| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175340 | A. Building<br>B. Wing | 01/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Gardens at Aldersgate | 3220 SW Albright Drive<br>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.

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|---|---|
| F 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure residents have reasonable access to and privacy in their use of communication methods.<br><br>The facility had a census of 161 residents. The sample included 34 residents. Based on the record review and interview, the facility failed to consistently deliver residents' mail on Saturdays.Findings included:- On 01/06/25 at 11:00 AM, during the resident council meeting, Resident (R) 141 stated the facility did not deliver residents' mail on Saturdays.01/07/25 at 08:00 AM, Administrative Staff B stated she was responsible for delivering mail to residents. She sorts out the mail for each unit and delivered it to the unit manager during the week; if they were busy, she delivered it to the residents. Administrative Staff B stated the residents' mail did not get delivered consistently on Saturdays unless she happened to come in.On 01/07/25 at 12:50 PM, Administrative Nurse D stated that the admission receptionist should deliver residents' mail during the week, and the unit nurse manager should deliver it on Saturday.The facility's Communications Within and External to the Facility Policy, implemented 03/04/25, documented the facility would ensure the resident had the ability to send and receive mail, letters, packages, and other materials delivered to the facility for the resident through a means other than a postal service. |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>The facility identified a census of 161 residents. The facility had one main kitchen and six kitchenette areas. Based on observation, record review, and interview, the facility failed to ensure food was properly labeled and stored in refrigerated areas. The facility failed to ensure the kitchenette areas and refrigerators were clean. Findings included:- On 01/05/26 at 07:05 AM, during the initial tour of the main kitchen area, an observation in the walk-in refrigerator, it was noted that a plastic vat container sat on a cart with what looked like prepared tuna salad. The container lacked any labeling, dates, or a cover. There was a scoop present in the container. The walk-in refrigerator had a clear container with a lid on it that was not labeled or dated, which contained what looked like prepared salsa. A refrigerator used for food prep and serving items contained an unlabeled, undated, and uncovered metal storage container that contained what looked like solidified grease. On 01/05/26 at 07:08 AM, the 400-hall dining room kitchenette had a black side-by-side refrigerator/freezer, that had a yellowish stain approximately three inches by three inches in the bottom drawer. Underneath the bottom shelf glass had numerous different-sized red dried stains. The refrigerator kick plate was off and lying on the floor in front of the refrigerator and had numerous different sizes of grayish fuzzy substances on it. The refrigerator contained eight (4 fluid ounce) undated vanilla Mighty Shakes. In the cabinet of the kitchenette was an open 27.1-ounce box of Raisin Bran; the plastic was not sealed in the box. On 01/05/26 at 09:11 AM, the refrigerator on the Mulvane Unit had eight frozen hamburger patties in the ice tray of the freezer. The hamburger patties were not dated, labeled, or in a sealed package. On 01/05/26 at 07:15 AM, Licensed Nurse (LN) I stated that kitchen staff were responsible for the cleaning, labeling, and dating of food items in the refrigerator in the kitchenette on the 400 hall. On 01/05/26 at 07:20 AM, Dietary CC stated that all items in any storage area of the kitchens should have a label, be dated, and have an expiration date if applicable, and be covered either with a lid or in a sealed bag. Dietary CC stated that dietary staff were also responsible for the cleaning of items in the kitchenette areas. Dietary CC stated staff would put the grease used from cooking in a metal container to cool in the refrigerator and then would dispose of it daily. On 01/07/26 at 10:30 AM, Dietary BB stated that kitchen staff were responsible for labeling, dating, and ensuring all items in the kitchen and kitchenette area were covered or in a sealed container. Dietary BB stated some of the dining areas on each hall did have refrigerators just for the residents' personal food items, but those all should be labeled with the residents' names. The undated facility's Food Storage (Dry, Refrigerated, and Frozen) policy documented food shall be stored on shelves in a clean, dry area free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. All food items would be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. Leftover contents of cans and prepared food would be stored in covered, labeled and dated contains in refrigerators and/or freezers. