STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967353	07/18/2016
NAME OF PROVIDER OR SUPPLIER **CALVINELLE ADULT HOME ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1627 NW 62 TERRACE** **MIAMI, FL 33140**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on , 2016. Calvinelle Adult Home ALF (AL#11422) with Limited Nursing Services and Limited Mental Health components had deficiencies identified at the time of the survey.

0077 Staffing Standards - Administrators

Based on record review and interview, the facility failed to maintain documentation of the facility manager's high school diploma onsite in the personnel record.

Findings included:

Record review of the facility manager's personnel file revealed that there was no documentation of the high school diploma.

The facility's manager stated on interview on at 12:35 pm that she will provide a copy of her high school diploma to be kept in her personnel file.

Class III

L243 LMH - Training

Based on record review and interview the facility failed to ensure that 2 out of 4 sampled employees who are in direct contact with mental health residents complete a training of no less than 6 hours related to their duties within 6 months of being hired (Staff C and D).

Findings included:

Personnel record review of Staff C revealed that she has been working in the facility since . Also revealed that she took 3 hours of continuing education in limited mental health on but failed to have the initial training.

Personnel record review of Staff D revealed that he has been working in the facility since / . Also revealed that he took 3 hours of continuing education in limited mental health on / / but failed to have the initial training.

On / at 12:08 pm the facility administrator stated that Staff C and Staff D T are scheduled to take

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967353	**07/18/2016**
NAME OF PROVIDER OR SUPPLIER **CALVINELLE ADULT HOME ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1627 NW 62 TERRACE** **MIAMI, FL 33140**	

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

the initial 6 hours training on .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2016

Administrator
Calvinelle Adult Home Alf
1627 Nw 62 Terrace
Miami, FL 33140

Dear Administrator:

This letter reports the findings of a state relicensure survey that was conducted on [illegible], 2016 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than [illegible], 2016.** 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure
XG90

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com