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
	AL11969056	A. BUILDING: _____ B. WING _____	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVINELLE WEST ALF INC	2045 NW 26 ST 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 Compliant (#2024003713) Survey was conducted at Calvinelle West ALF Inc on . . , . Deficiencies were identfied at time of survey.	A 000		
A 032 SS=G	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.	A 032		

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A 032	Continued From page 1 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview, the facility failed to follow its policies and procedures regarding elopement when one out of 14 sampled residents (Resident #1) eloped from the facility (Resident #1). Resident #1 had a history of elopement, and no interventions were implemented to prevent further elopements. The facility failed to ensure that residents identified as an elopement risk have identification on their	A 032		

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A 032	Continued From page 2	A 032		

persons, including their name and the facility's name, address, and telephone number. For one out of 14 sampled residents (Resident #2).

Findings included:

1) A review of the adverse incident report submitted by the facility documented on , at around 3:35 PM showed that Resident #1 left the facility after Staff B (caregiver) left gate opened while another resident was returning from . After a search by Staff A, law enforcement was called.

A review of the facility's admission/discharge log showed Resident #1 was admitted on .

A review of Resident #1's record showed he was admitted on . The health assessment completed on showed a medical history and diagnoses of AKI, COVID-19 , , and . The resident was independent with ambulation, , eating, toileting, and transferring and needed supervision with bathing, and self-care grooming. He needed assistance with self-administration of medications. The health assessment documented that the resident was not an elopement risk at the time of admission.

Interviewed on at 11:39 am Staff A stated, "I have worked here for four years. Resident #1 was . He was comical, joking around. He was never aggressive, nothing out of the ordinary. He never gave us any reason for alarm. From what I could see he never demonstrated he was , never saw him talking to himself. There were no changes in the last couple of weeks. The only friends he has a here in the facility. He communicated to the

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A 032	Continued From page 3 guardian that he wanted to leave, and she would let us know. [Staff B] was at the gate and took Resident #3 at the gate. We were the only ones on duty that day. Resident #3 usually arrive from . . , . . around 3:30 PM to 3:40 Pm. Resident #3 was already in with Staff B when they came in the facility. Both of us was in the dining area together. I was attending to complaint from . . . . . center about Resident #3 had his , done but was wearing a shirt that was too tight and so we had to relieve the pressure from his arm. I asked [Staff B] to get the scissors so we could cut the sleeve of the arm of Resident #3's shirt to relieve the pressure. About 4:14 PM the nurse came in and said he saw Resident #1 at the corner. I dropped everything I was doing and reacted and went out to look for him. I didn't see him, . I saw a car sitting there so in knocked and the man pulled down the window and I asked him if he had seen a man with dreads. The man pointed to where he went. I went up to the gas station, down to 21 Street and 19th street and could not find him. When I came to the facility and the nurse also took me in his car to look for Resident #1 and we did not find him. When I got to the facility, I called the police at 4:14 PM, Then I called the Administrator to let her know. [Staff B] said she was not aware that she had left the gate open. When the police arrived which was not very long. We still don't know where he is." Did he have any identification on him? "No, he did not have anything on him. The only id's he might have were the one from the special program. But I don't think he would have them because most of his id's are in his file. We did not give him any identifications." Interviewed on at 12:48 PM Staff B stated, "I have worked here for two in half years.	A 032		

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A 032	Continued From page 4 My duties include cleaning. I do not cook. I wash the residents' clothes, clean the bathroom, and help the residents with a shower and feed them. [Resident #1] he was always in his room or outside sitting down. The day that Resident #1 eloped I went out the gate to take in [Resident #3]. [Resident #3] was coming from his doctor's . . I opened the gate and pulled him and carried him inside into the dining area. Staff A was on the phone at the center. I forgot to go . . . to put the padlock On the gate and lock it. I was inside feeding [Resident #3]. The other resident were asked where [Resident #1] was they said he went through the gate. Staff A went out to look for him on the avenues. I stayed in the facility attending to the other residents." Did you call the police? "No, [Staff A] called when she returned. [Staff A] called the police and the Administrator. [Resident #1] got his medications in the morning and got his lunch. It was almost dinner time around 3:30 PM to 4 PM. I don't know if he has any ids. I don't think he had any identification from the facility. I did not speak to the police. [Staff A] did. It was only [Staff A] and I working that day. What is the facility's policy on how to handle an elopement? " When someone goes missing , I have to call police and report it to the boss." on at 10:38 am Participant #1 stated, "[Resident #1] is an elopement risk. He would say he wants to leave with his family. He has eloped before while he was living at the facility. He had gone out with a nephew of his and they went to a barber shop and the cousin went around the corner to the store and came and resident #1 missing for days. That occurred in . . . . , of 2022. I did let the facility know about this incident."	A 032		

