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	07/16/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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	07/16/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 114 residents. The sample included four residents, with one resident reviewed for abuse and neglect. Based on observation, record review, and interview, the facility failed to prevent an episode of staff-to-resident physical abuse of a cognitively Impaired Resident (R) 1. This deficient practice placed R1 at ongoing risk for preventable abuse and mistreatment.Findings included:- The Medical Diagnosis section within R1's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, repeated falls, and the need for assistance with personal care. R1's Quarterly Minimum Data Set (MDS) completed 07/01/25 indicated a Brief interview for Mental Status (BIMS) score of eight (moderate cognitive impairment). The MDS noted no upper or lower extremity impairments. The MDS noted he used a wheelchair for mobility. The MDS noted he required substantial to maximal assistance with toileting, bathing, transfers, bed mobility, personal hygiene, and dressing. The MDS noted he had hearing and vision difficulties. The MDS noted he had a history of falling with minor injuries. The MDS noted no behaviors. R1's Functional Abilities Care Area Assessment (CAA) completed 10/09/24 indicated he required staff assistance to complete his activities of daily living (ADL). The CAA noted he could verbalize his needs and answer yes and no questions. The CAA noted he wandered the unit and exhibited exit-seeking behaviors. The CAA noted he was at risk for falls related to his medical diagnoses and impaired cognition. R1's Care Plan initiated 09/24/24 indicated he required staff assistance with his ADLs. The plan noted he needed substantial to maximal assistance with bathing, toileting, dressing, personal hygiene, and transfers. The MDS indicated he had a history of behaviors and unsafe wandering. The plan instructed staff to provide redirection, activities, and diversion to prevent behaviors related to his cognitive impairment. The plan instructed staff to provide cues, reorient, and monitor him for changes in his behavior.A Facility Incident Report #6463 completed on 07/07/25 indicated R1 got into a physical altercation with Licensed Nurse (LN) G on 07/07/25. The report indicated Certified Nurse's Aide (CNA) M witnessed a physical altercation between R1 and LN G. The report indicated R1 was agitated and stood up from his wheelchair. The report indicated R1 then pushed LN G away from him. The reporter noted that LN G pushed R1 back and stated, We don't push here. The report indicated LN G was immediately suspended and terminated from the facility. The report noted R1 was assessed with no injuries found. The report indicated R1's medical provider and resident representative were immediately notified of the incident. The report noted that law enforcement and the state agency were notified. A Witness Statement completed by CNA M on 07/07/25 documented that she witnessed LN G and R1 get into a physical altercation. The statement documented that she witnessed LN G push R1 during the altercation on 07/07/25. A Witness Statement completed by Dietary Staff BB on 07/07/25 documented she witnessed LN G shove R1 during a physical altercation on 07/07/25. On 07/16/25 at 10:35 AM, R1's Resident Representative indicated R1 had behaviors at times due to his dementia but was often easily redirected. She stated that staff could talk to him or provide activities for him while he was upset or had behaviors. On 07/16/25 at 01:25 PM, CNA M stated the facility provided training and in-services for staff related to dementia care, abuse, communication, and resident rights. She stated staff were expected to treat all residents in a respectful manner and never should push or shove residents. On 07/16/25 at 01:33 PM, LN I stated that staff should always provide diversion or activities for the resident during a behavioral episode. She stated that staff should never threaten or put their hands on the residents in an aggressive manner. She stated that all staff are given abuse training annually and in-service throughout the year. On 07/16/25 at 01:25 PM, Administrative Nurse D stated that LN G was immediately terminated from the facility and reported. She stated all staff were provided abuse training, and all residents were screened. She stated that no other residents reported being affected by the incident or the staff involved. She stated that all staff are expected to treat the residents professionally. She stated the facility had a zero-tolerance policy for abuse. The facility's Abuse Prevention Program, revised 08/2024, indicated the facility was committed to protecting residents from abuse. The policy indicated all staff were trained to recognize and report allegations of abuse. The policy noted that the facility was to provide management for dementia and behavioral symptoms for residents at risk of abuse. The policy indicated that the facility promoted an environment safe for the treatment and care of the residents. The facility implemented the following corrective actions related to this incident:-All staff were educated on Abuse, Neglect, and Exploitation on 07/09/25. -The facility identified and screened all residents under the care of LN G. No other residents reported abuse. -The facility will track staff education