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>The facility identified a census of 161 residents. The facility identified 34 residents on Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP and personal protective equipment (PPE) for Resident (R) 113. The facility additionally failed to store R11, R63, R14, R104, R43, and R9's respiratory equipment in a sanitary manner. The facility further failed to ensure linen carts were transported in a sanitary manner. The facility further failed to ensure a process was put in place for water management for Legionella disease (Legionella is a bacterium that can cause pneumonia in vulnerable populations).Findings Included:- On 01/05/26 at 07:05 AM, a walkthrough of the facility was completed. An inspection of R113's room revealed no EBP indicator signage or personal protective equipment in or around the room related to his suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder).On 01/05/26 at 07:30 AM, an inspection of the Elmhurst Unit revealed uncovered clean linen carts next to utility closets 413 and 441 with no protective barrier for the linen. On 01/05/26 at 09:26 AM, R11's nasal cannula laid directly in the trash can and tubing connected to oxygen concentrator.On 01/05/26 at 09:38 AM, R63's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) and her nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) laid directly on her bedside table, unbagged.On 01/05/26 at 09:44 AM, R14's CPAP device laid directly on her bedside table.On 01/05/26 at 09:51 AM, R104's nasal cannula and oxygen tubing was wrapped around the handles of the wheelchair.On 01/06/26 at 09:50 AM, R43's nebulizer laid directly on the seat of his walker.On 01/06/26 at 10:12 AM, R9's CPAP laid on his bedside table. R9's CPAP mask was not contained in a sanitary manner.On 01/06/26 at 02:25 PM, R9's CPAP laid on his bedside table. R9's CPAP mask was not contained in a sanitary manner. On 01/07/26 at 08:22 AM, Certified Nurse's Aide (CNA) Q stated all oxygen tubing and equipment should be in the resident's drawer, or in a bag. CNA Q stated all rooms have signs and PPE for each resident on EBP. She stated staff follow the signs as to what PPE to wear when taking care of residents. CNA Q stated she does not do anything with laundry.On 01/07/26 at 09:45 AM, Licensed Nurse (LN) L stated any resident with open wounds or stoma (surgical opening), or catheters should be on EBP. She stated signs should be posted outside the rooms, and PPE made available during care. She stated linens should be covered when distributing. LN L stated CPAP tubing should be cleaned and placed on the bedside table, and the machines could be placed in a drawer.On 01/07/26 at 12:55 PM, Administrative Nurse D stated EBP signage should be placed outside of each room, each time a resident was admitted , and that the resident required EBP. Administrative Nurse D stated the signage would be done by the nurse in charge; she stated the unit nurses could check to ensure the signage was in place. Administrative Nurse D stated respiratory equipment not in use should be stored in a sanitary bag.On 01/06/26 at 08:57 AM, Maintenance Supervisor U stated the facility had a process in place for Legionella a couple of years ago. He stated the facility was unable to find the documentation upon request. Maintenance Supervisor U stated the facility did not have a process to track Legionella at this time.The facility's Handling Clean Laundry policy, dated 03/04/25, documented it was the policy of the facility to handle, store, process, and transport clean linen in a safe and sanitary manner to prevent contamination that could lead to infection.The facility's Legionella Surveillance policy, dated 11/01/19, documented surveillance was one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems.The facility's Enhanced Barrier Precautions policy, dated 06/14/23, documented it was the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.The facility's Infection Prevention and Control Program policy, dated<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 10/23/23, documented the facility had established and maintained an infection prevention program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.The facility's ?Oxygen policy, dated 03/04/25, documented oxygen was administered to residents who needed it consistent with professional standards of practice, the comprehensive person-centered care plans, the residents' goals and preferences. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 161 residents. The sample included 34, with four reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure potentially hazardous cleaning chemicals in a safe, locked area and out of reach of 16 cognitively impaired, independently mobile residents. The facility additionally failed to ensure Resident (R) 50's specialized call light was in place after her room transfer, resulting in a non-injury fall. Findings Included: - On 01/05/26 at 07:10 AM, a walkthrough of the facility revealed an unlocked rehab therapy room. An inspection of the therapy room revealed an unsecured closet with a hydrocollator (a heating device that uses water baths to heat up hot pads) in the room and turned on. An inspection of the closet door revealed the lock was broken and did not work. At 07:15 AM, Consultant GG entered the rehab room and verified the lock did not function. He stated the lock had been broken for a while. On 01/07/26 at 07:40 AM, a walkthrough of the Transitional Care revealed an unsecured exterior door propped open about five inches with a weighted dumbbell. No staff or residents were in the halls or outside area while the door was observed open. The exterior door led to an open field area. The door alarm had been turned off by staff when the door was opened for a resident. Staff conducted a resident head count with all the residents located.On 01/07/26 at 07:48 AM, Administrative Staff A was notified and shown the unsecured door. She removed the dumbbell and closed the door. She stated the door was not to be propped open and had an alarm. She stated staff may have propped it open to escort a resident outside and forgot to ensure it was closed. She stated the door required a code to open. On 01/07/26 at 10:35 AM, Certified Nurse's Aide (CNA) M stated the exterior doors and exit doors were to always be locked. On 01/07/26 at 12:43 PM, Administrative Nurse D stated the exterior doors were supposed to be locked, and staff were never to prop them open. She stated residents were not to have unsupervised access to the rehab room, and the hydrocollator should be locked.The facility's Accident and Supervision policy, revised 02/2020, indicated the facility will provide an environment that implements adequate supervision, interventions, and assessment to minimize the risks of hazards, accidents, preventable injuries, and falls.