STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106109	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kindred Hospital South Florida Hollywood	1859 Van Buren St Hollywood, FL 33020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision to prevent elopement and failed to ensure that safety measures were in place to prevent elopement for 1 of 1 sampled residents reviewed for elopement. The findings included:A review of the education titled Hollywood-Elopement Education (undated) documented the following: when a resident is monitored due to confusion or the concern that they may exit the Unit, this means that a staff member must always have the resident in their visual field. Residents who exit the Unit without staff knowledge, even if they remain inside the hospital, should be reported to facility leadership immediately as a potential elopement. Record review revealed Resident #1 was admitted to the facility on [DATE] and discharged on 6/12/202 with diagnoses of Acute Respiratory Failure, Heart Failure, and Muscle Weakness. The admission Minimum Data Set (MDS) dated [DATE], revealed Resident #1 has a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. Record review revealed that on 6/8/2025, Resident #1 was encountered on the first floor just below his Unit, which is on the second floor. Resident #1 waited for a visitor to come up on the elevator to the Unit (2nd floor) and entered the elevator before the doors closed. The 2nd floor Unit has keypads that require a code to be entered to leave the Unit. The elevator on the first floor does not require a code to access it, but it does require a code to exit the 2nd floor Unit. A visitor of another Resident came to the 2nd floor Unit by elevator, and once the doors opened on the Unit, Resident #1 entered the elevator on the second floor and rode back down to the first floor. In an interview conducted on 07/07/2025 at 8:00 AM with Staff B, Security Supervisor, who stated on 06/08/2025, he received a call from Staff J, Security Officer letting him know that while conducting her rounds she observed Resident #1 trying to get out by the East side back door near the Physician ' s parking lot. Staff B instructed Staff J to call the nursing staff on the 2nd floor Unit to come and retrieve Resident #1 from their Unit. According to Staff J, Resident #1 was trying to push the door open to the Physician ' s parking lot and was stopped by Staff F, Registered Nurse, who was just coming inside from the Physicians ' parking lot into the building. Staff B reported that Resident #1 came down from the 2nd floor Unit in his wheelchair and that a code is required to leave the 2nd floor Unit. If the elevator doors open on the 2nd Unit, it is possible to enter the elevator while the elevator doors are open without entering a code. In this interview, this Surveyor was able to see the video of Resident #1 attempting to leave the facility. Resident #1 was noted in his wheelchair wearing a hospital gown near the East side door by the Physician ' s parking lot. Staff A, Housekeeping, was noted passing by Resident #1, opening and closing the door behind her to the outside Physician ' s parking lot. She did not stop or acknowledge Resident #1, who was right by the exit door, as she walked outside the facility.In an interview conducted on 07/07/25 at 9:10 AM with Staff C, Housekeeping Manager, reported Staff A works all units depending on the coverage for the day, and that she worked on the 2nd floor Unit on 06/08/2025. His staff were trained in elopements. If they recognize a resident near a door or attempting to leave, they need to stay near the resident and notify nursing staff and supervisors of the situation. He further said that Staff A was educated with drills on elopement, and when asked to see documentation on education, he could not provide any. In an interview conducted on 07/07/2025 at 10:40 AM with Staff E, Registered Nurse, stated that she worked on the 2nd floor Unit on 06/08/2025 when she observed Resident #1 near the elevator. She was concerned that Resident #1 was attempting to leave the Unit and told Resident #1 to move away from the elevator area. Staff G, Registered Nurse, who was assigned to Resident #1, told her not to worry and that she was watching Resident #1 in the hallway. Staff E walked away to attend to her residents, leaving Staff G to watch Resident #1. Shortly after, they received a call from security informing them that Resident #1 was on the first floor, near the exit door, attempting to leave. In a phone interview conducted on 07/70/25 at 11:00 AM with Staff F, she stated that on 06/08/2025, she was coming back for her lunch break through the Physician ' s parking lot when she noticed Resident #1 wedged between the exit door in his wheelchair. She recognized Resident #1 as a Patient and used her cell phone to call security and nursing staff on the 2nd floor Unit. Staff G came from the 2nd floor Unit, and together they managed to get Resident #1 away from the doorway. Resident #1 was then taken to the 2nd floor Unit by Staff G. A chart review of the facility ' s elopement education revealed the following: an elopement education drill was conducted on 11/15/24 and on 05/13/2025. Closer observation did not show that Staff A or other housekeeping staff received any education on elopement. In an interview conducted on 07/07/2025 at 12:52 PM with the facility ' s Administrator, she