STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964636	03/17/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
PENINSULA (THE)	5100 WEST HALLANDALE BEACH BLVD HOLLYWOOD, FL 33023	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2014012356 and #2015001202, were conducted on at The Peninsula Assisted Living Facility. The facility had a deficiency identified at the time of the visit. Deficient practice identified for complaint # 2015001202.

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to submit adverse incident report's related to an incident where resident sustained a bone and was transferred from the facility to a facility providing acute level of care, for 2 of 4 residents' records reviewed (Resident #1 & #3).

Findings:

a) On at 10:00AM during the entrance interview the Administrator was asked for the Adverse Incident Reports for 2014 and 2015 to date. The Administrator stated that she had not filed any Adverse Incident Reports during that time.

Record review conducted on at approximately 1: 30 PM for Resident #1 revealed a Resident Health Assessment Form (AHCA form 1823) dated with diagnosis of Advanced and Physician indicated the resident required assistance with self- administration of medications and supervision with ambulation. Physician indicated that the resident ' s needs can be met in an Assisted Living Facility.

Review of Incident Report Log conducted on at approximately 1:15 PM revealed an ALF Incident Report dated for Resident #1. The incident report revealed that Resident #1 outside his trying to open it. He complained of pain in the left He was transported to Emergency Memorial Regional Hospital-Hollywood where he was assessed and treated for a of the left femur.

Record review conducted on for Resident #1 revealed Nurse ' s Notes dated stating resident admitted to hospital for of left femur. After surgery the resident was moved to a rehabilitation. Nursing Note dated revealed that the resident moved out of the area to be closer to his family.

b) Resident record review conducted on at approximately 2:00 PM for Resident #3 revealed a Resident Health Assessment Form (AHCA form 1823) dated with diagnosis of Type II. The physician indicated that resident is forgetful at times and requires assistance with self-administration of medications. The form also documented the resident is independent with ambulation.

Record review conducted on at approximately of Incident Report Log dated 2015. Incident Report dated concerning Resident #3 revealed the resident on the floor during an activity in the activity 11:15 AM. Resident was unable to state what she tripped over. Resident complained of pain in the right

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0165 Continued From page 1

leg. Resident transported to Emergency

Nursing Note dated revealed the resident was admitted and treated for right hip and was admitted to the hospital for surgery. Resident was transferred from the hospital to a Rehab center and is expected to return to the Assisted living Facility on

During an interview conducted on with the Administrator at 4:50 PM who stated she was not aware she had to file an adverse incident report for an incident where a resident sustained a and was transferred from the facility to a unit providing acute care.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Peninsula (the)
5100 West Hallandale Beach Blvd
Hollywood, FL 33023

RE: CCR #2014012356 & 2015001202

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2015 and , 2015 by a representative of 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 days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after 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 Mayo-Davis
Field Office Manager

AMD/sf
Enclosure
XG90

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