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 _____ | 04/23/2025 |

| 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<br><br>An unannounced Licensure Complaint survey, complaint number 2025005260, was conducted on at Peninsula (The). The facility had deficiencies at the time of the survey. | A 000 | | |
| A 053 | 59A-36.008(4) FAC Medication - Administration<br><br>(4) MEDICATION ADMINISTRATION.<br>(a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label.<br>(b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record.<br>(c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff.<br>(d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. | A 053 | | |

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| A 053 | Continued From page 1<br><br>Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on review of policy and procedure, interview and record review, the facility failed to ensure the following:<br>1) record the resident's Levels (BGLs) and treatment administered, as applicable for 7 of 31 days noted during the month of .<br><br>2) to document contact of the resident's health care provider, in the resident's record, for 1 of 4 sampled residents reviewed for fluctuating Levels, and Administration during the months of and , Resident #1.<br><br>The findings included:<br><br>Record review of the facility policy and procedure titled, "Policy and Procedure Manual Medication Program" provided by the Director of Health & Wellness (DHW) with a reformatted date of documented the following; Medication administering directions ...Injectable Medication: injectable medication is only given by authorized trained Staff as allowable by State Law and Board of Nursing Regulations ....The Wellness Director (or designee) will notify the Resident's Medical Provider and follow the Medical Provider's instructions ....<br><br>Review of Resident#1's file and Health Assessment revealed the following. Resident #1 was originally admitted to the facility on , | A 053 | | |

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| A 053 | Continued From page 2<br><br>and she was re-admitted to the facility on with diagnoses which included Type 2 with and and Dependence on . Resident<br><br>Record review of Resident #1's file revealed that the resident had experienced multiple hospitalizations since admission due to non-compliant with dietary orders( diet) and monitoring concerns.<br><br>During a telephone interview conducted with the Resident #1's daughter on at 1:30 PM, regarding the resident's Levels (BSLs), she indicated that the BSLs were not being monitored appropriately and adequately by the facility. Resident #1's daughter also said that the resident has had about three (3) hospitalizations between the months of and , due to Resident #1's extremely high BSLs some of which have which have read over 400.<br><br>1) On the physician's order documented, " 100 IU/ML --- 15 Minutes Before Meals with : more or equal 150=0 Units, 151-200=5 Units, 201-300=9 Units, 301-350=11 Units, 351-400=13 Units; more than 400=15 Units CALL Medical Doctor (MD)."<br><br>On Resident #1's Care Plan documented, Focus: "Resident has , Interventions: Administer/assist with medication as ordered by MD. Observe for side effects and effectiveness and report observed side effects/effectiveness to nurse. checks as ordered by MD. Observe | A 053 | | |

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| A 053 | Continued From page 3<br><br>for and report to nurse any s/sx of low ( ): sweating, shakiness (tremor), increased rate ( ), pallor, nervousness, , slurred speech, complaints of hunger, complaints of vision changes, complaints of , ....<br>Goals: Will be free from any signs and symptoms of and , through next review.<br><br>Computerized record review of Resident #1's Medication Administration Record (MAR) for the month of revealed for the following seven (7) days below:<br><br>Resident #1 would have been in the facility on Sunday at 12 Noon to have her BSL taken, but no documentation provided. Resident not out with family (in note above) until 5 PM, much later that same day.<br>Resident #1 on Wednesday at 12 Noon had no BSL documentation provided.<br>Resident #1 on Thursday at 12 Noon had no BSL documentation provided.<br>Resident #1 on Monday at 12 Noon had no BSL documentation provided.<br>Resident #1 on Monday at 8 PM had no BSL documentation provided.<br>Resident #1 on Friday at 12 Noon had no BSL documentation provided.<br>Resident #1 on Tuesday at 12 Noon had no BSL documentation provided.<br><br>There were no BSL entries recorded in Resident #1's MAR, no staff initials or signatures noted, no explanation provided in the nursing progress notes, nor any documentation of any treatment provided for Resident #1, during any of these seven (7) of thirty-one (31) days listed above, in the month of , for Resident #1. | A 053 | | |

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| A 053 | Continued From page 4<br><br>Further record review of Resident #1's computerized BSL logs revealed that on at 23:04 PM or 11:04 PM, and also at 23:05 PM or 11:05 PM, Resident #1 had a recorded BSL of 429.0 mg/dl.<br><br>Record review of Resident #1's MAR for , revealed that Staff A, a part-time 3 PM-11:30 PM Licensed Practical Nurse (LPN) had initialed or signed off that Resident #1 had been administered 15 units of the 100 IU/ML .<br><br>However, there was no documentation anywhere in the nursing progress notes to indicate whether or not Staff A had contacted Resident #1's physician, as ordered. Nor, whether any new orders were obtained for the resident, at the time.<br><br>During an interview conducted with Staff A, on at 4:38 PM she revealed that on Saturday at 23:04 and 23:05 PM, Resident #1's level read over 400; it was actually 429. Staff A stated that the order called for her to "call MD," she acknowledged that she had not documented anywhere in Resident #1's record whether or not she had contacted the resident's physician, nor whether or not any new orders were obtained for the resident, at the time.<br><br>2) On the physician's order documented, " ASPA 100 units/ml Pen ( 100 units/ml ) fifteen (15) Minutes Before Meals with : more or equal 150=0 Units, 151-200=5 Units, 201-300=9 Units, 301-350=11 Units, 351-400=13 Units; more than 400=15 Units CALL MD." | A 053 | | |

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| A 053 | Continued From page 5<br><br>Record review of Resident #1's computerized BSL logs revealed that on at 16:35 PM or 4:35 PM, Resident #1 had a recorded BSL of 407.0 mg/dl.<br><br>Record review of Resident #1's MAR for , revealed that Staff B, an LPN, working full-time on the 3 PM-11:30 PM shift) had initialed or signed off that Resident #1 had been administered 15 units of the 100 IU/ML<br><br>However, there was no documentation anywhere in the nursing progress notes to indicate whether or not Staff B, had contacted Resident #1's physician, as ordered. Nor, whether any new orders were obtained for the resident, at the time.<br><br>An interview was conducted with Staff B, on at 4:45 PM in which she also acknowledged that on Wednesday , Resident #1's level read over 400; it was actually 407. Staff B, stated that the order called for her to "call MD," she also acknowledged that she had not documented anywhere in the resident's record whether or not she had contacted the resident's physician, nor whether or not any new orders were obtained for the resident, at that time.<br><br>A side-by-side record review was conducted with the DHW in which the resident's two (2) elevated BSLs greater than 400, were noted; with no documented notification being made to Resident #1's physician, as ordered.<br><br>The DHW further recognized and acknowledged on at 4:46 PM that Resident #1's physician should have been contacted, as ordered, and that this contact should have been | A 053 | | |

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| A 053 | Continued From page 6<br>documented in the resident's record. Further record review also revealed that the facility had not implemented any preventive measure to ensure its licensed staff followed physican orders regarding _.<br><br>Class III | A 053 | | |