- The Medical Diagnosis section within R50's Electronic Medical Records (EMR) included dementia (a progressive mental disorder characterized by failing memory and confusion), chronic kidney disease, and major depressive disorder (major mood disorder). R50's admission Minimum Data Set (MDS) completed 12/02/25 indicated a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. The MDS indicated she had no upper or lower extremity impairments. The MDS noted she required partial to moderate assistance with dressing, transfers, bathing, personal hygiene, and her footwear. The MDS indicated she had no prior fall history.R50's Care Area Assessment (CAA) completed 11/21/25 triggered for falls, indicated she had severe cognitive impairment with short and long-term memory impairments. The MDS noted she required occasional cues (verbal direction) from staff to stay on task. The CAA noted she was at risk for falls and incontinence.R50's Care Plan documented the following interventions:11/21/25- R50 required staff assistance for oral hygiene, toileting, bathing, dressing, personal hygiene, and transfers.11/21/25- R50's plan encourages staff to anticipate her care needs, ensure she wears appropriate footwear, and to ensure her call light remains within her reach.12/07/25- R50's plan noted she was found by staff as she sat on the floor in her room. The plan noted her call light was replaced with a special flat call light.12/15/25- R50's plan noted she was found as she lay on the floor. The plan noted she changed rooms recently, and her special call light was not moved to her new room. The plan noted the special call light was moved to her new room.R50's EMR documented on 01/05/26, she was transferred to an acute medical facility due to ongoing health concerns.On 01/05/26 at 07:12 AM, R50 lay in her bed. Her flat call light rested beside her in bed.On 01/07/26 at 10:11 AM, Certified Nurses [NAME] (CNA) O stated all staff were responsible for ensuring the fall<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | interventions were in place after residents moved rooms. She stated staff were to ensure the rooms were inspected during each encounter.On 01/07/26 at 12:43 PM, Administrative Nurse D stated each shift was to ensure the call lights were within reach and functional every time they entered the rooms.The facility's Accident and Supervision policy, revised 02/2020, indicated the facility would provide an environment that implements adequate supervision, interventions, and assessment to minimize the risks of hazards, accidents, preventable injuries, and falls. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>The facility identified a census of 161 residents. The facility had one main kitchen and six kitchenette areas. Based on observation, record review, and interview, the facility failed to ensure dietary staff had and used the provided recipe to specify instructions on the preparation of pureed foods for nine residents.Findings included:- On 01/06/26 at 09:20 AM, Dietary CC began to prepare the pureed chicken pot pie for the lunch meal. Dietary CC had a clean Robo Coupe machine, container, and lid on the counter. Dietary CC had a metal container that contained the chicken pot pie mixture in it and scooped out 10 servings into the Robo Coupe container. He placed the lid on the container and started the machine. Dietary CC did not have the recipe for the puree diet present.On 01/06/26 at 09:25 AM, Dietary CC stated that the facility normally only added chicken or beef stock or milk to foods they pureed to maintain the flavor. Dietary CC stated the pureed food should be a pudding consistency, and the liquid should not separate from the food. Dietary CC stated normally the menu/recipe binder did have the puree recipe in it and did not know why they were not there for this week's meals.On 01/07/26 at 10:30 AM, Dietary BB stated that normally the cook should be following the recipe for the pureed diets, but had been made aware that those recipes were not in the binder for this week's menus. Dietary BB stated that the recipes were on the lead dietary manager's desk and had not been put into the recipe binder. Dietary BB stated the recipes should be followed to ensure nutritional value and flavor were preserved.The facility's Puree Food Preparation policy (undated) indicated all pureed food would be prepared using standard recipes to maintain quality, flavor, palatability, and maximum nutritive value. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep all essential equipment working safely.<br><br>The facility identified a census of 161 residents. The facility had one main kitchen and six kitchenette areas. Based on observation, record review, and interview, the facility failed to ensure essential kitchen and kitchenette equipment were in proper working condition. Findings included:- Upon the initial tour of the facility's main kitchen on 01/05/26 at 07:08 AM, it was observed that in the dishwashing room, the three-bin dishwashing sink had a dripping faucet for the sanitizing sink bin, and the faucet was not functional to fill the sink with hot water. The support pipes for the three-bin sink had numerous rusted-out areas. The main dishwashing machine had noted dripping hot water from a pipe spigot on the inside of the machine. On 01/05/26 at 07:45 AM, inspection of the 100-hall kitchenette area revealed the ice machine was not working, so dietary staff obtained ice from a portable chest cooler in the kitchenette area. The scoop