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
	AL11967577	A. BUILDING: _____ B. WING _____	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVINELLE ADULT HOME ALF #2	1786 NW 47 TERRACE MIAMI, FL 33142

(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 A complaint investigation (complaint number #2023012912) was conducted at Calvinelle Adult Home ALF #2 from , , to , , , . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident's representative or designee of the need for health care services and must assist in making , , , , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. 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	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, 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. (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 interview and record review, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being of one out of ten sampled residents (Resident #1). Resident #1 eloped from the facility and was found on the streets the next day. Findings include: A review of the adverse incident report filed on showed, "On , [Resident #1] was in the dining area located to the front of	A 025		

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A 025	Continued From page 2 the building. Transportation came to pick up another resident for an , , , [Resident #1] broke the gate and left the ALF." A review of Resident #1's progress notes dated showed that Resident #1 eloped from the facility from the backyard gate. 911 was called, and a police report was made. The resident's sister was also contacted. During an interview on at 6:12 AM, Staff C (caregiver) stated, "That morning he had breakfast. I was cleaning someone else and asked the other lady who works during the day where [Resident #1] was because I didn't see him out there. He was always pacing and forth in the front area. The other staff said he was in his room. I went and checked, and he wasn't there. We knew he couldn't get out from the front gate, so when we looked around the building, on the side was a gate that he forced open, and he was a tall man, so you could see where he stepped on top of it to go through the neighbor's yard." In an interview on at 3:15 PM, Resident #1's sister stated that she was contacted by the facility, saying that her brother had eloped from the facility and that if he came to her home, she would return him to the facility. She further stated, "The next day, a guy called and said that someone was using his phone, and when he passed the person the phone, I heard my brother. When I asked him what happened, he told me he had gone for a walk and got lost. He also told me that he was looking for my house. I asked him where he was, and he didn't know. He passed the guy whose phone he was using, and the guy gave me the address. I told my brother not to move. Where he was not close to my house or the facility, it was like 30 minutes I	A 025		

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A 025	Continued From page 3 had to drive to get there. I picked him up, and when I reached the facility, the Owner said she would not take him . . . ." During an interview on . . . . . at 9:58 AM, Staff D (caregiver) stated that she began her shift at 10 AM the day Resident #1 eloped. She said, "I went to clean his room, and he wasn't there. He must have already left before I came to work." During an interview on . . . . . at 9:29 AM, Staff B (caregiver) stated, "When I came to work, he was at the gate, and I told him to move from there. [Resident #8] was going to an , , , so [Staff C] was assisting me in getting her ready. [Staff C] wondered if he was in the bathroom. We didn't see him, and we looked in the room, and we didn't see him. After checking the room, I called [Owner] and the police. After I called the police, I realized he escaped from the side gate. The last time I saw him was at breakfast, which was at 8 AM. I asked the lady when she came for [Resident #8] if she saw him, and she said no. He was missing before she came." In an interview on at 11:34 AM, when asked at what time she was contacted by staff that Resident #1 had eloped, the Owner stated, "After breakfast between 8 and 9. That is when transportation was there to pick up another resident for an , , , ..." A review of a police report filed on . . . . . showed at 10 AM, officers responded to a call from the facility stating that one of their residents eloped. During the interview, staff told the police that the resident had been missing since 7 AM. A review of Resident #1's hospital record dated showed a 'History of Present Illness'	A 025		

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A 025	Continued From page 4 stating "male who presented to the ED (emergency department) sent from crisis. He had been residing at the ALF until three days ago when he stated that he went for a walk. A stranger found him two days later and called his sister. Per sister, baseline is that he is only oriented to self and requires help with most ADLs (activities of daily living). He repeated multiple times that he left the ALF because it felt like a prison." In an interview on at 6:55 AM, when asked if Resident #1 ever displayed any signs that he would elope, the Owner stated, "No, not that I saw with him. He had no prior history and never said anything about wanting to leave. When I spoke to his sister, she said she had given him money, which could have provoked him to leave." On at 6:12 AM, when asked if Resident #1 ever expressed his wanting to leave, Staff C stated, "He kept saying he wanted to leave to go get pizza. He didn't want to stay; that's what I heard he would say." On at 10:09 AM, Resident #5 stated he saw when Resident #1 eloped. He said, "He went on the side, broke the gate and jumped the other gate to the backyard next door. Then I saw him walk by, and he waved and said bye. Mentally, he was not good. He kept on saying that he couldn't stay. That it was like a prison." On at 9:58 AM, when asked if Resident #1 ever expressed his wanting to leave the facility, Staff D stated, "Since he came, he didn't want to stay. He said this place was like a prison. The day before, he stayed by the front gate and shook it."	A 025		

