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
	AL11968250	A. BUILDING: _____ B. WING _____	R 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVINELLE SOUTH ASSISTED LIVING FACILITY INC	1750 NW 41 STREET 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 152} SS=F	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}		

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{A 152}	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to provide the residents with a safe living environment that is free of hazards and to ensure that all building systems, furnishings and accessories are maintained in good working order. A non-working light switch on the stairs, a broken roof screen and hazardous materials in the patio were observed. Findings include: Observation on at approximately 9:10 am showed that the stairs leading to the second floor resident rooms were dark and poorly lit. Further observation showed that the light switch on the second floor stair landing was not working and would not turn on the light (Photographic evidence obtained) Observation on at approximately 9:12 am showed that the window blinds on # were broken and had two missing panels (Photographic evidence obtained) Observation on at approximately 9:30 am showed several rusty metal shutter panels and empty paint buckets on the patio. Further observation showed that the patio was a common use area that was accessible to the residents (Photographic evidence obtained) Observation on at approximately 8:48 am showed that a roof cover on the front of the facility was broken and appeared to be at risk of falling (Photographic evidence obtained) Interviewed on at approximately 11:39 am the Administrator stated that the blinds on	{A 152}		

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{A 152}	Continued From page 2 # had been fixed and the light switch of the stairs on the first floor worked. Class III	{A 152}		
{A 162} SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in	{A 162}		

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{A 162}	Continued From page 3	{A 162}		

paragraph 59A-36.007(1)(f), F.A.C.
(f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that not be taken.
(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.
(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C.
(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S.
(l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006,

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{A 162}	Continued From page 4 2005, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020,	{A 162}		

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{A 162}	Continued From page 5 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, the facility failed to update the health assessment for one (Resident #8) out of nine sampled residents after she was diagnosed with acute [illegible]. Findings: Interviewed on [illegible] 1:30 PM the Primary Care Physician stated that he first became aware of Resident #8's [illegible] was on [illegible] when he examined her at the facility, and he first ordered the [illegible] medication for her at that time. A record review of the medication observation record showed the prescribed medication Ofloxacin [illegible] for Resident #8. A review of Resident #8's health assessment dated [illegible] showed a diagnoses of [illegible], type 2 [illegible]. However, there was no new health assessment or diagnosis. Interviewed on [illegible] at 1:11 PM when asked if any of this information was documented in the facility records or the resident's records, the Administrator stated, "No. Nothing was documented. But the doctor documented it (in his records)." Uncorrected Class III	{A 162}		
{A 000}	Initial Comments A revisit survey from a complaint investigation	{A 000}		

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{A 000}	Continued From page 6 was conducted on [redacted] at Calvinelle South ALF. 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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. 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 [redacted] 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 resident diets in accordance with Rule 59A-36.012, F.A.C.	{A 025}		

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{A 025}	Continued From page 7 (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 observation, interview, and review of records, the facility failed to provide adequate supervision and failed to maintain awareness of the general health and wellbeing of one out of nine sampled residents (Resident #8) The facility failed to contact the health care provider of one out of nine sampled residents that had an , for an unknown amount of time (Resident #8) The facility also failed to maintain documentation, updated as needed, of any significant changes in condition of one out of nine sampled residents (Resident# 8) . Findings: Observation on at 9:45 am showed	{A 025}		

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{A 025}	Continued From page 8 that Resident# 8 was sitting on the front porch. Further observation showed that Resident# 8 had a white discharge from her left . Interviewed on at approximately 9:48 am the home health Nurse stated that he was caring for Resident# 8. The Nurse stated, "Yes, she had a very bad and on both , worse on the right . She has poor mobility, she is . The is much better, the was resolved, and her level is kept below 200." A review of Resident# 8's progress notes showed no documentation that the resident had an . A review of Resident# 8's health assessment dated showed diagnoses and medical history of , Type II , and . Further review showed she was alert and oriented (to person, time, place, and event), she required supervision with self-administration of medications, the administration of and precautions. A review of Resident# 8's ADL assesment (Activities of Daily Living) showed that she needed supervision with ambulation, bathing, , self-care, toileting and transferring. Interviewed on at approximately 10:48 am the Administrator stated that on Resident #8 was sent to the hospital via 911 because she felt weak. When asked if there was documentation available regarding Resident #8's he did not respond. Interviewed on at approximately 10:30 am Resident #8's home health agency Case Manager stated that she was not aware that	{A 025}		

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{A 025}	Continued From page 9	{A 025}		

Resident #8 had an , , but that she had noticed that the resident had a in her , and had asked her to wash her . When told that the Nurse had reported the Resident had an , , the Case Manager stated that she would check the records and the nurse that was familiar with the Resident would call .