was stored in a separate container outside of the cooler. On 01/06/26 at 09:05 AM, Dietary DD stated she was working on putting in work orders at this very time for the sanitizer sink faucet and to have someone look at the dishwashing machine leak. Dietary DD stated on 12/31/25, a work order had been placed to fix the ice machine in the 100-Hall. Dietary DD stated they had been using bagged ice and a large portable ice cooler to put ice in to use at mealtimes for the 100-Hall. On 01/07/26 at 10:30 AM, Dietary BB stated she had just been made aware yesterday about the dishwasher issue and the faucet not working for the sanitizer bin for the dishwashing sinks. Dietary BB stated an outside company would have to come look at the dish machine, and the order had been put in for the repair. Dietary BB stated a work order had been placed for the ice machine on 12/29/25 and is awaiting an outside source to come repair it. A policy for essential equipment was requested on 01/07/26, but was not received. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 161 residents. The sample included 34 residents, with three sampled residents reviewed for dignity. Based on observation, record review, and interview, the facility failed to preserve Resident (R) 7's dignity while hospice staff transported him on a shower chair from his room to the shower. The facility failed to ensure R16's dignity while assisting him with dressing, when staff left R16's door open.Findings included:- On 01/06/26 at 07:20 AM, an unidentified hospice staff member pushed R7, whose room was on the Cambridge unit, from his room, seated on a shower chair, down the hallway with a hospital gown tied at the neck. R7's lower extremities, back, and buttocks were exposed as the hospice staff pushed R7 down the hallway. The hospice staff turned R7, seated on the shower chair, around backwards through the double doors that led into the [NAME] Unit. Facility staff Certified Medication Aide (CMA) S, and an unidentified male Certified Nurse Aide (CNA) stood in the hallway and noticed R7 was not completely covered, but did not intervene or stop the hospice staff and R7 to ensure he was completely covered.On 01/06/26 at 07:25 AM, observation revealed Certified Medication Aide (CMA) O knocked on R16's closed room door and entered the room. R16 sat on the bedside in his underwear with the lower back, buttocks, and extremities exposed. Observation revealed CMA O left the room door wide open and assisted the resident in putting on his pants.On 01/07/26 at 07:30 AM, CMA O verified she had left the door open when assisting R16 with putting on his pants. CMA O stated she should have closed the door. On 01/08/26 at 10:15 AM, CMA T stated when a resident was transferred down the hall in a shower chair, the resident should be completely covered so no private areas were visible or exposed during the transfer.On 01/08/26 at 10:17 AM, LN H stated that privacy must be maintained any time a resident was being transferred to the shower and should be appropriately covered with no private areas exposed.On 01/07/26 at 12:50 PM, Administrative Nurse D stated she would expect staff to close the room door when staff assisted R16, who sat on the bed with his underwear on, with putting on his pants.On 01/08/26 at 12:51 PM, Administrative Nurse D stated that any staff or outside services, including hospice staff, should ensure that a resident was fully covered by a bath sheet, gown, or blanket, without any private areas exposed, before being transferred out into a hallway or public area.The facility's Promoting/Maintaining Resident Dignity policy, dated 09/20/20, documented it was the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhanced resident's quality of life by recognizing each resident's individuality. Resident's privacy would be maintained. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 161 residents. The sample included 34 residents, with two reviewed for accommodation of needs for assistive devices. Based on observation, record review, and interview, the facility failed to utilize foot pedals during wheelchair transports for Residents (R) 34 and R33. Findings Included: - On 01/05/26 at 09:15 AM, R34 (A severely cognitively impaired resident) sat in the dining room in the facility's [NAME] Unit. Licensed Nurse (LN) LL walked over to R34 and informed him that he had a phone call at the nurse's station. LN LL proceeded to push R34 to the nurse's station without foot pedals on his wheelchair. R34 placed his feet down several times while in transport.On 01/06/26 at 07:54 AM, R33 (a resident with noted impaired mobility and weakness) wheeled herself into the large common area next to the Sunflower Unit. An unknown staff member walked up to R33 and asked if R33 was tired from wheeling herself. R33 stated Yes, and asked if staff could push her. The unknown staff member proceeded to push R33 from the common area to her room. R33's wheelchair had no foot pedals, and her feet slid on the ground as staff pushed her. R33 wore slip-on shoes.On 01/07/26 at 10:11 AM, Certified Nurses [NAME] (CNA) O stated all the wheelchairs had foot pedals but some of the residents preferred to wheel themselves. She stated staff were expected to use them while pushing the wheelchair. She stated the resident's feet should never touch the ground while being pushed.On 01/07/26 at 12:43 PM, Administrative Nurse D stated staff were expected to use the wheelchair foot pedals while pushing residents.The facility's Accident and Supervision policy, revised 02/2020, indicated the facility would provide an environment that implemented adequate supervision, interventions, and assessment to minimize the risks of hazards, accidents, preventable injuries, and falls. The policy noted the facility would implement the appropriate assistive devices to prevent falls and injuries. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175340 | A. Building<br>B. Wing | 01/07/2026 |