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A 032	Continued From page 5 In an interview on [illegible] at 12:35 PM, the Home Health Nurse stated "I was coming in to see one of my patients at around 3:30-3:40. I was surprised that the gate was left opened halfway as it is never like this, and as I was walking up to the entrance, I saw [Resident #1] leave the facility through the opened gate. I began shouting to the staff that someone was outside, and the gate was open. [Staff A] took off running outside but he was already gone by the time she got outside. I got in my car and went looking for him, then I told [Staff A] to get in the car with me to search together, but we had no luck, he was gone. We came [illegible] to the facility and told [Staff A] to call the police and report the incident, and then he went on to see his patient whom he had come to see." 2) Observation on [illegible] at 12:30 PM showed that Resident #2 did not have an identification bracelet on himself that included the facility's name, address, and telephone number. A review of Resident #2's record showed he was admitted on [illegible]. The health assessment completed on [illegible] showed a medical history and diagnoses of [illegible]. The resident was independent with ambulation, eating, toileting, transferring, supervision with bathing, [illegible], and self-care grooming, and needs assistance with self-administration of medications. The health assessment documented that the resident was not an elopement risk at the time of admission. Interviewed on [illegible] at 12:30 PM Resident #2 stated that he did not have any personal identification on him. When asked if he knew the address and telephone number of the location of where he lived Resident #2 stated, "No, I can see the numbers on the building, but I do not have	A 032		

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A 032	Continued From page 6 any ids." Interviewed on [redacted] at 9:29 am with Staff A when asked if there were any elopement risk residents in the facility Staff A stated that Resident #2 was an elopement risk. Staff A stated that Resident #2 had stated he wanted to leave and had told the guardian also he wanted to le ave the facility. She further stated, "[Resident #2] is an elopement risk. He is [redacted], and he would say I want to live on the streets. He would like to be homeless. If he is given the opportunity he will sneak out. He has no family. I have informed the facility of this for both of them." A review of the facility's elopement policy documented "All staff is responsible for reporting elopement. If the client leaves should notify law enforcement immediately. " Class II	A 032		
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.	A 055		

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A 055	Continued From page 7 (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. (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,	A 055		

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A 055	Continued From page 8 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). (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 and interview, the facility failed to secure resident medications in a locked receptacle or container for seven out of 16 (Residents #1, 4, 9, 10, 13, 15 and 16) sampled	A 055		

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A 055	Continued From page 9 residents and failed to dispose of medications within 30 days of residents leaving the facility. Finding included: Observation on at 10:30 AM revealed prescription medications belonging to Residents #10 and #13. (Budesinide/ 160/4.5 mcg, and two bottles of) on top of the kitchen counter. Further observation revealed, in the refrigerator in the dining area was found unlocked in form of pens and vials belonging to Residents #1, 4 and 9 . There was also for Residents #15 and 16 who no longer resided at the facility since On at 10:30 AM Staff A acknowledge that the medications were not in a locked receptacle and stated that she could not recall the facility's Medication Disposal Policy. Class III	A 055		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and,	A 056		

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A 056	Continued From page 10 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care	A 056		

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A 056	Continued From page 11 provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, and interview the facility to properly store labeled prescription medications for 13 out of 16 (Residents #1, 2, 3, 4, 5, 7, 8, 9 10, 11, 12, 13, and 14) which medication tablets were pre-poured for medication assistance to be provided by an untrained staff person.	A 056		

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A 056	Continued From page 12 Findings included: Observation made on st 10:10 AM in the kitchen of medication closet. The closet was opened, and it was observed a tray and a bin was found with medications from their original containers dispensed and pre-poured into small bottle containers. The containers were labeled with Resident's #1, 2, 3, 4, 5, 7, 8, 9 10, 11, 12, 13, and 14 names on them and had medications tablets in each of them. In an interview on at 10:15 AM Staff A stated, "I placed them in those containers last month because I was going on vacation in , . I realized I didn't need to but forgot to put them ." Class III	A 056		
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:	A 152		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969056	A. BUILDING: _____ B. WING _____	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVINELLE WEST ALF INC	2045 NW 26 ST 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	Continued From page 13 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 . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe living environment, free of hazard, and failed to supply essential furniture. Findings included: On . . . . . at 9:50 AM, observation showed the supply closet was unlocked with cleaning supplies inside. On . . . . . at 9:51 AM, observation showed that # and # did not have dressers. On at 9:52 AM, Staff A (caregiver) stated, regarding the unlocked cleaning supplies, that "It is always locked I lock it, but in the	A 152		

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
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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 152	Continued From page 14 mornings, I leave it like this since I am constantly coming to get something or put something and don't lose time because I am helping the residents in the morning." On at 9:53 AM, Staff A (caregiver) stated, regarding the missing dressers, that "I didn't know it was required to have dressers." Class III	A 152		