2026 documented on 06/17/2026 around 11:15 AM, Administrative Staff B was notified by Licensed Nurse (LN) K that R1's clonazepam (antianxiety medication a class of medications that calm and relax people) 0.5 milligrams (mg) had extra dose signed for on the narcotic sheet; the extra does were not on his scheduled times. The extra nonordered doses were signed for on 06/03/2026, 06/04/2026, 06/05/2026, 06/08/2026, 06/09/2026, 06/10/2026, 06/11/2026, 06/12/2026, 06/15/2026, and 06/16/2026. The investigation further documented R2 also had extra doses of narcotics signed out, clonazepam 0.5 mg on 06/11/2026, and oxycodone (schedule II opioid pain medication with high use for misuse or addiction) 5mg on 06/11/2026, 06/15/2026, and 06/16/2026. The investigation documented Certified Medication Aide (CMA) R was the CMA that signed out these medications. The facility obtained a witness statement from CMA R. CMA R was immediately suspended pending the investigation. The investigation further revealed the facility would replace all the missing medication for R1 and R2, and a psychosocial follow-up would be done by the social worker for R1 and R2. The durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) and the physician were notified for R1 and R2. Administrative Nurse D stated law enforcement was notified. Administrative Nurse D stated the following residents were affected by misappropriation:R1's clonazepam 0.5mg-10 tablets,R2's clonazepam 0.5mg-one tablet, oxycodone 5mg-three tablets. On 06/29/2026 at 10:29 AM, LN G working on Elmhurst Unit stated the nurse or CMA coming on shift and the nurses or CMA going off shift count together and sign the narcotic count sheet. LN G stated the narcotic count sheets should be filled out at the end of each shift. LN G stated the CMA or nurse signs for the medication on the narcotic count sheet, and signs for the medication in Medication Administration Record (MAR). She stated the pharmacy would catch a discrepancy if the medication was ordered too soon. LN G stated she had not had training for the six rights of medication administration, since she started in 02/2026. LN G stated she would notify the unit manager or the director of nursing as soon as she found a discrepancy in the medication count.On 06/29/2026 at 11:50 AM, LN I stated nurses were to count each narcotic card. She stated nurses or CMA sign the narcotic sheet when the nurse comes on shift and signed the narcotic sheet when the nurse leaves her shift. She stated she had not had any training on the six rights of medication pass. LNI stated she did not work for the facility, she stated she was agency and had not had any training from the facility since she had worked at this facility. LN I stated she works at the facility often.On 06/29/2026 at 12:00 PM, Administrative Staff B stated the facility had not done any training with the agency nurses at this time. She stated the facility had put a packet together and was sending the packet to the agency's the facility uses. Administrative Staff B stated the nurse would have to read and sign the packet before working in the facility. Administrative Staff B stated most of the nurses and CMAs had finished the training for the six rights of medication pass.The facility's Abuse, Neglect and Exploitation policy, undated, The Facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in this policy. This includes, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This policy applies to all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (Associates).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interviews, the facility failed to ensure adequate narcotic reconciliation when nursing staff failed to sign-off and sign-on each shift on the Narcotic Shift Sheet on two of three units reviewed.Findings included:- On 06/29/2026 at 10:00 AM, on the Mulvane unit's medication cart in the narcotic count book, the Narcotic Shift Sign-in/Sign-off Sheet from 05/26/2026 to 06/28/2026 revealed that on 52 of 152 opportunities, nursing staff failed to sign-off or sign-on each shift. On 06/29/2026 at 10:15 AM, on the Elmhurst unit's medication cart in the narcotic count book, the Narcotic Shift Sign-in/Sign-off Sheet from 06/03/2026 to 06/28/2026 revealed on 56 of 152 opportunities nursing staff failed to sign-off or sign-on each shift. On 06/29/2026 at 10:15 AM, on the Elmhurst as needed (PRN) nurse units' medication cart in the narcotic count book the Narcotic Shift Sign-in/Sign-off Sheet from 05/31/2026 to 06/29/2026 revealed on 32 of 152 opportunities, nursing staff failed to sign-off or sign-on each shift. On 06/29/2026 at 10:29 AM, Licensed Nurse (LN) G stated nursing staff count all narcotic cards. She stated the nurse coming on and the nurse or certified medication aide (CMA) going off shift count together and sign the narcotic count sheet. She stated there was no way of ensuring a staff member was not taking medications and not giving the medication to the residents. LN G stated the CMA or nurse signs for the medication on the narcotic count and signs for the medication in Medication Administration Record (MAR) in the Electronic Medical Record (EMR). She stated the pharmacy would catch a discrepancy if the medication was ordered too soon. LN G stated she had not had training since she started in 02/2026. LN G stated she would notify the unit nurse or the director of nursing as soon as she found a discrepancy in the medication count.On 06/29/2026 at 11:35 AM, LN H stated each nurse going off shift and the nurse coming on shift count the narcotics. She stated each card was counted with the correct pill count.On 06/29/2026 at 11:50 AM, LN I stated nurses were to count each narcotic card. She stated nurses or med aides sign the narcotic sheet when the nurse comes on shift and signs the narcotic sheet when the nurse leaves her shift.On 06/29/2026 at 01:47 PM, Administrative Nurse D stated the expectation was the narcotic cards were counted every shift by the nurse coming on shift, and the nurse going off shift. She stated the Unit Manager was to spot check the count sheets daily and check the narcotic box daily.The facilities Controlled Substance Administration & Accountability policy dated 01/01/2020 documented the charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify medications removed from either the automated dispensing system or medication cart/cabinet have a documented physician order. An inventory count was prompted by the system each time a controlled drug or narcotic access key was used. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to ensure that medications were stored safely and securely as required. Findings included:- On 06/29/2069 at 11:35 AM, on the Mulvane Unit, the keys to the medication cart were placed in the Narcotic Count Sheet white three ring binder. The keys for the medication cart were not secured. The treatment cart in the same area was unlocked. The treatment cart contained prescription creams and dressings.On 06/29/2026 at 11:37 AM, Licensed Nurse (LN) H stated the keys were left in the narcotic count binder due to there being two LN's on the medication cart. She stated the treatment cart should be locked if the treatment cart was not in the view of nursing staff. LN H stated medication cart keys should always be on the nurse and should not be left on the medication cart.On 06/29/2026 at 01:47 PM, Administrative Nurse D stated the expectation was medication cart keys were to always be on the nurse or Certified Medication Aide (CMA). She stated carts should always be locked.The facility's Medication Storage policy dated 01/01/2020 documented it was the policy of this facility to ensure all medications housed on the premises would be stored in the medication carts or medication rooms to ensure proper security. Narcotics and controlled substances are stored under double-lock and key. Only authorized personnel have access to medication storage areas.