STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aberdeen Village	17500 W 119th Street Olathe, KS 66061

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** Based on observation, record review, and interviews, the facility failed to provide individualized care and services related to dementia care (a progressive mental disorder characterized by failing memory and confusion) for Resident (R)1, who displayed wandering behaviors into other resident's rooms. Findings Included:- R1's Electronic Medical Record (EMR) documented diagnoses of dementia, need for continuous supervision, adjustment disorder (a short-term, intense emotional or behavioral reaction to a stressful life change that is disproportionate to the event), muscle weakness, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), Post-Traumatic Stress Disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and cognitive communication deficient (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severe cognitive impairment. The MDS documented R1 required setup or clean up assistance for eating and oral hygiene. R1 required partial to moderate assistance for showers and bathing. The MDS documented R1 was independent for other Activities of Daily Living (ADLs) and mobility. The MDS documented R1 exhibited wandering behavior daily. The MDS documented the wandering behavior did not significantly intrude on the privacy or activities of others. The Cognitive Loss / Dementia Care Area Assessment (CAA), dated 01/23/26, documented R1 was at risk for potential alterations in his cognitive status. The CAA documented R1 had poor adjustment disorder with anxiety and PTSD. The CAA documented R1 used a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) due to exit seeking. R1's 01/21/26 Care Plan documented R1 was at risk for potentially leaving the neighborhood or facility unsupervised related to dementia, and anxiety. The Care Plan documented the following interventions:01/21/26 - directed staff to attempt redirection as needed. If R1 became aggressive, staff were to make sure he was safe and monitor him from a distance. The intervention directed staff to reapproach when R1 was calm.01/21/26 - WanderGuard placed on right wrist. WanderGuard for personal safety.01/21/26 - directed staff to check WanderGuard bracelet placement and function daily. Other care plan WanderGuard intervention directed staff to replace the WanderGuard as needed and change it every three months.01/21/26 - directed staff to notify R1's primary care provider (PCP) as needed for concerns or an increase in his behaviors. R1's 01/29/26 Care Plan documented R1 stayed on the facility's memory care unit. The Care Plan documented R1 had cognitive loss and had exit seeking behavior due to his diagnosis of dementia. The Care Plan documented the following interventions:04/28/26 - documented R1 had a desire to help some of the female residents in his neighborhood. The intervention directed staff to attempt to redirect R1 when it happened and notify R1's PCP as needed.05/15/26 - directed staff to call R1's daughter or his spouse if R1 became agitated or exhibited exit seeking behaviors. R1's 01/29/26 Care Plan documented R1 was at risk for potential alteration in cognitive function and mood related to dementia, adjustment disorder, anxiety, and PTSD. The Care Plan documented R1 stayed on a secure memory unit for his (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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