Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964636	A. BUILDING: _____ B. WING _____	09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA (THE)	5100 WEST HALLANDALE BEACH BLVD HOLLYWOOD, FL 33023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure complaint survey, Complaint Number 2019009152, was conducted on at The Peninsula. The facility had a deficiency at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.	A 025		

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A 025	Continued From page 1 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that adequate supervision was always in place to prevent elopement of 1 of 2 residents reviewed (resident #1), thus allowing resident 1 to leave the facility for several days. The findings included: Review of the facility's Elopement-Missing Resident policy states: "The Community will assure Resident's who are , mentally, emotionally and/or chemically and Residents who require a secure living environment area assessed for the risk of elopement. Review of confidential records revealed that Resident #1 left the facility on and was not found until at the (Government Bldg.) and was taken to (Hospital). Staff did not know (resident 1) was missing until they went to get him for dinner on , exact time Resident #1 left is unknown. In addition, Resident #1 was in	A 025		

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A 025	Continued From page 2 (hospital) under the care of the nursing staff receiving treatment. The (confidential representative) stated that during the . . . to . . . interview (while in the hospital) Resident 1 was severely disoriented, could not state his current location, nor the date, or time. The (resident) does not remember the past 38 hours nor the facility he escaped from. During review of Resident #1's file, this surveyor reviewed the resident's Agency for Health Care Administration (AHCA form 1823). The form dated . . . . . ., which indicated that Resident #1 was an Elopement risk. Further review revealed that the resident requires supervision. During interview with Employee A on . . . . . at 10:56 AM, Employee A stated that she has worked at the facility for 7 years. Relative to the elopement, employee A stated the resident had pushed the door and got out. The code before, we have to always make careful that when people are going in and out they don't go with them. The resident was gone out for a short period of time. Employee A stated that she was here that day. "Once I noticed the individual was missing, I went searching for him, got management involved and the police was called. Employee A stated that resident 1 didn't come . . . the same day." During interview with Employee B on . . . . . at 12:02 PM, Employee B stated she has been working at the facility about 4 years and was trained on the policies. Employee B also stated that the facility conducts elopement drills. Relative to elopement, employee B stated; "There was "one person that left, and they found him, about 7 or 8 months ago. He is no longer here." On at 12:58 PM this surveyor	A 025		

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A 025	Continued From page 3 interviewed the Administrator regarding elopements at the facility. The Administrator she had been the Administrator for 13 years and "never had an experience like this. It was harrowing. I was so nervous and concerned." She stated that (Employee) alerted her that they could not find (resident 1). So, we did an all-out search, alerted the managers that was here. We checked in rooms, closets, cars, parking lots; nowhere to be found. Law enforcement was called." During an interview with the Administrator on . . . . . at 1 PM, regarding Resident #1's elopement the following was revealed. The Administrator stated Resident #1 left the facility, just before 5:00 PM as we were getting ready for dinner. Law enforcement came out and did the same thing, they did their search. They were not able to find him, they used a sniffing dog and they could not find him. Family was notified. When we spoke to the (family members) the (family member) said he could either be at a bar, or at (Government Bldg.) trying to get a passport to go to France. This surveyor asked how long the resident was missing, and the Administrator stated; "Apparently, six days. We got a tip from one of the detectives stating he was found at the (Government Bldg.). We believe he stayed in a hotel the first night. His (family member) traced his card, but he obviously left the hotel after the first night. When he was found in the (Government Bldg.) they held him there until the (family member) or (Law Enforcement) got there. They took him to (Hospital) for a consultation. He stayed there a day or two and was admitted . . . to our facility. Both I and the Resident Care director went down to see him, I think it was on a Wednesday (after he was located)."	A 025		

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A 025	Continued From page 4 During further interview with the Administrator, this surveyor asked what door or gate he went through, and she responded the following. I don't really know what door he went through. At that time, family and others had the code. The policy/protocol regarding the code for the door and entrance/exiting the secured areas has changed since Resident #1 eloped. In which staff have been trained. The new policy/protocol , is that now one of us has to be there to escort family and others in and out. No one has the code now except staff." On . . . . . at 3:11 PM, this surveyor met with Administrator to conduct the Exit Interview. She was informed that the Elopement allegation was substantiated, which she acknowledged. Class III	A 025		