STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964636	R 10/05/2018
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

An unannounced re-licensure Revisit survey was conducted on 10/5/2018 at Peninsula (The), License #9196. The facility had deficiencies at the time of the visit.

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the facility failed to ensure that 2 of 5 resident's ordered medications (Resident #1 & #3) were provided as ordered.

The findings included:

a) During record review of the medication observation record (MOR) for Resident #1 on , it was noted that some sections of the MOR had no signature. In addition, there was a note that indicated that Resident's #1's machine for administration of the ordered "was not here" (at the facility). The order for the medication Pulminocort 0.5 mg/2 ML RES to inhale 1 vial (2 ml) via twice daily at 8:00 AM and 5:00 PM reflected a starting date of . At the time of the visit on there were no signatures in the MOR for this med from to . A yellow sticker indicating "machine not here" was placed on the section to sign.

During an interview with the nurse in charge on at 11:20 AM, she indicated that she had contacted Resident #1's daughter to bring the machine since she had reported to the facility that she had it, but she did not bring it.

Thereafter, a request to view prior MORs was granted and revealed that the initial order dated but it was never given to the resident. From the 18th of , 2018 to the 25th, staff documented the MOR by placing a circle on the pass time and discontinued to document thereafter until the 5th of , 2018.
During a phone communication with the resident's authorized family member on at 1:47 PM, she said that her mother had last year in and went to the hospital and was then given a which Resident #1 used for a while. Then, Resident #1, was again hospitalized in , 2018 and from that hospital Resident #1was discharged to this current facility for rehabilitation. The family member reported that she was not aware that she was supposed to bring the machine to the facility. She said she was contacted about the and was told by the staff member that her mother needed to use a , her impression was that they were simply informing her that Resident #1 needed to use a which the facility would have provided. But, not the one she had at home. Therefore, she did not bring it. She also explained that she was not sure that the doctor had reordered

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the . She said now that she understand that they want the one she has, she will bring it to the facility.

b) Review of Resident #3's MORs revealed two orders one for 20 mg. (take 2 Capsules 40 mg by mouth once daily) and another for 1 mg tab by mouth once daily. However, on there was a note on the MOR that indicated the medication was not at the facility. Resident #3's health Assessment indicated that she needed assistance with self-administration of medications and was diagnosed with , muscle and was Dependent with , among others.

Following an interview with the nurse in charge on at 1:08 PM, the evidence she provided proved that the reorder of the medication was not timely. First, the MOR showed that the last dose administered and signed for was on and the note revealed that the orders were faxed to the Pharmacy on . During an interview with the facility's Pharmacy liaison, thereafter, it also became clearer that the pharmacy did not fill the order because the pharmacist needed clarification from Resident's #3's physician on the order. Consequently, the medication was not supplied and the resident did not receive the dosages on .

Following this surveyor's communication with the Pharmacist and the nurse in charge, the facility received notification that the order would be sent to the facility before the end of the day or .

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP) to the county by the required deadline for approval.

The findings included:

During an interview with the facility's Assistant Administrator on at 9:50 AM, she stated that she did not have the CEMP. She reported that the Administrator took her CEMP documents to the Emergency management company and they rejected it because the facility did not have a current license. Consequently, she indicated that they did not know what to do.
Review of the facility's previous CEMP indicated that it expired in 2017.

Class III