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 _____	06/25/2026

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
ZZ875	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each	ZZ875		

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ZZ875	Continued From page 1	ZZ875		

employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers.
(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information,

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ZZ875	Continued From page 2 and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider.	ZZ875		

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ZZ875	Continued From page 3 (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , must complete the training required in this section before , . Proof of completion of equivalent training completed before , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that 3 of 3 sampled staff (Staff B, C, and D) received the required additional training in 's and related forms of , as mandated for facilities that advertise and provide specialized care for individuals diagnosed with .. The findings included: During an interview conducted on at approximately 8:30 AM with the Administrator she stated that the facility actively advertises that it provides care for residents diagnosed with	ZZ875		

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ZZ875	Continued From page 4 and confirmed that the facility operates a dedicated memory care unit. On , a review of the personnel files provided by the Administrator, for Staff B (Resident Assistant), Staff C and Staff D (Care Partners) were conducted. None of the files contained documentation verifying completion of the required additional 's and related forms of training. A record review of Staff B's (Resident Assistant) personnel file with a hire date of revealed no documentation verifying completion of the required additional 's and related forms of training. A record review of Staff C's (Care Partner) personnel file with a hire date of revealed no documentation verifying completion of the required additional 's and related forms of training. . A record review of Staff D's (Care Partner) personnel file with a hire date of revealed no documentation verifying completion of the required additional 's and related forms of training. During an interview conducted on at approximately 4:30 PM the Administrator was informed of the findings, and no additional documentation was provided. Class III	ZZ875		

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A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be	A 152		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 152	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to ensure a safe and clean living environment free of safety hazards by ensuring all existing mechanical electrical and structural systems are maintained in working order for residents that reside in the Assisted Living (AL) and Memory Care Unit (MCU). The census was 186 residents on the day of the survey. The findings included: On facility tour conducted between 9:00 AM and 3:30 PM on and , the following concerns were identified in the Memory Care Unit. A) First Floor , had a strong smell, missing ceiling tile (exposed hole in the ceiling), large brown stains on ceiling tiles. , was missing ceiling tile and rust like on the Air Conditioning (A/C) vents panel. , ceiling tiles had large brown stains and rust like on the A/C vent panel. , had a loose tile, the closet floor was dirty and a large brown stain on the door, the shower faucet trim plate was loose, water was dripping from the shower knob and shower wall had yellowish discoloration. , which houses four residents, had exposed pipes visible from the ceiling due to missing ceiling tiles, and the remaining ceiling tiles had large brown discoloration stains.	A 152		

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A 152	Continued From page 2 , which houses four residents, had ceiling tiles with large brown stains, an electrical outlet with a missing faceplate, and bathroom ceiling tiles above the sink that were loose, stained dark brown, and missing in some areas, leaving a ceiling hole exposed. , had yellowish, water-like stains on the wall from the ceiling to the baseboard, large dark brown stains on the ceiling, yellowish discoloration on the closet wall, and an exposed ceiling hole in the bathroom. , large brown stain on ceiling tile near linen closet, bathroom had a brown stain on the ceiling tile and closet had a large brown ceiling stain. , had an A/C vent on the wall that was partially covered with cardboard secured by gray tape, while the other half of the vent had black, mold like residue inside and around the vent frame. The ceiling above the A/C vent had a large dark brown stain, and there was a brown, mold like stain near the ceiling vent. Common areas in the MCU, A/C vents near had large brown stains and ceiling tiles with visible dark brown spots near . MCU - Satellite kitchen The kitchen floor was greasy and dirty, with black stains and grease-drip grime on the wall near the hot bar. The closet door was off its hinge, and the ceiling above the wash sink had a hole and large brown stains. During an interview on at approximately 5:00 PM, the Administrator was	A 152		