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

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>The facility had a census of 161 residents. The sample included 34 residents. Based on observation, record review, and interview, the facility failed to keep Resident (R) 24's protected health information (PHI) private on a medication cart parked in the main dining room. The facility also failed to provide privacy for R113 during activities of daily living.Findings included:- On 01/05/26 at 10:45 AM, an observation revealed a medication cart parked in the Elmhurst hallway with a laptop computer sitting on the top; the computer screen was unlocked and open with R24's PHI on the screen, visible to all who passed by the medication cart. The information visualized included R24's medications, date of birth , allergy information, and code status. No nursing staff were in view of the medication cart. Licensed Nurse (LN) J exited another room into the hallway.On 01/05/26 at 10:57 AM, Certified Nurse Aide (CNA) M entered R113's room to provide assistance with personal hygiene. CNA M failed to close R113's curtains when providing peri-care, exposing R113's buttocks to the open window. On 01/06/26 at 09:35 AM, Certified Medication Aide (CMA) R stated R113's curtains should be closed during personal hygiene and dressing.On 01/05/26 at 10:49 AM, LN J stated the computer should be cleared and not have PHI on the screen. LN J stated that the Certified Medication Aide (CMA) was responsible for that medication cart. LN J stated that she would do some education with the CMA about PHI. On 01/06/26 at 09:50 AM, LN G stated the window curtains should be closed when staff provided care for the residents to provide privacy.On 01/07/26 at 12:55 PM, Administrative Nurse D stated she would expect the window curtains to be closed during personal care.The facility's Resident Rights policy dated 08/01/19 documented the facility would inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility would ensure that all staff members were educated on the rights of residents and the responsibility of the facility to properly care for its residents. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 161 residents. The sample included 34 residents, with seven reviewed for unnecessary medication. Based on record review and interviews, the facility failed to ensure Resident (R) 9's as-needed clonazepam (antianxiety (a class of medications that calm and relax people) medication had a 14-day stop date.Findings included:- R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), retention of urine, end-stage renal disease (ESRD- a terminal disease of the kidneys), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS documented R9 had an impairment of both sides of his lower body. The MDS documented R9 was dependent on staff for toileting, bathing, and needed set up or clean up assistance from staff with eating. The MDS documented R9 received an antidepressant (a class of medications used to treat mood disorders) and antianxiety medication during the observation period.R9's Psychotropic Use Care Area Assessment (CAA) dated 12/28/25 documented R9 was a new admission following a hospital stay. The CAA documented R9 required oxygen at baseline and continues to require oxygen. The CAA documented R9 required substantial-dependent assistance with his activities of daily living (ADL). The CAA documented R9 had bowel incontinence. The CAA documented that R9 received hemodialysis (a procedure where impurities or wastes are removed from the blood) three times weekly. The CAA documented R9 received clonazepam.R9's Care Plan documented:12/08/25- R9 used anti-anxiety medications related to anxiety disorder.12/08/25- Directed staff to administer anti-anxiety medications as ordered by the physicians and monitor for side effects and effectiveness every shift.12/08/25 - Directed staff to educate caregivers about the risks, benefits, and side effects of anti-anxiety medication.R9's EMR under Orders documented the following physician's order: Clonazepam oral tablet 0.5 milligrams (mg), give one tablet by mouth as needed for anxiety twice daily, dated 12/18/25.R9's Clonazepam lacked a 14-day stop date.The EMR lacked a rationale for extended use, past 14 days.On 01/06/26 at 10:20 AM, R9 laid flat on his bed. R9's eyes were open and had his nasal oxygen in place. R9 was in a pleasant mood. R9 stated starting dialysis has made him very anxious.On 01/07/26 at 08:42 AM, License Nurse (LN) L stated all anti-anxiety medication should have a 14-day stop date. She stated it was the physicians writing the order, and the nurse entering the orders responsibility to ensure all medication was documented in the residents EMR correctly.On 01/07/26 at 12:55 PM, Administrative Nurse D stated clonazepam should have a 14-day stop date. She stated it was the nurse's responsibility that was taking the order from the physician to ensure the order was correct.The facility's Use of Psychotropic Drugs policy dated 01/01/20 documented residents were not given psychotropic drugs unless the medication was necessary to treat a specific condition. The policy documented a diagnosis would be documented in the clinical record, and the medication was beneficial to the resident, as demonstrated by monitoring and documentation of the resident. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>The facility identified a census of 161 residents. The sample included 34 residents, with two residents reviewed for hospitalization. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 7 and R90 and their representatives were provided a written notification of transfer, as soon as practicable, upon their transfer to the hospital.Findings included:-R7's Electronic Medical Record (EMR) recorded Discharge Minimum Data Set (MDS) dated 04/28/25, which documented an unplanned discharge to an acute hospital with a return anticipated.R7's Entry MDS dated 05/08/25 documented a re-entry to the facility from an acute hospital.The facility lacked the required written notification of transfer, as soon as practicable, upon his transfer to the hospital between 04/28/25 to 05/08/25.R7's Discharge MDS dated 06/12/25 documented an unplanned discharge to an acute hospital with a return anticipated.R7's Entry MDS dated 06/19/25 documented a re-entry to the facility from an acute hospital.The facility lacked the required written notification of transfer for R7, as soon as practicable, upon his transfer to the hospital between 06/14/25 to 06/19/25.R7's Discharge MDS dated 08/07/25 documented an unplanned discharge to an acute hospital with a return anticipated.R7's Entry MDS dated 08/14/25 documented a re-entry to the facility from an acute hospital.The facility lacked the required written notification of transfer for R7, as soon as practicable, upon his transfer to the hospital between 08/07/25 to 08/14/25.R90s Discharge MDS's, dated 08/14/25, 09/04/25, and 12/30/25, documented an unplanned discharge to an acute hospital with a return anticipated.R90's Entry MDS's, dated 08/19/25, 09/09/25, and 01/03/26, documented a re-entry to the facility from an acute hospital.A review of R90's EMR revealed a lack of a written notification of transfer was provided to his representative, as soon as practicable, when R90 was transferred to the hospital on the above dates.On 01/07/26 at 10:49 AM, Social Services X stated that she would educate social workers about completing the written notification of transfers as required when a resident was discharged and/or transferred to the hospital. Social Services X stated a Performance Improvement Plan (PIP) had not been put in place regarding the required written notification of transfer yet.On 01/07/26 at 11:40 AM, Social Services X verified the facility lacked documentation regarding the resident representative's written notification when R90 was transferred to the hospital.On 01/07/26 at 12:15 PM, Administrative Staff A stated that the PIP had been put in place for the Bed Hold, but one had not been put in place for the written notification. Administrative Staff A stated she would get one put in place to ensure the written notification of transfer was completed as required.The facility's Bed Hold policy dated 02/05/25 documented as part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility would provide the resident and/or the resident representative written information that specifies: the duration of the stated bed-hold policy, during which the resident is permitted to return and resume residence in the nursing facility; the reserve bed payment policy in the state plan policy; the facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. In the event of an emergency transfer of a resident, the facility would provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility would document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The facility would keep a signed and dated copy of the bed-hold notice information given to the resident and/or representative in the resident's file and/or medical record. The facility would provide this written information to all facility resident, regardless of their payment source.The facility's Transfer and Discharge policy dated 02/01/20 documented for emergency transfers/discharges initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident shall obtain a physician's order for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis. The facility would notify the resident and/or representative. A<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | notice of the resident's bed hold policy would be provided to the resident and representative at the time of transfer, as soon as possible, but not later than 24 hours after the transfer. Provide a transfer notice as soon as practicable to the resident and representative. The social services director, or designee, shall provide notice of transfer to a representative of the state long-term care ombudsman via a monthly list. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 161 residents. The sample included 34 residents, with six residents reviewed for activities of daily living (ADL) care. Based on observation, record review, and interviews, the facility failed to ensure staff assisted Resident (R) 8 with bathing as needed and as scheduled.Findings Included: - R8's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) pressure ulcer of sacral region (triangular area at the base of the spine), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (elevated blood pressure), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid).The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R8 was dependent on staff for toileting and needed substantial to maximal staff assistance for bathing.R8's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 10/07/25 documented R8 was a new admission following a hospitalization. The CAA documented R8 was having recurring falls at home. R8's CAA documented R8 required substantial-dependent assistance with ADLs. The CAA documented R8 was incontinent of bowel and bladder. The CAA documented R8 was admitted with a multitude of wounds to his feet and a skin tear and was treated by the facility's wound care team.R8's Care Plan documented the following:10/06/25- Directed staff R8 needed substantial to maximal assistance from staff with his showers.10/06/25- Documented R8 needed partial to moderate assistance from staff for all toilets and