STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964636	01/22/2016
NAME OF PROVIDER OR SUPPLIER **PENINSULA (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **5100 WEST HALLANDALE BEACH BLVD HOLLYWOOD, FL 33023**	

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

0000 Initial Comments

A complaint investigation was conducted at The Peninsula on 12/10/15,01/08/16 and 1/22/16. The Peninsula had a deficiency at the time of the investigation.

0025 Resident Care - Supervision

Based on interview and record review, it was determined that the facility failed to notify a resident's physician upon the resident exhibiting significant behavior changes, for 1 out of 1 sampled residents. This is evidence of the facility failure to notify Resident #4's physician regarding the increased aggressive behavior exhibited by the resident.

The findings included:

A) Resident #4 was admitted to the memory care unit of the facility on / / . Review of the resident ' s / Health Assessment for Assisted Living Facilities (AHCA Form 1823) revealed that the resident ' s medical diagnoses included ' , major , type II , chronic kidney , , and . At the time of the / / medical examination, the resident was oriented to person only. The resident was assessed by his physician as requiring supervision for ambulation, transfers, and eating. The resident was assessed as requiring assistance for bathing, dressing, , and toileting. The section of AHCA Form 1823 titled ' Nursing/treatment/ requirements ' indicates that the resident requires " full assistance " .

Review of Resident #4 ' s facility Memory Care Functional Assessment revealed that the resident was assessed on by the facility ' s Resident Care Director (RCD), who is a licensed practical nurse. The functional assessment indicated that the resident required from staff for bathing, , dressing, and toileting management of incontinence. The functional assessment indicated that the resident required for mobility and was to be monitored for stability. The resident was assessed as requiring for medication management, as well as for awareness due to being "often forgetful " . The resident was assessed as requiring only minimal assistance for safety.

Upon review of the mobility care needs section of the functional assessment, the following discrepancies were noted:
1) The facility assessment reported that the resident did not use a mobility aide, which is in conflict with the / progress note recorded by the RCD, which indicates that the resident ambulated with a walker, as well as a note elsewhere on the mobility assessment indicating that the resident used a

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walker.
2) The assessment also reported that the resident had no special needs for mobility, which is in conflict with a note recorded elsewhere on the mobility section of the assessment, which indicates the resident was to be monitored for stability.
3) The question ' does resident exhibit urgency or incontinence? ' is answered no. This is in contrast to the continence section of the assessment, which indicated that the resident required with toileting due to incontinence, and that the resident wore pull ups.

Further review of the facility functional assessment for Resident #4 revealed that the resident was assessed by the facility ' s RCD as requiring minimal behavior support, and that the resident required no special precautions in regard to behavior support. The functional assessment was not signed by a registered nurse, the facility executive director, or the resident ' s health care proxy.

A / / progress note indicated that during rounds the memory unit certified nursing assistants (CNAs) had observed the resident had been of . The notes revealed that upon approaching the resident, he "would not let anyone touch him-combative, backed up against the bed and slid to the floor- still swinging out to hit with his fist and kicking ". The note indicates that the RCD and Assistant Executive Director, as well as the resident's daughter were notified of the resident's behaviors. The nursing note indicates that the resident's daughter stated that the resident ' hadn ' t been combative in about 3 years'. There is no documentation that the resident ' s physician was informed of Resident #4 ' s change in behavior, and no documentation of orders for medical or evaluation were obtained.

A 1:00 AM nurse's note indicated that the resident was of but was refusing to allow the staff to clean him. The note further stated that the resident "bent one of the staff member's fingers back" and was trying to bite and push the staff. The note further indicates that the resident " was left alone-not able to get near him " . There is no documentation that the resident's family or physician was informed of the resident's aggressive behaviors. There is no documentation of any order for further medical or evaluation of the resident's behaviors in the resident's chart.

