

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2025
NAME OF PROVIDER OR SUPPLIER Regent Park Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 10604 East 13th Street N Wichita, KS 67206	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 73 residents, with three reviewed for elopement. Based on record review, observation, and interview, the facility failed to provide sufficient supervision for Resident (R) 1 to prevent R1 from exiting the building after an employee. This deficient practice placed R1 at risk for elopement, falls, and injury. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of nontraumatic brain dysfunction (brain damage that occurs from internal factors), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R1 required supervision or partial assistance with all of his activities of daily living (ADL) except for locomotion in his wheelchair, which he was independent. The Annual MDS, dated [DATE], lacked Care Area Assessments (CAA).R1's Care Plan documented R1 was at risk for elopement and had a wanderguard. Staff were directed to check for the placement of R1's wanderguard and the wanderguard's functioning. The care plan directed staff when R1 wandered or was exit seeking to redirect R1 (09/01/23).The Health Status Note, dated 03/22/25, documented it was around 07:00 PM when R1 was found wandering in the parking lot. This nurse explained to R1 he could not be by himself outside and wheeled him back into the building. Staff told R1 that if his friend showed up, staff would let him know. R1 agreed and was pleasant. Checked wander guard twice and read ok. Called Administrative Nurse D and the manager on-call. R1 did not get hurt or upset from bringing him back to the building. The Health Status Note, dated 03/22/25, documented the nurse reported to R1's responsible party that R1 had gotten out of the facility despite having his wanderguard on. R1's wanderguard was active. R1's responsible party was made aware R1 was outside in the parking lot for no more than five minutes. R1's responsible party was appreciative of being notified and had no concerns for R1's safety.The Facility Incident Report, dated 03/24/25, documented on 03/22/25 at 06:58:50 PM, R1 was at the front door (which is where he usually sits, and this is his norm) and informed a PRN (as needed) therapist staff X he could go outside. The therapist staff member attempted to open the door, but R1's wanderguard kept locking the door down because he was so close. At 07:00:11 PM, the PRN therapist staff X opened the door by inputting the code, and she and R1 went out the doors together. The PRN therapist staff X went to her vehicle in the parking lot and left. Approximately five minutes later, an unknown family member went to the nursing station and asked if the gentleman in the wheelchair should be outside. LN G looked at the monitor, and the screen had not turned orange, which indicated an elopement. At 07:07:20 PM, R1 was brought back inside by the charge nurse. R1 was pedaling in his wheelchair in the middle of the parking lot. LN G asked him what he was doing, and he said he was waiting for his friend. R1 was unharmed upon assessment.On 07/07/25 at 10:00 AM, observation revealed a smooth transition from the front door down into the parking lot. The parking lot is smooth and without cracks or bumps. The parking lot led out to a roundabout with one exit leading to the assisted living building and the other exit heading toward the street.On 07/07/25 at 10:30 AM, observation revealed R1 sat in his wheelchair out by the nurses' desk, moving his wheelchair back and forth with his feet. A wanderguard was in place on R1's right wrist.On 07/07/25 at 10:40 AM, Licensed Nurse (LN) H stated R1 never stayed on the unit and was always up around the front desk by the front door. R1 talked to people entering and exiting the building.On 07/07/25 at 11:00 AM, Administrative Nurse D stated all staff education was completed regarding elopement. DON stated it was a perfect storm because they did not know the call light/elopement system was not functioning until this happened. She stated nursing checked the wanderguard system quarterly, and then the actual wanderguards that were on the residents were checked every shift.On 07/07/25 at 11:15 AM, Maintenance person U stated he checked the alarm system weekly, and they got a new system to integrate with the old system, and the reader stopped functioning and talking between the two systems and had since been fixed.The facility's undated Elopement Policy documented the facility wished to ensure the safety of those residents who had been identified as being at risk for elopement. It was the policy of the facility to identify those residents at risk for elopement and take precautions to ensure their safety and well-being. Special secure living units were provided by the facility, and additional security, including a Wanderguard door locking system, was provided The facility completed corrective actions by</p>		