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A 152	Continued From page 3 informed of the physical plant concerns noted in the MCU, AL and the facility elevator. She acknowledged the findings. B) Elevator This is a 5-story resident occupied building, with 4 multiple passenger hydraulic elevators. The 4 elevators are located in the main lobby area of the building. On facility tour between 9:00 AM and 3:30 PM on and elevators #9472 and #9474 were observed in use and accessible to residents, staff and visitors. Observations made during the tour at 9:30 AM on noted that there was no current and valid Certificate of Operation displayed on elevators #9472 and #9474 as required for safe operation of vertical conveyances in a licensed healthcare facility. Observations made during the tour at 9:30 AM on noted that elevators 9473 and 31602 were not in use and had a sign posted on the doors stating working on upgrade. During an interview on at 1:30 PM with the Administrator, she explained that elevators 9473 and 31602 are pending a county inspection before they can receive the current certificates of operation. She further explained that the corporate office was handling the current certificates of operation for elevators 9472 and 9474 During an interview on at approximately 10:00 AM with the administrator, the elevator certificate of operation, inspection reports, and maintenance records were	A 152		

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A 152	Continued From page 4 requested. The Administrator failed to provide any current documentation on the elevator's maintenance and service reports, inspection records, and approvals or renewal to show that the elevator had a current Certificate of Operation On , a review of the facility's documentation on elevator 9472 revealed that the Certificate of Operation for the facility's passenger elevator expired on . No current or renewed certificate was available for review at the time of the survey. On , a review of the facility's documentation on elevators 9474, 9473, and 31602 revealed that the Certificates of Operation for the facility's passenger elevators expired on . No current or renewed certificate was available for review at the time of the survey. During an interview on at approximately 4:30 PM, the Administrator confirmed that the facility had not received the renewed Certificates of Operation. The facility failed to maintain current Certificates of Operation for their 4 passenger elevators posing a safety hazard to the residents, staff , and visitors who rely on the elevators for movement throughout the facility. The facility failed to maintain current Certificates of Operation for their 4 passenger elevators posing a safety hazard to the residents, staff , and visitors who rely on the elevators for movement throughout the facility. c) In a confidential interview with an advocacy agency representative, issues of longstanding sanitation deficiencies and environmental hazards at the facility including pests, non-functioning elevators, leaking ceilings and	A 152		

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A 152	Continued From page 5 stained ceiling tiles were reported. On at approximately 9:15am, observation of # revealed three brown-stained ceiling tiles with areas of black spots creating a mold-like appearance outside of the bathroom and directly behind the air conditioning vent. The vent itself had drip marks extending from its metal bottom down the wall creating long, dark colored stains. The carpet, specifically between the entry and the bathroom, was heavily stained and almost black in appearance. Small flies were observed throughout the space and were more plentiful in the bathroom where they were observed across the ceiling and walls. On at approximately 7:35am upon entry to the facility, this Surveyor observed dried on the floor in the main lobby. The Administrator requested housekeeping to clean the area. On at approximately 7:50am on a walkthrough of the kitchenette in the Memory Care Unit both live and pests were observed - one was seen running across the ceiling directly above the food service area and several behind the coffee station. In a confidential interview at the time of the observation, Staff stated they were glad this Surveyor had seen the pests and that pests are seen often in the facility. This Surveyor observed yellow-colored, cloudy water in the food warmer. This writer inquired of Staff about the water and Staff stated that they did not want to hide anything from this Surveyor, and the people who complained had seen this as well. This writer observed food delivery from main kitchen at 8:00am and prepared foods were placed into the	A 152		

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A 152	Continued From page 6 food warmer. Behind the table containing the food warmer was a wall outlet. In the top plug was an unknown object with the appearance of a broken metal prong no longer attached to a plug. The food warmer which was plugged into the bottom plug. The bottom half of the walls of the kitchenette were covered in brown streaks, and the floors had a residue causing this Surveyor's shoes to stick in spots. This Surveyor observed debris across the floor, gathered more heavily in certain areas - behind furniture and in the groove of the closet door specifically. There were also black and brown speckles staining the ceiling tiles above the food service area. Inside the closet in the kitchenette a ceiling tile was removed, leaving the area open. Class III	A 152		
A 160	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log	A 160		

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A 160	Continued From page 7 listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a , ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and	A 160		

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A 160	Continued From page 8 responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing	A 160		

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	AL11964636	A. BUILDING: _____ B. WING _____	06/25/2026

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

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A 160	Continued From page 9 services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined, the facility failed to create and utilize a policy on communication with third party service providers as required to structure collaboration between the facility and healthcare providers. The findings included: On , in an interview with the Administrator, facility policies including 3rd Party Service Policy, were requested. A record review of all facility policies provided revealed that no Third Party Service policy was included. On at approximately 10:30am, in an interview with the Administrator after reviewing the admission documents, this Surveyor requested for the Administrator to point to where the Third Party Service policy was outlined. Administrator stated it was not included in the admission documents. On at approximately 2:35pm, in an interview with the Administrator and Staff G, Director of Nursing (DON) the missing Third Party Service policy was identified as a concern. No additional documentation was provided by the facility. Class	A 160		
A 000	Initial Comments An unannounced Relicensure, Complaints	A 000		