Interviewed on at approximately 11:17 am the home health Nurse stated that about 15 to 20 days earlierhe had noticed that Resident #8 had in her , . The Nurse stated that he contacted the PCP (Primary Care Physician) via text message and the PCP ordered , , for the Resident. The Nurse stated that the Resident's , was improving, and he had recommended to the staff not to let her sleep on her side, because it could aggravate her , condition.

Interviewed on at approximately 11:35 am the Pharmacist stated that the PCP had submitted an electronic prescription request for , , (Ofloxacin 0.3% every 12 hours for acute ,) for Resident #8 on and the medication was delivered to the facility on .

A review of Resident# 8's MOR (Medication Observation Record) showed that the facility started administering Ofloxacin 0.3% , , on both , every 12 hours for acute , on .

Interviewed on at approximately 12:11 pm when asked if he knew about Resident #8's , the Administrator stated that the staff noticed it, and they notified the nurse, and the nurse notified the doctor. When asked why it

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{A 025}	Continued From page 10 took two days for the facility to start administering the , , to the Resident the Administrator stated that he had to review the record, but he was not at the facility. When it was mentioned to him that the PCP could not be reached at the number listed in the resident's record, the Administrator stated that he would look up another contact number for the PCP and would call . . . . The Administrator called . . . . , provided a new contact number for the PCP, and stated that the medication had been received on but because a MOR for the Resident was not available the documentation did not start until . Interviewed on at approximately 1:30 pm Resident #8's PCP stated that he first became aware of Resident# 8's , when he examined her at the facility on during a routine visit. The PCP stated that he ordered Ofloxacin 0.3% . , . . . , every 12 hours for acute , . The PCP also stated that the nurses reported to him daily via text message about the Resident's vital signs and . , ... , and that on . . . . . he received notification from one of the nurses that the Resident's , . medication was not at the facility, and he re-ordered it. The PCP stated that on . . . . . he received text message confirmation from the nurse that the medication had been received at the facility. According to The Mayo Clinic, "Pink . , . (,) is an of the transparent . . . . . that lines the , . . and eyeball. Pink , . is also called , . . Because Pink . , . can be . . . . , . . . , getting an early diagnosis and taking certain precautions can help limit its spread. In both children and adults, pink , can cause in the	{A 025}		

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{A 025}	Continued From page 11 . . . . . that can affect vision. Prompt evaluation and treatment by your health care provider can reduce the risk of complications." Class II	{A 025}		
{A 027} SS=D	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making . , , ... and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , ... health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to make medical arrangements for healthcare for one (#8) out of 9 sampled who was diagnosed with acute , ... and went without treatment for an unknown period. The facility failed to provide transportation to pick up Resident #8's . , . medication after it was prescribed by the Primary Care Physician, and remained for more than two days at the pharmacy before the resident received the medication. Findings:	{A 027}		

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{A 027}	Continued From page 12 Interviewed on . . . . . at 11:17 AM the Home Health Nurse for Resident #8 stated that about 15 to 20 days ago he noticed Resident #8 had a from her left , and he immediately texted her PCP. The Home Health Nurse stated further that the PCP ordered , , for the Resident (#8). Interviewed on . . . . . at 1:27 PM Staff D (Caregiver) regarding the in Resident #8's left , . . Staff D stated, "I saw her , , . . It looked like what we called at home, [pink ,]. I told the Administrator. This happened about two weeks ago. I bathe her every day, so I saw it." The facility's emergency policy and procedure states: "It is the policy of [facility] that in case of a medical emergency, staff will exercise all possible measures to assure the injure/ill person will receive immediate emergency evaluation and treatment of all medical and dental problems. The administrator/designee will make an immediate assessment of the event and take actions as necessary. In the event the administrator is not available for the following actions should be taken: Notification of an administrator on duty, notification of the client's physician, and notification of the resident's guardian if applicable." A record review of the facility's records and Resident #8's progress notes found no documentation that the facility made medical arrangements for Resident #8 , , including notifying the primary care physician. Interviewed on . . . . . at 10:30 AM Resident #8 Case Manager who stated that she was not aware that the Resident #8 had an , ... The Case Manager stated that she had noticed a	{A 027}		