A / 12:00 AM nurse's note indicated that that during rounds, a CNA opened the resident's door to check on him. Per the notes, the CNA was " punched in the chest as soon as she opened the door ...then resident preceded to chase after her and another CNA in the (memory care unit). The nurse and myself was called to come ...resident speaking in Spanish-not listening to verbal command to settle down. Resident running around in the area scratched up a bag belonging to [staff name]. Took out her

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bottle of water and throwing the water all over the piano, the tables and chairs and trying to wipe it off with sandwiches. Unable to calm resident ". The note documents that the resident's daughter and wife were called. There is no documentation in the resident's chart of the resident's physician being informed of the resident' s behaviors, and no new orders were obtained.

An /// 3:00 PM nurse ' s note indicates that the resident was observed to have a area to the left , and that the resident was having difficulty walking. Per the nurse's note, the resident' s physician and family were notified, and at 4:00 PM the resident was transported to a hospital by emergency medical services.

B) Review of an / 2:30 PM written statement from Staff A, revealed that the CNA and a second staff member observed the on the resident ' s left , and that the was reported to the nurse on duty and the RCD. The written statement indicates that the resident had received a shower during AM care, and that there was no sign of at that time.

During a / 4:09 PM interview with the RCD and Assistant Executive Director, the RCD stated that on the day the was found on the resident, the resident had refused care in the morning. The RCD stated that he had been present when the resident was given a shower later that morning, and that " nothing happened " in the shower. The RCD stated that he had also helped to dress the resident.

The RCD stated that the on the resident ' s occurred between breakfast and lunch. The RCD stated that the was approximately 8 to 10 inches long. The RCD stated that the staff had found the when toileting the resident and had called him. He stated that the area was red and warm to the touch, and that the resident was ambulatory.

The Assistant Executive Director stated that it was her understanding that on the date of the injury, the staff were having difficulty giving Resident #4 a shower, and that the RCD had assisted the staff in showering the resident at about 8:00 AM. The Assistant Executive Director stated that she understood that after lunch a staff member had attempted to change the resident, but he had resisted. She stated that the staff were able to take the resident to the approximately 2:30 PM, and that the had been observed by the CNAs at that time.

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During the interviews, the RCD and Assistant Executive Director were asked for a copy of the accident report or documentation regarding the incidents for Resident #4, but none were produced. The facility was unable to produce any documentation of Resident #4 ' s physician being notified of aggressive behavior or refusing care during the resident ' s stay at the facility.

C) Review of Emergency (ER) records revealed the following.
1) Review of the / / Emergency Services Transport Form for Resident #4 revealed that emergency services received the call for assistance on / / at 4:10 PM, arrived at the facility at 4:16 PM, left the facility with the resident at 4:25 PM, and arrived at the hospital with the resident at 4:31 PM. The section of the form titled ' Injuries ' indicated that the resident had sustained blunt from an unknown cause.

2) Emergency :40 PM initial physician ' s note revealed the following entry:
" Patient presents to the ED (emergency department) with to his left lower back, onset today. The patient ' s family brought him to the ED because they noticed a large to his lower back, but there is no witnessed or other known . The patient is nonverbal secondary to advanced and is unable to provide any history. The daughter states that at baseline, the patient stands and ambulates independently, but he is unable to stand or bear weight on his left lower extremity today. There are no other complaints at this time "

3) On / at 10:42 PM, the orthopedist recommended that the resident be transferred to a different hospital for further evaluation of his left hip. Resident was transferred to second hospital ER on / / . Resident was admitted to the hospital on / and discharged on / / from the hospital to a skilled nursing facility. The discharge diagnoses were , , and a muscle . The resident was to receive physical at the skilled nursing facility.

During an interview with Resident #4's physician on / at 10:13 AM, the physician stated that he had received no phone calls from anyone at the facility concerning Resident #4 between / and / . The physician stated that he was contacted upon the resident ' s transfer to a hospital in of 2015, but that he was never contacted concerning the events of / , , or / / . The physician stated that his last face to face encounter with Resident #4 was on when he examined the resident and completed the AHCA Form 1823. The physician again stated that he had not been contacted by the facility concerning the resident since / / .

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Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
The Peninsula
5100 West Hallandale Beach Blvd
Hollywood, FL 33023

RE: CCR #2015011591

Dear Administrator:

This letter reports the findings of a Complaint survey that was conducted on , 2016 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 13, 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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
Enclosure
XG90

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