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A 000	Continued From page 10 (#2025003945, 2026000657, 2026000336, 2026010082, 2026010440, 2025015039, 2026010949) and Generator Monitoring survey was conducted from to at Peninsula (the). The facility had a deficiencies related to the Relicensure and licensure complaints at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is	A 010		

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A 010	Continued From page 11	A 010		

agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.
(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical .
2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.
3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must

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A 010	Continued From page 12 notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner,	A 010		

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A 010	Continued From page 13 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A [redacted] ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.	A 010		

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A 010	Continued From page 14 (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to ensure the Health Assessment (AHCA Form 1823) was accurate and reflective of the Resident's current care needs and diagnoses for 1 of 4 sampled residents (Resident #23). The findings included: A review of the Resident Health Assessment for Resident #23 dated included the following: Nursing/Treatment/ , , Services: Patient with , . Home Health. Assisted x 1. Medication assist. Needs can be met in ALF? No Type of assistance needed for meds: Needs medication administration A review of Resident #23's record revealed a progress note dated stating that Resident has returned from the hospital and is now under the care of a hospice provider. On at approximately 1:00pm, this writer observed a medication pass for Resident #23 conducted by Staff R (Medication Technician) who is unlicensed and therefore unable to provide medication administration. On at approximately 1:00pm in an interview with Staff G (Director of Nursing) this Surveyor inquired about why medication administration is listed on Resident #23's 1823. Staff G stated there is no reason for it. This	A 010		

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A 010	Continued From page 15 Surveyor asked questions regarding the Resident's placement at the facility as his Resident Health Assessment reflects he is not appropriate for Assisted Living Facility level of care. Staff G stated a plan to have Resident #23's Resident Health Assessment updated by the hospice provider. This Surveyor noted that hospice itself is also not reflected on the Resident Health Assessment. Staff G reported a plan to have all identified issues corrected. Staff G stated they are errors and Resident #23 is appropriately placed in the facility and can be accommodated at the current level of care. On at approximately 2:35pm in an interview with the Administrator and Staff G (Director of Nursing) the mismatch in the care ordered on the Resident Health Assessment and the care being provided was discussed. No additional information was provided by the facility. Class III	A 010		
A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to	A 031		

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A 031	Continued From page 16	A 031		

coordinate with the facility regarding the resident's condition and the services being provided.
(b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs.
(c) The administrator or designee must ensure that:
1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility;
2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and
3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition.
4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the

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A 031	Continued From page 17 timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to maintain documented communication from a third party service provider as ordered by a physician, demonstrating a lack of coordination of care for 2 of 26 sampled residents (Resident #15 & #21). The findings included: 1) Record review for Resident #21, admitted on , showed a Health Assessment (AHCA Form 1823) dated documenting nursing and treatment requirements for hospice services. Further review revealed no hospice admission order and no written communication or progress reports from the third party hospice provider in the resident's file. During an interview with the DON on at 8:58 AM, the Director of Nursing (DON), she stated she would need to call the hospice provider when hospice records were requested. The facility was unable to provide any	A 031		

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A 031	Continued From page 18 communication notes reflecting coordination with hospice. The DON confirmed Resident #21 receives hospice services but did not recall the date of hospice admission. During interview with the Administrator on at 8:59 AM, the Administrator reported that the facility did not have policy and procedures governing third party provider coordination. A review of the facility's binder revealed no written policy or procedure coordination of care with third party providers. No policy outlining communication requirements was present. 2) Record review for Resident #15, admitted on , showed a Health Assessment (AHCA Form 1823) dated documenting nursing and treatment requirements for hospice services. A request of hospice file was requested on at 8:45 AM and was not recieved. A record review of documents revealed that no hospice admission order and no written communication or progress reports from the third-party hospice provider in the resident's file. During an interview with Staff G, Director of Nursing (DON) On at 9:38 AM, she stated that she would need to call the hospice provider. On at 11:21 AM, Staff G was reminded of the file and she stated that she wwill bring the file. The DON confirmed Resident #15 receives hospice services but did not recall the date of hospice admission. During interview with Staff G on at	A 031		

