

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105679	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2025
NAME OF PROVIDER OR SUPPLIER Regents Park of Sunrise		STREET ADDRESS, CITY, STATE, ZIP CODE 9711 W Oakland Park Blvd Sunrise, FL 33351	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide supervision and a safe environment to prevent an elopement for 1 of 4 sampled residents (Resident #1). Resident #1 was a vulnerable resident who exited the facility's main front door unsupervised on 10/11/25. She was found about half mile away from the facility on a very busy 6-lane roadway at 7:32 PM by the police who were driving down the road by chance and noticed she needed assistance. The police took the resident to the facility, and the facility staff were unaware Resident #1 had left. The facility's failure to prevent Resident #1 from eloping placed this resident at a likelihood of serious harm, injury or death. While out of the facility on 10/11/25, Resident #1 was confused and unable to report to the police officer where she lived. Resident #1 could have fallen and sustained injuries, particularly while walking in the dark; drowned in nearby bodies of water; or have been struck by a car. The Nursing Home Administrator was given the Immediate Jeopardy Template on 10/28/25 at 4:39 PM. The Immediate Jeopardy (IJ) began on 10/11/25 and was removed on 10/13/25 according to the facility's Immediate Jeopardy Removal Plan. The findings included: Review of the facility policy titled Elopement and Wandering Residents revised on 03/16/23 revealed the following: 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systematic approach of monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Record review revealed Resident #1 was admitted to the facility on [DATE]. The residents' diagnoses included Dementia, Memory deficit, Cerebral infarction, Atrial fibrillation and Type 2 Diabetes mellitus. The resident's medications included Aricept and Memantine for Dementia; Eliquis (a blood thinner) for Atrial fibrillation; and Metformin for Diabetes. The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident's Brief Interview of Mental Status (BIMS) score was 06/15, which indicated severe cognitive impairment. An Elopement Risk Evaluation dated 08/11/25 showed that Resident #1 was at risk for elopement with a score of 1 (0 indicating no risk for elopement and 1 indicating risk for elopement). Further review indicated that Resident #1 needed a walker to ambulate. After the elopement incident, Resident #1's daughter had the resident moved to a facility with a secure unit to care for residents who are at risk for eloping on 10/21/25. Review of the Police Report dated 10/11/25 documented that Resident #1 was found by the police while she was walking in traffic after sunset (sunset at 6:56 PM) East bound on a busy 6-lane roadway at 7:32 PM. In that report Resident #1 told the police officer that she walking to her daughter's house in Miami and when asked where she was coming from, she was unable to provide a location. Resident #1 was wearing dark clothing and was only able to provide her first and last name. The police officer's report indicated the officer was concerned for her safety under these hazardous conditions. The police officer had another officer check the surrounding facilities in the area, who then contacted an employee of the facility in question and confirmed that Resident #1 lived there. Resident was then returned to the facility by the police. Review of the facility's timeline investigation revealed that on 10/11/25 Resident #1 was seen by Staff B, Licensed Practical Nurse (LPN) at 7:15 PM on the B Wing and was last seen between 7:00 and 7:30 PM by Staff A, Physical Therapy Assistant (PTA) on the B Wing hallway. At 7:48 PM a police officer arrived at the facility to let them know that they found Resident #1. At 8:05 PM Resident #1 was brought back to the facility by another police officer. The facility staff timeline did not align with the time police found the resident after she walked about a half mile. On 10/28/25 at 9:02 AM, the surveyor retraced the probable steps the resident took. The walk started on B wing. Walked to the front main lobby doors and exited the facility. Walked the green sidewalk towards the parking lot. At the end of the sidewalk there's a ramp for wheelchair accessible into the parking lot. Continued walking towards the front entrance of the facility's driveway, turned left onto the sidewalk and within a few steps noted there is a non-fenced body of water on the left of the sidewalk (photographic evidence obtained). Continued walking following the sidewalk, Resident #1 crossed a driveway (a Tennis Club opened till 9:30 PM) where the sidewalks have ramps for wheelchair access on both sides. Resident #1 then crossed 95th Terrace and walked by a park and she passed another non-fenced body of water. Resident #1 again crossed a street, NW 94th Avenue, which has a traffic light for turning options between Oakland Park Boulevard into NW 94th Avenue (photographic</p>		