STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175527	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Park Rehabilitation and Healthcare	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. The facility reported a census of 61 residents; the sample included 15 residents. Based on interview and record review, the facility failed to inform Resident (R) 12, R7, and R4 and/or their representative regarding the risks related to psychotropic (alters mood or thoughts) medications. Findings included:- Review of both Electronic Health Record (EHR) and paper records revealed the following: 1. R12's EHR under the Orders tab revealed orders for the following: Mirtazapine (antidepressant medication used to treat mood disorders), 15 mg to be given orally at bedtime for depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dated 08/15/23. Fluoxetine HCL (a medication used to treat depression), 40 mg to be given orally in the morning for depression, dated 03/12/25. Alprazolam (antianxiety medication), 0.5 mg to be given orally three times daily for anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dated 10/29/24. R12's scanned documents revealed a psychotropic medication consent for R12, dated 01/18/25, signed and dated by R12 on 10/15/25. The consent did not list the psychotropic medications or the medication dosages, route, or number of times to be given daily. 2. R7's EHR Orders tab revealed orders for the following: Mirtazapine, 30 mg to be given orally at bedtime for insomnia (inability to sleep), dated 07/11/25. Fluoxetine HCL, 40 mg to be given orally in the morning for mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), dated 07/11/25. R7's scanned documents revealed a psychotropic medication consent for R7, which was signed and dated 07/11/25, and did not list the psychotropic medications or the medication dosages, route, or number of times to be given daily. 2. R4's EHR Orders tab revealed orders for the following: Sertraline HCl (antidepressant medication), 100 mg by mouth in the morning for depression, dated 11/30/23. Quetiapine Fumarate (antipsychotic medication), 12.5 mg by mouth in the evening for major depressive disorder (MDD- major mood disorder that causes persistent feelings of sadness) and behavioral disturbances (persistent, intense patterns of disruptive, impulsive, or defiant actions), dated 10/26/25. Quetiapine Fumarate 50 mg, give 0.5 tablet by mouth at bedtime for MDD and behavioral disturbances, dated 01/28/25. Mirtazapine, 30 mg to be given orally at bedtime for depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dated 09/12/24. Lorazepam (antianxiety medication), 0.5 mg by mouth three times a day for anxiety, dated 11/30/2023. R4's scanned documents revealed an unsigned psychotropic medication consent for R4 dated 05/11/25. It did not list the psychotropic medications or the medication dosages, route, or number of times to be given daily. On 02/10/26 at 10:59 AM, Certified Medication Aide (CMA) R stated informed consent was required before starting or making any changes to psychotropic medications. On 02/10/26 at 11:17 AM, Licensed Nurse (LN) G stated informed consents were for psychotropic medications, and they were obtained before the psychotropic medication was started and any time there was a change made to the medication. LN G also said that the informed consent was provided to the residents and/or their legal (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representatives. On 02/11/26 at 10:45 AM, Administrative Nurse E stated she attended an educational seminar related to informed consents, and when she returned, a PIP (performance improvement plan) was implemented to correct the informed consent process. Administrative Nurse E also stated the facility was not aware that the informed consents, which had already been completed, needed to be corrected. The facility policy Psychotropic Medication Use, dated 11/11/25, documented that every psychoactive medication, on initiation and with any dosage increase, will initiate a signed informed consent to ensure the designee has reviewed with the resident and/or resident representative the potential adverse effects of the order of any psychoactive medication.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility identified a resident census of 61. The sample included 15 residents, with three reviewed for beneficiary notifications. Based on interviews and record review, the facility failed to provide the Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Notice of Non-coverage (ABN) Form CMS-10055, for Resident (R) 22.Findings included: -R22's facility provided documentation noted his Medicare Part A last covered day was 01/28/26. The resident remained in the facility for long-term care. Upon request, the facility was unable to provide evidence that Form CMS-10055 was provided to R22. A Social Service Note, dated 01/30/26 at 05:02 PM, documented the social worker provided the SNF ABN. R22 would remain on private pay for approximately 30-60 days until an apartment was available. The private pay quote was provided to R22's representative. A Social Service Note, created on 02/09/26 at 10:52 AM, with an effective date of 01/30/26 at 10:52 AM, documented the resident requested staff review the SNF ABN with his representative, who was not present at that time. R22 was unsure what time she would arrive. In an email communication from the facility to R22's representative on 01/27/26 at 05:41 PM, Social Services X explained there was a form which R22 would need to sign that reviewed his appeal rights and his right to appeal if he thought Medicare should cover the long-term care stay. The email indicated the appeal could take up to four months to process but the facility would continue with therapy during that time frame. If the appeal was unfavorable, the facility would bill the room, board, and therapy costs. Review of the email communication chain lacked mention of the SNF ABN or the estimated cost to continue the therapy services should the resident wish to do so. On 02/10/26 at 02:10 PM, Social Services X stated the ABN should be provided to the resident or resident's representative prior to discharge. Social Services X said she provided the form, but the resident did not sign or return the form as he wanted to review it with his representative. Social Services X verified she was unable to show the resident was provided with the ABN Form CMS-10055; she did not have a