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A 031	Continued From page 19 1:27 PM, she stated that the facility did not have policy and procedures governing third party provider coordination. A review of the facility's binder revealed no written policy or procedure _ coordination of care with third party providers. No policy outlining communication requirements was present. No additional information was provided during the time of the survey. Class III	A 031		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons	A 032		

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A 032	Continued From page 20 that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by:	A 032		

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A 032	Continued From page 21 Based on observation, record review, and interview, it was determined that, the facility failed to implement adequate elopement prevention policies and procedures to ensure that Resident #2, who was identified as at risk for elopement, had identification on their person, for 1 out of 2 sampled elopement risk residents. The findings included: Review of the facility's records indicated that its Elopement Policy and Procedures did not include details regarding staff responsibilities to ensure that residents at risk for elopement have identification on their person, which must include the resident's name, the facility's name, address, and telephone number, as a precaution in the event of an elopement. Observations conducted in the Memory Care Unit on through between 9:00 AM and 4:00 PM revealed that Resident #2 was observed ambulating near the exit doors (front lobby entrance and parking lot access) at times without supervision during activities and mealtimes. During an interview on at approximately 11:00 AM, Staff G (Wellness Director) was asked to provide a list of residents who were at risk for elopement. She stated that the facility does not have any residents identified as elopement risks. However, she confirmed that the facility has a Memory Care Unit (MCU) and an Enhanced Assisted Living (EAL) program for residents in Assisted Living (AL) who require a higher level of care in a secured environment. She further stated that those residents spend the day in the Memory Care Unit as part of the program. Staff G was asked to provide a	A 032		

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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 032	Continued From page 22 complete file for Resident #2. A review of Resident #2's file documented that she was admitted on . Review of Resident #2's health assessment dated and signed by an Advanced Practice Registered Nurse (APRN) revealed the following: Medical diagnosis as Physical limitations: ambulates at liberty status: alert times one and pleasantly Nursing services required: needs assistance with activities of daily living and medication management. Elopement risk: yes Activities of Daily Living (ADLs): independent with ambulation and transferring, supervision with eating and toileting, assistance with bathing, , and grooming. In reviewing the health assessment form, the following additional concern was noted: a) The resident's current AHCA Form 1823, dated , failed to identify the decline in the resident's ADLs. The resident requires supervision with ambulation due to exit seeking behavior. Further review of the resident's file documented that Resident #2 eloped on and was brought to the facility by the local police department. The resident was found approximately three (3) minutes away from the facility. During an interview on at approximately 1:000 PM, Staff O (Memory Care Director) was asked if Resident #2 had any identification on her (her name, facility name, address and phone number). At that time, she stated no. She further stated that she was not	A 032		

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A 032	Continued From page 23 aware that the residents that were elopement risk / exit seekers in the memory care unit needed some kind of identification that included their name, facility's name, address and phone number on their person . During an interview on at approximately 2:00 PM, Staff G was informed of the findings noted. She was given an opportunity to provide an updated AHCA Form 1823 and the most current assessment for elopement risk (completed quarterly or with significant change), as required by the facility's policy and procedure titled Elopement Missing Resident (revised). During an interview on at approximately 5:00 PM, the Administrator and Staff G were informed of the findings and concerns noted. Staff were reminded that the facility needed to ensure daily monitoring of residents at risk for elopement (Resident #2) and ensure they have identification on their person that includes their name, the facility's name, address, and telephone number, as a precaution in the event of an elopement. Class III	A 032		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper	A 052		

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A 052	Continued From page 24 dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.	A 052		

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A 052	Continued From page 25 (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with	A 052		

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A 052	Continued From page 26 procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or	A 052		

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A 052	Continued From page 27 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was determined, the facility failed to ensure that medications passed by unlicensed staff were announced in 2 out of 7 medication passes observed. The findings included: On at approximately 11:50am, this Surveyor observed Staff R (Medication Technician) conduct medication pass for Resident #26. Staff R was observed to compare the packs of medication to the Medication Observation Record (MOR.) She was then seen to pop the medication out of the pack and into a medication cup. Staff R then took the medication cup and cup of water into Resident's room and stated this is your noon medication to Resident. Medications were not announced. In an interview at the time, Staff R was asked by this Surveyor if that was the usual process she follows for medication pass. Staff R confirmed	A 052		

