STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964636	03/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Peninsula (the)	5100 W. Hallandale Beach Blvd. Hollywood, FL 33023	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced complaint survey, CCR# 2013012203 and # 2014000398, was conducted on [redacted] at The Peninsula. The facility had deficiencies found at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on observation,interview and record review, the facility failed to ensure the Resident Health Assessment form (AHCA Form 1823) was completed upon significant change and reflective of the resident's current health status and care needs, for 2 out of 11 sampled residents (Resident #7 and #4).

The findings include:

1. Resident # 7 was admitted on [redacted] with medical diagnosis of s/p [redacted] Accident, right occipital [redacted] acute infarct, Aphasia, [redacted] and [redacted]. Review of the 1823 form dated [redacted] reveals the resident is alert and oriented x 3, he requires total assistance with ADL (Activities of Daily Living) care and assistance with self-administration of medications.

Review of the Progress Notes dated [redacted] revealed the resident was observed leaning over more than normal and drooling more than usual. He is not able to feed himself and has poor appetite. The physician is notified and the resident is sent to the ER for evaluation for possible [redacted] and [redacted]. On [redacted] the resident returns to the facility. On [redacted] the Notes document the resident has increased [redacted] and requires additional ADL care. A request for a Hospice consult was ordered.

On [redacted] the resident was admitted to Hospice services for decline in function and weight loss.

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The initial Hospice evaluation documents the following. Resident at very high risk for he is disoriented x 3 at all times, he has balance problems with sitting and moving side to side. He complains of pain in his left foot expressing pain by grimacing and moaning. He requires pain medications 2-3 times a day as needed. He is currently on pureed diet and has poor appetite, never completes a meal, poor food intake, with loss of weight. Weight 156#, on admission to Hospice- 85 #. He is of bowel and and wears a brief. He has excessive secretions orally and drools from the right side of mouth. He has a sacral , which is pink with no drainage.

On at approximately 2:00 PM during an interview with the Resident Care Director, she reviewed the medical record and confirmed that the resident was placed on Hospice Care on She was unable to provide an updated 1823 form reflective of the residents current medical condition after aforementioned significant health change.

2. Resident #4 was admitted on Her medical diagnosis includes a history of Meningioma, and a history of Review of Resident#4's Health Assessment form reveals the resident requires assistance with all ADL care and self administration of medication. She is ordered a diet.

Review of 2014 Medication Observation Record (MORs) documents glucose being monitored two times a day and administration by the Home Health Nurse. The 1823 Resident Health Assessment form does not reflect the resident's need for daily glucose monitoring and injection by the Home Health Nurse.

On at approximately 2:00 PM during an interview with the Resident Care Director, she reviewed the medical record and confirmed that the resident has been receiving Home Health nursing care for care. She was unable to provide an updated 1823 form reflective of the resident's current medical condition and/or nursing needs.

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0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on observation, interview and record review, the facility failed to adequately provide care and services appropriate to the needs of the residents. As evidenced by facility failure to provide supervision to prevent for residents identified at risk for for 2 of 11 sampled residents (Residents #2 and #9).

The findings include:

a) Resident #2 was admitted to facility on with history of Hematoma, and Resident #2's Resident Health Assessment form (AHCA Form 1823) dated documents the resident as alert and oriented and poor gait and needs assistance with ambulation. The 1823 form also documents the resident requires assistance with other ADL care also.

Further record review revealed the following regarding Resident#2.
1) The resident had decline in function and was moved to the facility Memory Care unit on

2) Review of the Progress Notes dated reveals the resident is found on floor with a laceration on back of head and above left eye, she is sent 911 to ER for evaluation. The resident is readmitted on on for and she has on her forehead.

3) Resident admitted to Hospice for decline in health due to on

4) Review of the Progress Notes dated reveals the aide reports that the resident had with no apparent injury. The resident complains of back pain later in the day; the Physician and Hospice were notified.

5) Review of the Progress Note dated reveals the resident is found lying on floor in her her back against a clothes chest. The resident was unable to move her left leg and had a large on left shoulder; the Physician and Hospice were notified. The resident was sent 911 to the hospital for evaluation. The resident is readmitted to facility on on Hospice 24 hour Crisis care for requested pallatative pain management for the left hip. The resident was to see her Orthopedic physician in 1 month. The resident expired on while on 24 hour Crisis Care. The resident's 1823 form, dated reveals the resident has history of left hip memory loss and increase risk. The form does not reflect the resident is on Hospice Care.
Review of the facility Incident Reports documenting each of the revealed care interventions to

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prevent further ..... as "closer monitoring of resident".

On ..... at approximately 2:30 PM during an interview with the Resident Care Director (RCD) and Associate Executive Director (they stated that the resident expired while on Hospice Care. The RCD reviewed the record and could not provide documentation that the facility had reassessed the resident after the ..... and had implemented interventions to protect the resident from additional risk (including supervision). The RCD stated that the resident was mobile and ambulatory throughout the Memory Care Unit. The RCD and ..... agreed that the resident was an identified ..... risk, and furthermore the resident had not been reevaluated after the ..... to determine continued admission appropriateness for the facility.

b) Resident # 9 was admitted on with and ..... The resident has unsteady gait at all times, and has memory and ..... she is oriented to name only. Review of the 1823 Resident Health Assessment Form dated ..... reveals the resident requires special precautions for wandering. She requires assistance with bathing, supervision with self- care, dressing and toileting. The resident is on ..... and ..... The resident is independent for ambulating and eating.