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A 025	Continued From page 5 A review of the facility's elopement policy showed "Elopement is described as leaving the premises/outside , , without permission or notice. The administrator and staff will be aware that patients are at high risk for elopement: 1) Express desire to elope. 2) History of attempted/successful elopement. " A review of Resident #1's record showed no documentation that the facility contacted the resident's physician about the resident's desire to leave or if they sought guidance on preventing the occurrence. A review of Resident #1's health assessment dated showed medical history and diagnoses of subacute with and , right MCA (middle ,) with left-sided , , , and undifferentiated , . The resident was independent with eating, toileting, and transferring and needed supervision with ambulation, bathing, , grooming and self-administration of medication. The health assessment indicated that Resident #1 was not an elopement risk. Class II	A 025		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely	A 030		

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A 030	Continued From page 6 accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard	A 030		

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A 030	Continued From page 7 precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . . . . . . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate	A 030		

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A 030	Continued From page 8 living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of	A 030		

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A 030	Continued From page 9 medications, assistance in making for health care services, the provision of or arrangement of transportation to health care , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or	A 030		

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A 030	Continued From page 10 special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, [illegible], and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible], Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and	A 030		

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A 030	Continued From page 11 his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide the residents with 45 days' notice of relocation or termination of residency for one out of 10 sampled residents (Resident #1). Findings include: A review of the facility's admission/discharge log showed Resident #1 was admitted on [redacted], discharged on [redacted] due to "eloping from ALF", and discharged to a "more secure facility." A review of Resident #1's progress notes showed, "[Resident #1] 's sister returned [Resident #1] to ALF. Per [hospital program], he has to go to [hospital crisis unit] to be evaluated. Sister was notified and will take him to [hospital crisis unit]." During an interview on [redacted] at 3:15 PM, Resident #1's sister stated, "They called me and said my brother eloped from the facility and if he came to my house to return him to the facility. The next day, a guy called and said that someone was using his phone, and when he passed the	A 030		

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A 030	Continued From page 12	A 030		

person the phone, I heard my brother. When I asked him what happened, he told me he had gone for a walk and got lost. I picked him up, and when I reached the facility, the Owner said she would not take him . . . . I asked her what she wanted me to do, and she gave me the hospital's address and told me what to say. When I got to the hospital, I told them he needed to be Backer acted. He sat in the car until the police arrived. The police went with him to the hospital. They told me that they were going to keep him for medication."

A review of Resident #1's hospital record dated . . . . . showed a 'History of Present Illness' stating "male who presented to the ED (emergency department) sent from crisis. He had been residing at the ALF until three days ago when he stated that he went for a walk. A stranger found him two days later and called his sister. His sister brought him . . . to the ALF, and they denied readmission due to the fact that the patient damaged their property and sent them to ED for physician evaluation. His sister then brought him to crisis, after which he was Backer acted and brought to the ED by police for medical clearance."

In an interview on . . . . . at 11:34 AM, when asked about Resident #1's discharge from the facility, the Owner stated, "[Resident #1] sister was the one that called and said she found him. When she came, I told her to let me speak to the [hospital program] to ask for directives, and they told me to take him to [hospital] for evaluation. I couldn't accept him because the protocol is they have to be evaluated."

A review of Resident #1's record showed no documentation from the physician stating that he

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	AL11967577	A. BUILDING: _____ B. WING _____	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVINELLE ADULT HOME ALF #2	1786 NW 47 TERRACE MIAMI, FL 33142

(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 030	Continued From page 13 needed a higher level of care. Class III	A 030		
A 032 SS=E	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 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	A 032		

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A 032	Continued From page 14 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: Based on observation, review of records and interview the facility failed to follow its own policies and procedures to ensure that one out of ten sampled residents with a history of elopement (Resident #2) had a form of identification on her person that included her name, the facility's address, and telephone number. Findings:	A 032		

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A 032	Continued From page 15 Observation on [redacted] at 8:28 am showed that Resident #2 did not have an identification bracelet on her person that included the facility's name, address, and telephone number. Interviewed on at 8:28 am Resident #2 stated that she did not have any personal identification on her person. When asked if she knew the address and telephone number of the location of where she lived Resident #2 stated, "No" When asked if she knew the city, that she lived in Resident #2 stated, "I don't know." Interviewed on at 9:29 am when asked if there were any elopement risk residents in the facility Staff B stated that Resident #2 was an elopement risk. Staff B stated that Resident #2 had eloped from a program that she used to attend. Interviewed on [redacted] at 11:38 am Resident #2's Guardian stated, "She eloped on from a program. She is not oriented, she is very , she has , , she can talk to you, but she doesn't make any sense." A review of Resident #2's record showed a copy of a notification letter dated from the Owner stating that Resident #2 was an elopement risk and should be closely monitored. Further review of Resident #2's record showed that there was no documentation of the Resident's picture on file. A review of the facility's elopement policy showed that residents with a history of attempted or successful elopement should be considered at high risk for elopement.	A 032		

Agency for Health Care Administration

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A 032	Continued From page 16 A review of the facility's elopement procedures showed that the facility will ensure that residents at risk of elopement have a photo identification with the resident's name, facility name, address, and telephone number. Interviewed on . . . . . at 11:39 am when asked if the facility provided identification bracelets to residents that were at risk of elopement the Owner stated, "Yes, bracelets to all of them, they all had bracelets." Class III	A 032		