

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Kindred Hospital South Florida Hollywood		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, interview and record review, the facility failed to: 1) treat a resident in a dignified manner, as evidenced by, allowing a resident to leave the facility for a doctor's appointment only wearing a hospital gown and an incontinence brief and waiting at the doctor's office for an extended period of time after the appointment; and 2) contact or notify the resident's responsible party in advance of a Doctor's appointment, in a timely manner, which allowed the resident to attend the appointment alone and unattended for 1 of 3 sampled residents reviewed, Resident #1. The findings included: Review of the facility policy and procedure titled, Quality of Care provided by the acting Director of Nursing (DON) dated 10/2022 documented in the Policy Statement: The Subacute Unit (SAU) identifies and provides needed care and services that are patient centered, in accordance with the patient's preferences, goals for care and professional standards of practice that will meet each patient's physical, mental, and psychosocial needs to ensure each patient receives necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being, consistent with the resident's comprehensive assessment and plan of care Procedure: 1. Determine by comprehensive assessment of the highest level of functioning and well-being possible for the patient based on the patient's current functional status and potential for improvement or potential functional decline. 2. Base the clinical care of patients on current evidence-based practice or professional judgment of healthcare professionals. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Patient Appointments outside the Subacute Unit (SAU) provided the DON dated 10/2022 documented in the Policy Statement: [NAME] SAU will assist with making arrangements for patient visits outside of the Unit. Responsible Discipline: Social Services, Licensed Nurse. Procedure: 1. Notify family/responsible party of the scheduled appointment in advance so they may accompany patient. 2. If family/responsible party is unable to make the scheduled appointment, offer the option to re-schedule the appointment at a time convenient for them. 3. In the event the family/responsible party is unable to accompany the patient, determine if the patient is physically and mentally able to go to the appointment unattended. If the Patient is Physically and/or Mentally unable to be unattended 4. Make arrangements for transportation. 5. Make arrangements for someone to accompany the patient until the patient returns to the SAU. 6. While outside the SAU, remain with the patient unless attended by personnel at the appointment location Documentation Guidelines: 1. Document in the patient's medical record the date and time of scheduled appointment. 2. Document in patient's medical record notification of family/responsible party of time and date of scheduled appointment. 3. Document in patient's medical record: a. Date and time patient left SAU for appointment. b. Name of person accompanying patient. c. How patient left for appointment (i.e. wheelchair, stretcher, etc.) d. How patient was transported (i.e. ambulance, private transport, etc.) e. Paperwork sent with patient if applicable. f. Verification of patient's arrival at physician's office if applicable. g. Date and time patient returned from appointment . Resident #1 was admitted to the facility on [DATE] with diagnoses which included Dementia, Parkinsonism, Diabetes Mellitus Type II, Osteomyelitis, Anemia, Altered Mental Status, Hypertension, Spinal Stenosis, Presence of Cardiac Pacemaker, Essential Tremor and Atherosclerotic Heart Disease. Record review of the Minimum Data Set (MDS) sections A, C and GG dated 08/23/24 for Resident #1 indicated that he used a walker and wheelchair, assistive devices. He had impairment on both sides of his lower extremities. The resident required partial to moderate assistance with eating, oral and personal hygiene, roll left and right, sit to lying and lying to sitting on side of bed. He required Substantial to maximal assistance with upper body dressing, sit to stand, chair/bed to chair transfer, toilet transfer, and he was dependent for toileting hygiene, shower/bathing, lower body dressing and putting on/taking off footwear. He had a Brief Interview Mental Status (BIM) score of 13, indicating intact cognition. Record review revealed that documentation dated 08/16/24 Hospital Discharge Summary and After Visit Summary documented the following: Discharge Disposition: Skilled Nursing Facility. Discharge Diagnoses: Atrioventricular (AV) Block, Dysuria, Benign Prostatic Hypertrophy (BPH) Serum Total Bilirubin elevated, Normocytic Anemia, Change in Mental Status---Alert, Disoriented. Dementia, Elevated Troponin Level, Insulin Dependent Type 2 Diabetes Mellitus, Right Bundle Branch Block (RBBB) and 1st Degree AV Block and Hypertension. And placement of Cardiac Pacemaker (CPM). The After Visit Summary also included an appointment for the Resident which was originally scheduled for Wednesday August 21st at 2 PM, with the Advanced Registered Nurse Practitioner (A.R.N.P.) at the Hospital. Record review of the facility's Physician's order dated 08/17/24, entered by Staff A, a Licensed Practical Nurse (LPN) documented, follow-up appointment with Advanced Registered Nurse Practitioner (A.R.N.P.) on 08/21/24 at 2 PM. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Computerized record review of the Daily Skilled Progress Note dated 08/22/4 at 1:33 PM by Staff B a Registered Nurse (RN), documented for the resident: Mental Status within normal limits: No. Oriented to person, place. Mental Assessment involving: Anxiety, Depressed/Agitated/Disoriented/Confused were all listed as: Yes. There was also an entry by the nurse, He is able to follow simple commands Assistance with care provided as needed. Record review revealed that Facility's Schedule Book for the Cardiology appointment was recorded with instructions for: 11:30 AM appointment with a pick-up time of between 10:20-10:50 AM. And, return time from between 12:45 to 1:15 PM. Record review of the Resident #1's Care plan initiated 08/19/24 indicated Focus: Activities of Daily Living (ADL): Resident #1 has an ADL Self-care performance deficit related to status post Pacemaker implanted, Osteoarthritis, Hypertension, Diabetes Mellitus, Cervical Myelopathy, Radiculopathy, Parkinson's Disease, Bowel and Bladder Incontinence with impaired mobility and generalized weakness. Interventions: assist as needed .assist to complete ADLs with limited to extensive assist with ADLs .and total assist with meeting elimination needs assist and monitor safe mobility techniques and transfers with assistive devices Goal: Resident will improve/maintain current level of function in .transfers .dressing, toilet use and personal hygiene through review date. Further record review of the Resident #1's Care plan initiated 08/19/24 indicated Focus: Bowel and Bladder Incontinence: Resident #1 has episodes of Bowel and Bladder incontinence related to impaired mobility with weakness. Interventions: Check for incontinence: clean and dry skin if wet or soiled. Document when Resident is incontinent. Perform assessment of skin. Note areas of redness. Use pads/briefs to manage incontinence .Provide hygiene after toileting to prevent skin breakdown. Goal: Incontinence will be managed by staff without evidence of skin break down over the next 90 days. During a telephone interview conducted on 09/04/24 at 7:06 PM with Resident #1's family member, regarding her Resident #1's doctor's appointment on Thursday, August 22, 2024, she stated that someone from the facility called her and her younger sister, the very same day about 15 minutes or so, before the actual appointment. She further explained that Resident#1 had already left the facility (by a transportation company) and was on his way to the appointment (unaccompanied). The family member stated that multiple other family members had been coming in and out of the facility on a daily basis to visit him, but no one from the facility ever said anything to any of them about this appointment. She said that he was to see a Cardiologist for his 2-week post-surgical follow-up for his Pacemaker placement. Furthermore, she added that none of Resident #1's clothing had been sent over to [NAME] from the hospital. She indicated that after the Doctor's office told her that Resident #1 was only in a hospital gown, she asked [NAME] over the telephone where his belongings were and she said that they told her, he did not have any belongings, and they didn't know anything about them. She further stated that when she asked the facility regarding the appointment, they only initially provided vague information to her and only then provided more specific, detailed information after she asked them about it repeatedly. She said that she questioned why the facility had not tried to contact the other family members who live here and visit him regularly in the facility, much earlier regarding this upcoming appointment so that they could provide clothing for Resident #1, if needed. She further said that the Resident had been picked up two (2) hours after the appointment was finished and as a result, he urinated on himself while only wearing a hospital gown with no underpants and no assistance with personal hygiene care. She said that it greatly disturbed her that Resident #1 told her that he was cold. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident #1 on 09/05/24 at 2:29 PM, in which he provided information to this Surveyor, during a conversation regarding his visit to his last doctor's appointment in the facility. He stated that, one (1) time a driver came to pick him up and drop him off and then he left. And, then Resident #1 said that a different driver picked him up from his appointment and brought him back to [NAME], after a long time. The resident went on to say that he was wearing a hospital gown, and he said that thinks he had a diaper on that day when he urinated on himself, but he said that he wasn't sure and could not remember. Resident #1 ended by saying that, it bothered him to be wearing a hospital gown instead of wearing clothes and dressed, as he prefers. During an interview conducted on 09/05/24 at 2:56 PM with the facility's Staff C, Unit Clerk/Scheduler, she was asked about Resident #1's doctor's appointment scheduled for Thursday August 22, 2024, outside of the facility. Staff C responded first by saying that she was the one responsible for this appointment. She said that she remembered calling one (1) of the Resident's daughters on the day of the appointment but said that she does not remember the exact time of the call, nor the exact conversation, nor which daughter she called; there was no documentation by her to confirm this. By her own admission, Staff C stated that she had not obtained confirmation from the family member indicating that they would be accompanying the resident to the appointment that day. Therefore, she added that the Transportation company was allowed to take the resident to the appointment alone. Staff C verbalized that, she would not do this again. And, she admittingly stated that she had not thought of just re-scheduling the appointment to another, more convenient day, because she did not want the resident to miss his appointment. On 09/05/24 at 5:08 PM a telephone interview was conducted with the Advanced Registered Nurse Practitioner (ARNP) from Resident #1's Cardiology office, in which she was asked briefly about the events that occurred on Thursday August 22, 2024. The ARNP stated Resident #1 was to return there for his 2-week Pacemaker placement follow-up Cardiology appointment visit. However, she said that the Resident was very disoriented, with a diagnosis of Dementia, he had no idea that he was even had a Pacemaker, nor that he was there for his Pacemaker follow-up. And, she added that he was just dropped off alone, in a hospital gown, and waited there for hours in the doctor's office and they had to call the family members to speak with them and find out what was going on. During an interview conducted on 09/05/24 at 5:10 PM with Staff D, Certified Nursing Assistant (CNA), she acknowledged that, Resident #1 did go to an appointment on Thursday August 22, 2024, wearing a hospital gown. She said that she believed he was wearing pull-ups because that was what he would always wear, but she was not sure. And, she added that he was not accompanied by anyone that day to the appointment, that she was aware of. On 09/05/24 at 4:25 PM a telephone interview was conducted with Staff B, a Registered Nurse (RN), on the 7 AM to 7 PM dayshift, in which he was asked about Resident #1's orientation status. Staff B stated that sometimes the Resident is alert and sometimes he is not, and he can be confused sometimes. Staff B further stated that he did not remember exactly what the Resident was wearing that day, nor if the Resident had on a diaper or incontinence brief, to the Doctor appointment. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted with the acting DON on 09/05/24 at 5:20 PM, regarding Resident #1's Doctor's appointment on Thursday August 22nd 2024, she indicated that she was not aware of the exact time of the appointment that day and she revealed that she was sitting next to Staff C, on that day and she asked Staff C if she had reached out to the family to see if they could meet Resident #1 at the doctor's office and bring over some clothes to go out to the appointment. The acting DON said that one (1) of Resident #1's daughters, who lives locally, told them that she could not go. The acting DON then said that, at that point, Resident #1 was alert and oriented x3, so he was sent out to the appointment in what he was wearing, a hospital gown with something on underneath. Further investigation revealed there was no nursing clinical documentation on file to show the name and type of Doctor's appointment, nor the exact time of when he left and ultimately returned to the facility, nor whom he left the facility with, nor of his current condition/status at the time of his leaving from the facility. Moreover, there was no documentation to indicate that the resident's responsible party had been notified of this appointment. During an interview on 09/05/24 at 5:40 PM, the Administrator acknowledged that the circumstances surrounding Resident #1's medical appointment should have been handled or addressed more promptly and appropriately with better communication between the facility and the Resident's representatives. This was not done.		