Further record review revealed the following regarding Resident#9.
1) Review of the Progress notes dated ..... reveal the resident was found on the floor, ... from her forehead. She was alert but unable to describe the incident. The resident was transferred to the hospital for evaluation and returned the same day; Physician and family were notified.

2) Review of the Progress Notes dated ..... reveals the resident was found on the floor at the foot of her bed. She was moaning and could not stand on her legs. She was transferred to the hospital for evaluation; the Physician and family were notified.

3) Review of the Progress Note dated ..... reveals the resident informed the aide she had ..... but could not provide details. The resident was observed with a large hematoma on the back of her head. The resident was sent to the ER for evaluation; The Physician and family were notified.

4) Review of the Progress Notes dated , the resident is documented as having a on her right ..... The resident is unable to describe the details of the injury. She continues to ambulate around the Memory Unit with her walker; the Physician and family are notified.

5) Review of the Progress Notes dated document the resident was found sitting on the floor, holding her left shoulder and a ..... is noted on her left hand. The resident is assessed and made

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comfortable but she is unable to communicate the details of her injury. The Physician is notified and an x-ray of the left shoulder is ordered. The resident is observed sleeping thru the night and awakens the following morning moaning and holding her shoulder, with no noted. An x-ray was completed on which revealed of the surgical head of the left The resident was unable to move her arm and complained of pain. She was transferred to the ER by the physician for treatment.

On at approximately 2:30 PM during an interview with the Resident Care Director (RCD) and Associate Executive Director (they stated that the resident did not return to the facility, that she was admitted to a rehabilitation facility after repair of the arm. The RCD reviewed the record and could not provide documentation that the facility had reassessed the resident after and had implemented interventions to protect the resident from additional risk. The RCD stated that the resident was mobile and ambulation throughout the Memory Care Unit. The RCD and agreed that the resident was an identified risk and after each had not been reevaluated as to the residents continued appropriateness for the facility. Review of the facility incident reports documenting the with the RCD, revealed interventions to prevent further as "closer monitoring of resident".

On at approximately 10:00AM during an interview with the RCD and they stated that the facility protocol after a resident is to order a OT evaluation for safety. The RCD stated that both Resident #9 and #2 resided on the Memory Care Unit, and sessions would not have provided the long term results needed to decrease risk. The stated that the facility has been exploring a new policy to inform the resident and families of the risks with repeated .She stated that the facility has not regularly discussed any other interventions or higher level care options with the resident's families.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC

Based on record review and interview, it was determined the facility failed to complete and submit an adverse incident report (1 day and 15 day report) to the Agency, for 1 out of 11 sampled residents (Resident #9).

The findings include:

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b) Resident # 9 was admitted on with and The resident has unsteady gait at all times, and has memory and she is oriented to name only. Review of the 1823 Resident Health Assessment Form dated reveals the resident requires special precautions for wandering. She requires assistance with bathing, supervision with self- care, dressing and toileting. The resident is on and The resident is independent for ambulating and eating.

Further record review revealed the following regarding Resident#9.
1) Review of the Progress notes dated reveal the resident was found on the floor, from her forehead. She was alert but unable to describe the incident. The resident was transferred to the hospital for evaluation and returned the same day; Physician and family were notified.

2) Review of the Progress Notes dated reveals the resident was found on the floor at the foot of her bed. She was moaning and could not stand on her legs. She was transferred to the hospital for evaluation; the Physician and family were notified.

3) Review of the Progress Note dated reveals the resident informed the aide she had but could not provide details. The resident was observed with a large hematoma on the back of her head. The resident was sent to the ER for evaluation; The Physician and family were notified.

4) Review of the Progress Notes dated the resident is documented as having a on her right The resident is unable to describe the details of the injury. She continues to ambulate around the Memory Unit with her walker; the Physician and family are notified.

5) Review of the Progress Notes dated document the resident was found sitting on the floor, holding her left shoulder and a is noted on her left hand. The resident is assessed and made comfortable but she is unable to communicate the details of her injury. The Physician is notified and an x-ray of the left shoulder is ordered. The resident is observed sleeping thru the night and awakens the following morning moaning and holding her shoulder, with no noted. An x-ray was completed on which revealed of the surgical head of the left The resident was unable to move her arm and complained of pain. She was transferred to the ER by the physician for treatment.

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Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2014

Administrator
Peninsula (The)
5100 W. Hallandale Beach Blvd.
Hollywood, FL 33023

Dear Administrator:

Re: CCR #2013012203 and #2014000398

This letter reports the findings of a complaint survey that was conducted on . 2014 by a representative from this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within **thirty (30)days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2014** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene -Davis
Field Office Manager

AMD/dso
Enclosure: State 5000-3547
XG90

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