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{A 027}	Continued From page 13 . . . . . in one , . and asked her (Resident #8) to wash her . Interviewed on . . . . . at 11:35 AM the Pharmacist who stated that the PCP submitted a prescription request for , ... , . (Ofloxacin 0.3% every 12 hours for acute ,) for Resident #8 electronically on . . . . . and the medication was delivered to the facility on . . . . . . Interviewed on . . . . . at 12:07 PM When asked if he was aware of Resident #8's , ... , the administrator stated that staff told him that she noticed it and he contacted her doctor. When asked for the PCP's number, the administrator stated that he did not know it and had to get the number. When asked why it took two days for Resident #8 to receive the , medication, the administrator stated that he would have to check the medication observation record (MOR). The administrator stated, "It takes time for the medication to come." Interviewed on at 1:30 PM the PCP stated that he first became aware of Resident #8's , on when he examined her at the facility, and that he first ordered the , medication for her at that time. The PCP stated further that the nurse reported to him daily via text message about the Resident #8's vital signs and . , ... , and that on he received notification from one of the nurses that the Resident #8's . , . medication was not at the facility, and that he re-ordered it. The PCP stated that on . . . . . he received a text message from the nurse which confirmed that the medication was at the facility. A review of the Medication observation record showed Resident #8 first received Ofloxacin	{A 027}		

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	AL11968250	A. BUILDING: _____ B. WING _____	R 11/01/2023

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{A 027}	Continued From page 14 on . A review of Resident #8's health assessment with a completion date of showed a diagnoses of , type 2 , but no new diagnosis for acute . Resident had a precaution. Activities of daily living showed Resident was independent in eating, but needed supervision in ambulation, bathing, , self-care, toileting and transferring. The Center for Control and Prevention states: "Acute is an of the transparent that covers the white part of the inner surface of the . It is commonly known as pinkeye. The condition can be caused by or , reaction, or irritants such as smoke, dust, or chemicals. If untreated, and damage to the are possible but permanent vision lost is rare. Left untreated, the underlying may worsen and possibly cause: , and " Uncorrected Class III	{A 027}		
{A 036} SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is	{A 036}		

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{A 036}	Continued From page 15 an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to reduce the risk and transmission of for two (#4, #7) out nine sampled residents. Staff H (Caregiver) failed to change gloves and sanitize her between providing medication for Resident #4 and #7. Findings: A review of the facility's policies and procedures found no control poilcy. Observation on at 1:05 PM Staff H (Caregiver) popped a 50 MG and a 02 MG into Resident #7's while wearing latex gloves. After she gave Resident #7 her medication, without removing the latex gloves and sanitizing her , Staff H retrieved the for Resident #4 and placed on the table	{A 036}		

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{A 036}	Continued From page 16 for her (Resident #4) treatment. Interviewed on [redacted] at 1:48 PM the Administrator acknowledged that this was a problem and stated, "Okay." Uncorrected Class III	{A 036}		
A 052 SS=E	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 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	A 052		

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A 052	Continued From page 17 (d) Applying [illegible] 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 [illegible], including removing the cap of a [illegible], opening the unit dose of [illegible] solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the [illegible]. (4) Assistance with self-administration of medication does not include: (a) Mixing, [illegible], converting, or [illegible] medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (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 [illegible] of the body. (d) Administration of [illegible] preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [illegible], or [illegible] 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	A 052		

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A 052	Continued From page 18 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 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.	A 052		

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A 052	Continued From page 19 (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 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, record review and interview, the facility failed to follow the procedure outlined by the state when assisting two of nine sampled residents with self-administration of medications (Resident #7 & #8).	A 052		

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A 052	Continued From page 20 Findings: Observation on at 1:10 PM Staff H (Caregiver) popped a , 50 MG and a , 02 MG tablets into Resident #7's without naming the medication and dosage. Staff H then touched the medications with her latex gloves. A review of Residents #7 and #8 records showed no written medication waiver to opt out of orally being advised of the name and dosage of the medications. Interviewed on at 1:48 PM the Administrator acknowledged the problem of the medication pass and stated, "Okay." Class III	A 052		
A 054 SS=F	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is	A 054		

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A 054	Continued From page 21 offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain an up-to-date medication observation record (MOR) for one out of nine sampled residents that was prescribed an [illegible] medication (Resident #8) There was no documentation that the Resident was started on the medication for two days after the [illegible] medication had been delivered to the facility. The facility failed to update the MOR immediately after passing medications (Staff H) to nine out of nine residents (Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10). The facility also failed to ensure that the MOR included the resident's known [illegible] and the name and telephone number of the prescribing health care provider of two out of nine sampled residents (Resident #2, Resident #10) Findings include: Interviewed on at approximately 1:30	A 054		

