Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964636	A. BUILDING: _____ B. WING _____	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA (THE)	5100 WEST HALLANDALE BEACH BLVD HOLLYWOOD, FL 33023

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A 000	Initial Comments An unannounced Complaint (#2023000763) survey and Generator Monitoring survey was conducted on through at The Peninsula. The facility had deficiencies identified related to the complaint at the time of the survey.	A 000		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close	A 030		

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A 030	Continued From page 1	A 030		

proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible

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A 030	Continued From page 2 telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the	A 030		

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A 030	Continued From page 3 facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care . , , ..., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . , ..., the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care	A 030		

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A 030	Continued From page 4 Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for	A 030		

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A 030	Continued From page 5 exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . . , ... or . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observations, interview, and record review the facility failed to notify the appropriate State agencies when an allegation of , , ... related to Resident #1, was brought to the attention of the Director of Wellness Staff A. The findings included: Review of the facility policy on Reporting,	A 030		

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A 030	Continued From page 6 -Neglect- , states in part: 'Staff witnessing, suspecting or having knowledge of , neglect, and/or , of a Resident have an to report immediately, or as soon as practical to the required agency. Staff who reports to the Executive Director, must assure the Executive Director has made a report to the required agency. The Executive Director (or designee) will notify the Regional Director of Operations. The Executive Director is responsible for: *Seeking immediately emergency care if needed *Notifying the Resident's Medical Provider *Notifying the Resident's authorized Responsible Party of the report *Notifying local law enforcement for any physical injury, , or other crime related to the alleged . *Investigating the allegation, enlisting Adult Protective Services, the State Regulatory Agency, and Ombudsmen as needed and required. *Assuring the proper reporting (Meridian Senior Living Regional Director and management, State Regulatory Agency, and Insurance Reporting) is completed. *Required documentation is completed within the required time frames. ACTIONS: *An employee alleged to have abused a Resident will be placed on suspension pending the outcome of the investigation. If the allegation is substantiated, the employee will be terminated. In an interview conducted with the Director of Wellness Staff A on she stated on at approximately 1:00 PM, a private duty aide came to the nurses station stating that one of the staff has abused Resident #1 and her are black and blue. The Director of	A 030		

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A 030	Continued From page 7 Wellness Staff A immediately informed the Administrator, and they went up to Resident #1's room. On [redacted] at 12:40 PM, Resident #1 was observed by Licensed Practical Nurse (LPN) Staff B being aggressive with her walker pushing the walker into the elevator. On [redacted] at 12:45 PM, Resident #1 was observed using her walker returning from a doctor's [redacted]. She displayed short patience. An attempt was made to interview Resident #1, but she was unable to give details of the allegations of [redacted], however when asked if staff is hitting her, she responded by stating 'the staff hits me.' Resident #1 abruptly left and refused to answer any additional questions. On [redacted] at 11:30 AM, an interview was conducted with Director of Wellness Staff A who stated she noticed Resident #1 rubbing her [redacted] prior to the unexpected alleged [redacted] allegation from the private duty aid who stated the facility staff [redacted] Resident#1 on [redacted]. She further stated she had notified the resident's family member of the allegation who stated he will be contacting AHCA (Agency for Health Care Administration) to make a report. Director of Wellness Staff A stated she has not heard from the Department of Children and Family Services (DCF) or the police. Further investigation revealed the facility had not contacted the State Agency or DCF when apprised of the alleged [redacted] allegation against Resident #1. Review of Resident #1's record revealed she was admitted to the facility on [redacted]. Review of the Resident Health Assessment (AHCA form 1823) dated [redacted] revealed Resident #1's	A 030		

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A 030	Continued From page 8 diagnoses to include [redacted] and [redacted]. Status: Stable. Resident #1 required assistance with all Activities of Daily Living (ADL'S) except eating. During an interview conducted on [redacted] at 11:10 AM with the Administrator and Director of Wellness Staff A, they stated they went to Resident #1's room after being told by the private duty aide a staff member had [redacted] Resident #1. Both stated they did not see any [redacted], black and blue marks or [redacted] of the [redacted] of Resident #1. Director of Wellness Staff A was asked if an Adverse Incident report was submitted to AHCA or if they had reported the alleged [redacted] incident to DCF as required. The Director of Wellness Staff A stated no Adverse Incident Report was submitted and further stated she would have called DCF and AHCA if there were any indications of [redacted] no matter what staff member it was, but we did not see any [redacted]. [redacted] at 11:55 AM, the Director of Wellness Staff A provided Progress Notes related to the alleged [redacted] incident of Resident #1. The incident was reported to the facility Risk Manager, however there was no evidence of any further follow up or investigation or staff interviews conducted to determine the status of the alleged [redacted] complaint which was brought to their attention on [redacted]. On [redacted] at 1:00 PM during an interview conducted with the Administrator and Director of Wellness Staff A, they acknowledged the findings and no additional documentation was provided. Class III	A 030		

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A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation	A 081		

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A 081	Continued From page 10 which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:	A 081		

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A 081	Continued From page 11 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and employee record review the facility failed to ensure that 2 out of 14 sampled employees completed the 1 hour required training on Reporting Major Incidents, Reporting Adverse Incidents, Incident Reporting	A 081		

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A 081	Continued From page 12 and and Neglect training, specifically Staff A and Staff B. The findings included: Review of the facility -Neglect- , policy dated states in part,' Employees will receive training during orientation and annually in the detection, prevention, reporting and documentation of and neglect. Training will include a review of the consequences for Resident , neglect and , such as termination, civil liability and referral to law enforcement for criminal prosecution. Employees will sign that they have received the training. Training records will be filed in the personnel file.' Review of the facility policy on Reporting -Neglect- , states in part: 'Staff witnessing, suspecting or having knowledge of , neglect, and/or , of a Resident have an to report immediately, or as soon as practical to the required agency .... Investigating the allegation, enlisting Adult Protective Services, the State Regulatory Agency, and Ombudsmen as needed and required.' On , an alleged , allegation was made by a private duty aide to the Director of Wellness Staff A. The private duty aide stated a facility staff member , , Resident #1 and her are black and blue. Review of the employee records revealed the following 2 staff members who had knowledge of this allegation of , against Resident #1, did not have evidence of the and Neglect training in their records and did not follow	A 081		

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PENINSULA (THE)	5100 WEST HALLANDALE BEACH BLVD HOLLYWOOD, FL 33023

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A 081	Continued From page 13 their policy to notify Adult Protective Services or the State Agency per their policy. 1) Review of the employee record for the Director of Wellness Staff A revealed a date of hire of . Further review of the employee record revealed no evidence of the mandatory training documentation on Reporting Major Incidents, Reporting Adverse Incidents, Incident Reporting and and Neglect training. 2) Review of the personnel record for the Licensed Practical Nurse Staff B revealed a date of hire of . Further review of the employee record revealed no evidence of the mandatory training documentation on Reporting Major Incidents, Reporting Adverse Incidents and Incident Reporting and and Neglect training. On at 1:00 PM, an interview was conducted with the Administrator and Director of Wellness Staff A who acknowledged the findings and provided no further documentation to review. Class III	A 081		