copy. A policy dated 12/01/17 stated that for residents admitted based on Medicare reimbursement, and the Medicare coverage ends, the facility will follow regulations and policies regarding appropriate notification of discharge from Medicare services, including the right to appeal. If the residents continued to need long-term care services, the facility designee will assist in discharge planning. The appropriate notification of discharge from Medicare services was not provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 61 residents. The sample included 15 residents with one resident reviewed for range of motion (ROM). Based on observation, interview, and record review, the facility failed to provide care and services to prevent a reduction in ROM or contractures (abnormal fixation of a joint or tendon) for Resident (R) 49 when staff failed to follow the order for device to reduce risk or complications related to her left-hand contracture. Findings included:- R49's Electronic Medical Record (EMR) revealed the following diagnoses: hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a stroke (a sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the left nondominant side and contracture (abnormal permanent fixation of a joint or muscle) to the left hand. R49's admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS recorded R49 had hemialgia and a contracture of the left hand. R49's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R49 had impaired physical functioning related to a past stroke with left sided weakness. R20's Care Plan, dated 10/03/25, directed staff to place a clean, dry, rolled washcloth between R49's fingers and palm and ensure good hygiene. R49's Physician's Orders documented an order to place a clean, dry, rolled washcloth between fingers and palm and ensure good hygiene every day and night shift, ordered on 09/26/25. R49's February 2026 Medication Administration Record (MAR) from 09/26/25 to 02/11/26 documented the rolled washcloth it was in place every day and night with no refusals noted. R49's Progress Note lacked documentation R49 refused this treatment or that it was not completed. On 02/09/26 at 10:00 AM, R49 sat at the dining room table in her wheelchair. The wheelchair had a partial padded tray attached to it. R49's left arm was not on the tray. Her hand hung down, in a loose fist, and was swollen. She had nothing in hands to address the contracture. On 02/10/26 at 02:00 PM, R49 was in bed with the head of the bed elevated. R49's left elbow was on a pillow with her hand dangling. Her hand was swollen and in a loose fist, but she did not have a rolled cloth or any device in her hands. On 02/10/26 at 03:03 PM, R49 laid in bed. R49 stated she worked with therapy, and they gave her something to wear in her hand, she said it was a pool noodle with a strap to keep it in her hand and to prevent her hand from contracting. Observation revealed it was across the room, on her dresser. When asked when she was supposed to wear it, she stated she should be wearing it at that time. On 02/10/26 at 02:48 PM, Consultant Staff GG stated he completed an evaluation on 10/02/25 for a request for therapy from the provider for a left-hand contracture. He evaluated R49 and found she did not have a contracture at that time but did have tone which indicated some resistance. He provided her with a simple resting hand splint to be worn, or they could use a rolled-up hand towel. Consultant Staff GG said R49's left arm was completely flaccid (weak and flabby) which increased the risk for contractures. On 02/11/26 at 09:38 AM, Licensed Nurse (LN) H stated the nurse was to place a clean towel or splint in R49's hand and confirmed it should be there all the time. LN H stated the nurses verified and documented its placement on the MAR. On 02/11/26 at 10:39 AM, Administrative Nurse D stated she expected the nurse to place the splint on R49's hand to prevent contractures, and to document it correctly in the MAR. The facility's REST Initiative/Restorative Nursing Documentation policy documented the goals for all elders receiving restorative nursing services will include goals to prevent contractures.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 61 residents. The sample included 15 residents with one resident reviewed for respiratory care. Based on observation, interview, and record review, the facility failed to provide care and services for Resident (R) 49 when oxygen was not provided to the resident when orders were in place. Findings included:- R49's Electronic Medical Record (EMR) revealed the following diagnoses: pneumonia (an infection in the lungs), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a stroke (a sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R49's admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS recorded R49 received oxygen. R49's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R49 had impaired physical functioning related to a past stroke with left sided weakness. She required staff assistance with all care. R49's Care Plan, dated 09/26/25, documented R49 was on oxygen related to ineffective gas exchange. R49 was to be on two liters of oxygen continuously. R49's Physician's Orders documented an order to monitor oxygen saturation and oxygen at two liters every day and night shift, ordered on 09/25/25. On 02/09/26 at 10:00 AM, R49 sat at the dining room table in her wheelchair with an oxygen tank attached to the back of the wheelchair in a bag. A bag was attached by the oxygen tank with the nasal cannula tubing partially in the bag. The cannula's nasal prongs were out of the bag and hanging freely. R49 was not wearing or receiving her oxygen. On 02/09/26 at 10:05 AM, Licensed Nurse (LN) I came up to R49 and placed the nasal cannula on the resident. LN I then attempted to turn on the oxygen, but the tank was empty. LN I verified that R49 was supposed to have continuous oxygen and took her back to the room to place the resident on oxygen via a concentrator. On 02/11/26 09:35 AM, Certified Medication Aide (CMA) S stated she thought R49 was supposed to have oxygen all the time. On 02/11/26 at 09:38 AM, Licensed Nurse (LN) H stated R49 required oxygen all the time. On 02/11/26 at 10:39 AM, Administrative Nurse D stated she expected the nurse to follow the orders for oxygen. The facility's Oxygen Therapy policy documented that residents would use oxygen from a portable source when they are off the main concentrator.