STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964636	05/20/2014
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 - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR #2014002878 and CCR #2014003059, was conducted on [redacted] at The Peninsula. The facility had a licensure deficiency found at the time of the visit. Deficient practice identified at A025 for CCR #2014003059.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record reviews and interviews, the facility failed to honor resident rights as evidenced by they failed to notify the responsible parties of a change in condition for 3 out of 3 residents (Residents #2, #5 and #6).

The findings are:

On [redacted] at 2:30 PM during an interview with an aide in the [redacted] unit, she said "the entire unit was treated" for the [redacted] Three resident records of residents residing in the [redacted] unit were reviewed (Residents #2, #5 and #6).

Resident #5's record was reviewed and documented that on [redacted] the resident received "Lindane 1 percent lotion apply one ounce to entire body from neck down and thoroughly wash after 8 hours." There were no notes that the resident's family was notified.

Resident #6's record was reviewed. The resident is the [redacted] of Resident #5. The medication record, progress notes and physician orders were reviewed and there was no documentation that the resident received any treatment, and no documentation that the responsible party was notified.

Resident #2's record was reviewed. The resident's record did not contain any documentation regarding treatment for [redacted] including no documentation on the progress notes, on the medication observation record or in the physician orders.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964636	05/20/2014
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)		

On [redacted] at 3:10 PM, an interview was conducted with the Resident Care Director. She stated that in [redacted] of 2014 the entire [redacted] unit was treated for [redacted]. She was unable to locate any documentation that the families of the sampled residents were notified. She agreed that the families should have been notified, especially if they did the resident's laundry, and also agreed there should have been documentation in the records of treatment rendered to the residents. She further stated that the health care professionals disagreed on whether there was [redacted] or not. She said that she did remember that Resident #2's family called the facility when they received a bill from the pharmacy for the [redacted] treatment.

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 #2014003059 and #2014002878

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,

J Hodges-Evans, Supervisor

for Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924