STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967577	06/17/2015
NAME OF PROVIDER OR SUPPLIER **CALVINELLE ADULT HOME ALF #2**	STREET ADDRESS, CITY, STATE, ZIP CODE **1786 NW 47 TERRACE MIAMI, FL 33142**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An Extended Congregate Care (ECC) Monitoring Survey was conducted on , 2015. Calvinelle Adult Home Alf #2 had deficiencies identified at time of the survey.

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview the facility failed to maintain a clean and safe environment to residents.

Findings included:

Observation on at 9:16 am the backyard had several (5) woods standing up against the facility wood fence, there were broken wheel chairs (3), and they needed to be through away.

Interview on at 9:13 revealed that the Staff A revealed that the facility's Residents have access to the backyard.

Interview on at 9:30 am revealed that Staff A stated that they will clean through away everything.
Class III

0161 Records - Staff

Based on record review and interview the facility failed to have a completed personnel file for Staff B.

Findings included:

Record review on revealed that the facility had ECC Component, and the ECC nurse's (Staff B) license was expired on . Also, Staff B's licensed was dated on ( ); it needed to be updated.

Interview on at 9:30 am by phone with the Administrator revealed that she acknowledged that the Nurse's license was expired, and she will fix it.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Calvinelle Adult Home Alf #2
1786 Nw 47 Terrace
Miami, FL 33142

Dear Administrator:

This letter reports the findings of a Extended Congregate Care Monitoring Survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure
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