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A 054	Continued From page 22 pm the PCP (Primary Care Provider) stated that on he reordered Ofloxacin 0.3% { } every 12 hours for acute for Resident #8. According to The Mayo Clinic, "Pink ( ) is an of the transparent that lines the and eyeball. Pink is also called . Because Pink can be , getting an early diagnosis and taking certain precautions can help limit its spread." Interviewed on at 11:35 AM the Pharmacist stated that on the PCP ordered Ofloxacin 0.3% every 12 hours for acute for Resident #8 and the medication was delivered to the facility on . A review of Resident #8's medication observation record showed no documentation that she was given the medication on and . The MOR was left blank for the medication Ofloxacin 0.3% on and . (Photographic evidence obtained) Interviewed on at 1:11 PM when asked why Resident #8 had not received her medication on and , the Administrator stated that the MOR was not delivered with the medication. The Administrator stated, "[Staff B, Caregiver] gave the medication to the Resident the next day ( ) at 8:00 AM and realized that there was no MOR and called it in. When the MOR came the documentation was started on ." Observation on at 8:48 am showed that Staff H (Caregiver) was alone in the facility	A 054		

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A 054	Continued From page 23 caring for the residents. A review of the MOR showed that the medications that were passed to the residents on [redacted] at 9:00 AM were not documented. Interviewed on [redacted] at approximately 10:00 am when asked why she did not update the MOR immediately after passing the medications Staff H stated, "I give all the medications in the morning. When I finish, I look at the labels on the bottles and write it in the MOR. I do it like that because I have nine residents to give medications in the morning and everything else that I have to do. I give medications on Wednesdays, Thursdays, and Fridays." When asked if she had medication training Staff H stated, "Yes." A review of Staff H's record showed documentation of six hours of training on assistance with self-administration of medication and record keeping dated [redacted] ("Certificate of Attendance 6 Hours of Resident Assistance with Self-Administration of Medication Training, Safe Medication Handling and Record Keeping. Prevention of Medication Errors, [redacted].") A review of the MOR found no documentation of the resident's known [redacted] and the name and telephone number of the prescribing health care provider of two out of nine sampled residents (Resident #2, Resident #10) (Photographic evidence obtained) Interviewed on [redacted] at 1:48 PM the Administrator acknowledged that there was a problem with the medication observation record.	A 054		

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A 054	Continued From page 24 Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C.	A 055		

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A 055	Continued From page 25 (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f).	A 055		

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A 055	Continued From page 26 (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to lock and secure medications for two (Residents #7 & #8) out of nine sampled residents. Findings: Observation on at 1:00 PM found a small white refrigerator with the following medications belonging to Resident #7 and #8: Invega Sustenna, 1 Injection Pen 100 units/mL, 1 , Prefilled Syringe Injection Pen 100 units/mL, 1 bottle Ofloxacin , 0.3% , . Interviewed on at 1:48 PM the Administrator acknowledged that the medications were unlocked. Class III	A 055		
{A 077} SS=F	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If,	{A 077}		

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(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 077}	Continued From page 27	{A 077}		

during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.

429.52
(4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.
(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.

59A-36.010
(1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.
(a) An administrator must:
1. Be at least [illegible];
2. If employed on or after [illegible],

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have, at a minimum, a high school diploma or G.E.D.;
3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.;
4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and,
5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C.
Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department.
(b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must:
1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and,
2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.
(c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise

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{A 077}	Continued From page 29 more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that it was under the supervision of an Administrator who ensured and the provision of appropriate care of all residents. The Administrator failed to make	{A 077}		

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{A 077}	Continued From page 30 health care arrangements for Resident #8 who had an , . The Administrator failed to maintain a written record updated as needed of a significant change. The administrator failed to ensure the employees were effectively trained regarding , , , first aid and control and self-administration of medication. The facility failed to ensure Resident #8 had a medication observation record (MOR) for prescribed medication. Findings: 1) Interviewed on at 11:17 AM the Home Health Nurse for Resident #8 stated that he noticed 15-20 days ago he noticed a in her left , . and he immediately texted the primary care physician for Resident #8. Interviewed on at 1:30 PM the Primary Care Physician stated that he first became aware of Resident #8's , on when he examined her at the facility, and he first ordered the , medication for her at that time. Interviewed on at 12:07 PM when asked if he was aware of Resident #8's , , the administrator stated that Staff D (Caregiver) told him that she noticed it and I contacted her doctor. When asked if the doctor was notified and if he had the number to the primary care physician, the Administrator stated, "Yes." The administrator stated further that he did not have the PCP's number and that he would have to get. When asked if any of this information was documented in the facility records, the Administrator stated, no. "Nothing	{A 077}		