showers.10/08/25- Documented R8 had an open skin tear, right and left heel, and a coccyx (area at the base of the spine) wounds.R8's EMR under Report Bathing documented not applicable on R8's shower record, from 12/16/25 to 01/05/26.On 01/05/26 at 08:22 AM, R8 sat in his recliner looking at his laptop. R8 sat in his recliner, wore a dirty shirt, and smelled of sweat. R8 stated he did not get his showers. He stated he was unsure if he was supposed to ask staff if he could have his shower on his shower day. R8 stated his shower days were Tuesday and Saturday. R8 stated staff told him he could not have a shower because there was not enough staff. R8 stated he liked his showers as he had wounds, and he was incontinent of bowel and bladder.On 01/07/26 at 08:25 AM, Certified Nurse Aide (CNA) Q stated residents were to have two showers a week. She stated the CNA Q would ask the resident what time the resident would like their shower and try to give the shower at that time. CNA Q stated there were times a resident did not get a shower due to pain or behaviors. CNA Q stated there are Saturday's that there were call-ins and showers were not given. CNA Q stated the process was if the shower was not given, the information would be reported to the next shift, and the next shift would give the shower.On 01/07/26 at 12:55 PM, Administrative Nurse D stated she was not aware of showers not given to residents. She stated the facility did have enough staff to give showers. Administrative Nurse D stated showers should be given; if a shower was not given on the scheduled day, the shower was rescheduled for the next day or the following day.The facility's Bathing a Resident policy dated 01/09/24 documented it was the practice of the facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 161 residents. The sample included 34 residents, with two residents reviewed for bowel and bladder incontinence, and a catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). Based on observation, record reviews, and interviews, the facility failed to provide appropriate treatment for Resident (R) 4's indwelling catheter (tube placed in the bladder to drain urine into a collection bag). The facility also failed to ensure R4's drainage bag was not resting on the floor.Findings included:- R4's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of encephalitis (inflammatory condition of the brain), kidney disease (damaged and cannot filter blood effectively, leading to waste buildup), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and hypertension (elevated blood pressure).<br><br>The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS documented R4 was dependent on staff for all activities of daily living (ADL) except eating and required assistance with cleanup or setup. The MDS documented R4 had an indwelling catheter during the observation period.<br><br>R4's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 12/15/25 documented that R4 had returned from the hospital and was now requiring increased assistance with activities of daily living (ADL). The CAA documented R4 had cognitive impairment (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The CAA documented R4 had an indwelling catheter.<br><br>R4's Care Plan documented the following:12/16/25- Documented R4 had an indwelling catheter related to urinary retention.12/16/25- Directed staff to provide catheter care every shift and as needed.12/16/25- Directed staff to monitor urinary output every shift.12/16/25- Directed staff to monitor for signs and symptoms of discomfort and frequency of urination.12/17/25- Documented R4 had a urinary tract infection and would be on an antibiotic for seven days.<br><br>12/23/2025 - Directed staff to anchor R4's catheter tubing to prevent injury. Catheter care every shift and as needed.<br><br>R4's EMR under Orders documented:Indwelling catheter care with soap and water every shift and as needed when soiled, dated 12/09/25.Monitor output every shift, dated 12/09/25.<br><br>On 01/05/26 at 07:25 AM, R4 laid on his bed with his head elevated and the bed in a low position. R4's catheter did not have a privacy bag, and the bag was placed at the bottom of the bed. R4's catheter was on the floor.<br><br>On 01/07/26 at 08:22 AM, Certified Nurse Aide (CNA) Q stated that catheters should be placed below the bladder, in a privacy bag, and not drag the floor. CNA Q stated R4 moves around in his bed and can move his own catheter. CNA Q stated staff tried to watch to ensure the bag did not drag the floor.<br><br>On 01/07/26 at 08:42 AM, Licensed Nurse (LN) L stated that catheters should be in a privacy bag if the resident was out of his room. She stated the catheter bag should not touch the floor.<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 01/07/26 at 12:55 PM, Administrative Nurse D stated the catheter bag should be off the floor and below the bladder.<br><br>The facility's Catheter Care Policy, revised 01/09/24, documented that it was the policy of the facility to provide catheter care to all residents who have an indwelling catheter to reduce bladder and kidney infections. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 161 residents. The sample included 34 residents, with one resident reviewed for dialysis (a procedure where impurities or wastes are removed from the blood) and end-stage renal disease (ESRD- a terminal disease of the kidneys). Based on observation, record review, and interviews, the facility failed to provide standards of care related to Resident (R) 9's dialysis.Findings included:- R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), retention of urine, end-stage renal disease (ESRD- a terminal disease of the kidneys), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS documented R9 had an impairment of both sides of his lower body. The MDS documented R9 was dependent on staff for toileting, bathing, and required assistance with set-up and clean-up with eating. The MDS documented R9 received dialysis during the observation period.R9's Functional Abilities (Self-Care and Mobility Care Area Assessment (CAA) dated 12/28/25 documented R9 was a new admission following a hospital stay. The CAA documented R9 required substantial to dependent assistance with activities of daily living (ADL). R9's CAA documented he had an indwelling catheter (a tube inserted into the bladder to drain urine into a collection bag) in place and received hemodialysis (a procedure where impurities or wastes are removed from the blood) three times a week. R9 planned to return home with his spouse.R9's Care Plan documented the following:12/18/25- R9 had a history of renal disease with dialysis. R9 would start dialysis on 12/19/25.12/19/25- R9's dialysis chair time would be 02:05 PM on Monday, Wednesday, and Friday. Staff were to plan rest periods.R9's EMR under the physicians' Orders tab lacked direction for staff to monitor R9's port site. The EMR lacked a physician order for R9's dialysis.The EMR lacked direction to staff for R9's dialysis location, transportation provider, and the date and times that R9 received dialysis.The EMR for R9 lacked orders prior to the start of the survey on 01/05/26. On 01/07/26 at 08:42 AM, Licensed Nurse (LN) L stated an order for dialysis should have been placed in the chart when the resident was admitted or became dependent on dialysis. LN L was unsure if the times the resident went to dialysis, and where he went to dialysis, should be in the orders, as she knew that information was in the plan of care. LN L stated checking the dressing should be an order, and if the resident had a fistula, the bruit and thrill should be checked and documented.On 01/07/26 at 12:43 PM, Administrative Nurse E stated there should be an order in the resident's EMR. Administrative Nurse E stated the dialysis port dressing should be checked every shift.The facility's Hemodialysis policy, dated 01/01/20, documented the facility would provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of the resident receiving hemodialysis. |

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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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>The facility identified a census of 161 residents. The sample included 34 residents, nine medication carts, eight treatment carts, and nine medication rooms. Based on observation, record review, and interviews, the facility failed to properly store medications in two of the eight treatment carts.Findings included:- During the initial tour on 01/05/26 at 07:04 AM, a treatment cart on the Transitional Care Unit was unlocked and unattended in an unlocked storage room. The treatment cart contained medicated ointments and creams.On 01/06/26 at 07:20 AM, an unattended and unlocked treatment cart was on the Sunflower hallway. The treatment cart contained medicated ointments and creams.On 01/05/26 at 07:10 AM, Licensed Nurse (LN) JJ stated they never locked that treatment cart because they did not have a key to unlock the cart. LN JJ stated yes, the cart should be locked.On 01/07/26 at 12:55 PM, Administrative Nurse D stated she would expect all the medication and treatment carts to be locked when not being used.The facility's Medication Storage, dated 01/01/20, documented it is the policy of this facility to ensure all medications housed on our premises would be stored in the medication carts or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175340 | A. Building<br>B. Wing | 01/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Gardens at Aldersgate | 3220 SW Albright Drive<br>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 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>The facility identified a census of 161 residents. The sample included 34 residents, with five reviewed for immunization status. Based on record reviews and interviews, the facility failed to offer or obtain an informed declination for influenza for Resident (R) 72 and the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial pneumonia infections) vaccination for R72, R16, and R4. Findings included:- Review of R72's clinical record revealed no documented PCV20, and last documented influenza vaccine was 12/14/22. R72's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or a physician documented contraindication.Review of R16's clinical record revealed the PCV13 was administered on 03/10/13, and the PSV23 was administered on 03/17/17. R16's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or a physician documented contraindication.Review of R4's clinical record revealed the PCV13 was administered on 01/18/16, and the PSV23 was administered on 11/17/03 and 03/13/17. R4's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or physician documented contraindication.On 01/07/26 at 10:09 AM, Administrative Nurse E stated she would investigate the PCV20 declinations and stated R72 was on the next list for influenza vaccines to be given in the facility. Administrative Nurse E was unable to provide declination or consents for PCV20 or influenza as requested on 01/06/25 at 12:30 PM.The facility's Pneumococcal Vaccine policy dated 01/13/22 documented it was the policy of the facility to offer residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current Centers for Disease Control (CDC)guidelines and recommendations.The facility's Influenza Vaccination policy dated 05/31/22 documented it was the policy of the facility to minimize the risk of acquiring, transmitting, and experiencing complications from influenza by offering residents, staff members, and volunteers immunizations against influenza. |