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A 052	Continued From page 28 that it was. On at approximately 12:49am, this Surveyor observed Staff R (Medication Technician) conduct medication pass for Resident #27. Staff R was observed to compare the packs of medication to the Medication Observation Record (MOR.) She was then seen to pop the medication out of the pack and into a medication cup. Staff R then handed the medication cup and a cup of water to Resident and observed her take the medications. Medication was not announced. On at approximately 1:40pm, in an interview with Staff E (Licensed Practical Nurse) and Staff B (Medication Technician), this Surveyor inquired if the facility uses waivers for medication announcement. Both stated they were not familiar with the term and stated they did not use any waivers. On at approximately 2:00pm, in an interview, Staff G, Director of Nursing (DON) stated that the facility sometimes uses announcement waivers on the memory care unit but not on the assisted living unit. Medication pass observations were made on the assisted living unit. On at approximately 2:35pm, in an interview with the Administrator and Staff G the lack of announcement of medication by an unlicensed staff passing medication was discussed. No additional information was provided by the facility. Class III	A 052		

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A 075	Continued From page 29	A 075		
A 075	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility. (4) Facility staff may withhold or withdraw , , or the use of an automated external defibrillator if presented with an order not to executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing , , or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing , , or use of an automated external defibrillator as otherwise permitted by law. (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on record review, interview and	A 075		

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A 075	Continued From page 30 observation it was determined that the facility failed to properly maintain an ( ) on its premises at all times. The findings included: A review of www.mayoclinic.org revealed the following: Keep the working properly. Install new batteries as needed, typically every four years. Replace electrode pads as needed. Have spare pads on . Follow the manufacturer's instructions. A record review of the facility policies revealed a page in the Policy & Procedure Manual, Version 2024-1 titled Automated External Defibrillator ( ) Use that included the following: Procedure: Where required, the facility will obtain and maintain an adequate number of devices per facility census. devices will be stored and plainly identified in areas where access is readily available to all. Upon hire, and quarterly, all staff will be trained in the care and use of the device using Manufacturer recommended instructions. The facility will ensure documented, ongoing, training of all staff in the care and use. The Executive Director or designee will ensure that monthly maintenance is completed and documented in the TELS maintenance system. On at approximately 12:15pm this Surveyor went to the first floor nurse's station to observe the . This writer requested one of the three facility staff present remove the from the wall and turn it on to evidence to this Surveyor that it was in good working order. Staff B (Medication Technician) removed the from	A 075		

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A 075	Continued From page 31	A 075		

the wall and noted it was covered in dust. Staff B attempted to turn on the unit but was unable to do so. Upon the unit being opened, this Surveyor observed that the electrode pads had a printed expiration date of 2025- . Staff R (Medication Technician) also attempted to turn on the unit but was unable to do so. In an interview at the time, both Staff S and Staff R stated they had not been trained on use of the . Staff E (LPN) also attempted to turn on the unit but was unable to do so. Staff E stated the battery may be . The Administrator arrived and also attempted unsuccessfully to turn on the . The Administrator stated she would need to contact Staff G (Director of Nursing). In an interview with Staff E, Staff B and Staff R at the time, it was reported the non-working was the only on site at the facility.

On at approximately 12:45pm, Staff G arrived at the nursing station and asked what the issue was with the . She had in a replacement electrode , . However, this Surveyor observed that the replacement , had an expiration date of 2024- . In an interview at the time, Staff G stated that only herself of another Licensed Practical Nurse (LPN) is allowed to use the . Staff G further stated that the facility does not provide training for direct care staff to include medication technicians and that in the case of an emergency, they are to call 911.

On at approximately 11:30am, this Surveyor observed the unit still on the counter in the first floor nursing station and not returned to its identified place on the wall. In an interview at the time, Staff E stated that there had been no change in the 's status since . It remained non-functional.

Agency for Health Care Administration

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A 075	Continued From page 32 On at approximately 2:35pm in an interview with the Administrator and Staff G (Director of Nursing) the non-functioning and lack of alignment between the facility's policy and implemented protocols were discussed. No additional information was provided by the facility. Class III	A 075		