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{A 077}	Continued From page 31 was documented. But the doctor documented it (in his records). 2} Observation on at 9:24 AM Staff G (caregiver) working with nine residents. Interviewed on at 10:00 AM when asked how she would know a resident needed , Staff G (Caregiver) stated that she would call 911 and did not state what she would do next. Interviewed on at 11:03 AM when asked what she would if she had to give to a resident, Staff D (Caregiver) stated that she would give 30 breaths and three 3} Observation on at 1:00 PM Staff H (Caregiver used the same gloves to prepare meals in the kitchen, open and close the front door, returned to the kitchen and continued to prepare meals. Observation on at 1:05 PM Staff H provided medication to Resident #7 and #4 without sanitizing her and changing gloves between medication pass. 4} A review of the MOR for Resident #8 showed , 2023, was left blank for the medication Ofloxacin , Interviewed on at 1:11 PM the Administrator stated that the MOR did not come with the medication. The Administrator stated,	{A 077}		

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{A 077}	Continued From page 32 "[Staff B Caregiver] gave the medication to the Resident the next day ( ) at 8:00AM and realized that there was no MOR and called it in. When the MOR came the documentation started on . Interviewed on at 11:35 AM the Pharmacist stated that the medication was delivered to the facility on . Interviewed on at 1:48 PM the Administrator acknowledged that there was a problem with the medication observation record. Uncorrected Class III	{A 077}		
{A 078} SS=F	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must	{A 078}		

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{A 078}	Continued From page 33 submit a health care provider's statement that the individual does not constitute a risk of [redacted]. 2. If any staff member has, or is suspected of having, a communicable [redacted], such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable [redacted]. (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility [redacted] to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be	{A 078}		

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{A 078}	Continued From page 34 conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview, and review of records, the facility failed to ensure that it had qualified staff who performed their assigned duties according to their level of education, training, and preparation (Staff H) The caregiver (Staff H) that was caring for the residents was unable to describe how to perform ( ) Findings include: Observation on at 8:48 am showed that Staff H (Caregiver) was alone in the facility caring for 9 residents. Interviewed on at approximately 11:12 am when asked to describe the technique Staff H was unable to accurately explain the procedure. Staff H did not know how many and breaths were required. She stated, "I push, I call 911" When asked how many and how many breaths Staff H did not know. Interviewed on at approximately 11:20 am when asked if she had received First Aid/ training Staff H stated, "Yes, I know how to do it, but I get nervous and I can't say how it is done." According to the American Association, "For healthcare providers and those trained: conventional using and to breathing at a rate of 30:2 to breaths."	{A 078}		

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{A 078}	Continued From page 35 A review of employee records showed that Staff H had a hire date of . Further review showed documentation that she had received training on , valid through . Interviewed on at approximately 11:39 am when told that Staff H was observed alone caring for the residents and she did not know how to perform the Administrator did not say anything. Class III	{A 078}		
{A 079} SS=F	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy	{A 079}		

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beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and .
6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or

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manager.
7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement.
8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule.
9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.
(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.
(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents,

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{A 079}	Continued From page 38 resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively.	{A 079}		

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{A 079}	Continued From page 39 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide and post a staff schedule that reflected the minimum required 212 Hours/Week for nine (9) residents to meet their scheduled and unscheduled needs. Findings: Observation on at 8:47 AM Staff H (Caregiver) working with nine residents in the facility. Observation on at 9:24 AM Staff G (Caregiver) arrived at facility and working with residents. A record review of the Staff Schedule for the Month of showed no weekly hours for all the employees listed to include Staff B (Caregiver), Staff C (Caregiver), Staff D (caregiver), Staff E (Caregiver), Staff G Caregiver), Staff H (Caregiver), Staff I (Caregiver), Staff J (Caregiver), and Staff K (caregiver). Interviewed on at 1:48 PM the administrator stated that he had the staff schedule and provided the schedule for the Month of without the weekly hours listed for the employees. The Administrator stated further, "Okay." Uncorrected Class III	{A 079}		

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{A 093}	Continued From page 40	{A 093}		
{A 093} SS=F	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of	{A 093}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968250	A. BUILDING: _____ B. WING _____	R 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVINELLE SOUTH ASSISTED LIVING FACILITY INC	1750 NW 41 STREET MIAMI, FL 33142

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{A 093}	Continued From page 41 the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal.	{A 093}		

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{A 093}	Continued From page 42 Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of ˍ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to post a current menu for the week of , . Findings: Observation on at 8:47 AM found an expired posted menu dated Sunday, , -Saturday . Interviewed on at 1:48 PM the	{A 093}		

Agency for Health Care Administration

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{A 093}	Continued From page 43 Administrator acknowledged the problem and stated, "Okay." Uncorrected Class III	{A 093}		