STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967353	**07/05/2018**
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 , 2018 and concluded on , 2018. Calvinelle Adult Home ALF with limited mental health and limited nursing components (License #11422) had the following deficiencies identified at the time of the survey:

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview, the Assisted Living Facility (ALF) failed to 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 for one (#5) out of nine sampled resident. The facility's Resident Elopement Response Policies and Procedures did not have the minimum requirement. Resident #5 eloped from the ALF, lost in the street and was hospitalized.

Findings included:

Review of facility's adverse incident report showed that on Resident #5 at 6:30 PM had snack and medications. On at 6:45 PM, staff did the and did not find the resident. The police and the program were notified at 7 PM.

Review of Resident #5's record revealed that there was no documentation that the resident wandered from the facility on . There were no progress notes indicating when nor where the resident was found. The resident was not evaluated or assessed after the elopement incident.

Review of Resident #5's record revealed that the health assessment (AHCA form 1823) completed on . It showed medical history and diagnoses: , and , . The resident ambulated independent and was alert and oriented x 3 (knew people, places and time). The resident was independent for ambulation, eating, toileting and transferring, and the resident needed supervision for bathing, and dressing self-care. Special diet: no added salt, and low fat/low . The resident needed assistance with self-administration of medications. There was no documentation that the resident wandered from the facility on . There were no progress notes indicating when nor where the resident was found. The resident was not evaluated or assessed after the elopement incident. There was no photo ID in the record.

On at 3:40 PM the administrator revealed that there was no documentation that the resident wandered from the facility because she just came back from hospital.

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Review of the hospital record showed that Resident #5 was admitted on and discharged on . History of illness revealed that the resident was admitted early morning on when she Resident after going for a walk and saw everything black. The resident had sensory motor , which can cause her unstable gait. The resident admitted to hospital to rule out . According to American Association, syncopal episode is a temporary loss of that usually related to insufficient flow to the . It can be or a symptom of an underlying medical condition.

Review of facility's elopement policy and procedure showed:
- Search for the resident in the surrounding neighborhood, and or follow the resident.
- Notify the law enforcement/ court
- Notify the administrator
- Notify the guardian/family
- Notify case manager
- Notify immediate family/guardian after the situation is resolved.

The facility's written policies and procedures for responding to a resident elopement did not include any information about the continued care of all residents within the facility in the event of an elopement. There was no documentation that the facility conducted elopement assessments on admission.

Class II

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that the staff read medications' names aloud to residents for two out of ten sampled residents (# One and 10) .

Findings included:

On at 7:21 AM, Staff C assisted with self-administration of medication to Resident #1. After the staff prepared medications, Resident #1 walked to the med . Staff C handed a cup with medications inside to the resident. The resident put medications in her hands and walked away from the staff. Staff did not read aloud medications' labels. Staff initialed the Medication Observation Record for Resident #1.

Reconciliation of Resident #1's medications on at 7:22 AM revealed that 9 AM medications showed that the resident took:

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- Low 81 mg tab- take one tablet by mouth daily.
- 30 mg cap- take one capsule by mouth daily.
- 20 mg tab- take one tablet by mouth daily.
- 100 mg cap- take one capsule by mouth every morning.
- 20 mg tab- take one tablet by mouth once daily.
- 500 mg tab- take one tablet by mouth once daily.
- 25 mg tab- take one tablet by mouth once daily.
- 100 mg softgel- give 2 capsule by mouth per day.
- MAPAP ER 650 mg tab- take one tablet by mouth per day.
- D3 2000 units tab- take one tablet by mouth once daily.
- 0.25mg tab- take one tablet by mouth in the morning and at bedtime.

On at 7:34 AM, Staff C assisted Resident #10 with self-administration of medication. Staff C stated to the resident, "These are your meds." Staff did not read aloud the medications' labels.

Reconciliation of Resident #10's medications revealed that 7 AM medications were:
- Low 81 mg tab- take one tablet by mouth daily.
- 1 mg tab- take one tablet by mouth daily.
- 75 mg tab- take one tablet by mouth daily.
- 0.4 mg cap- take one capsule by mouth daily.
- 1000 mcg tab- take one tablet by mouth daily.
- 5 mg tab- take one tablet by mouth daily.
- 25 mg tab- take one tablet by mouth daily.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation and record review, the Assisted Living Facility failed to have an accurate Medication Observation Record (MOR) for one (#1) out of 10 sampled residents.

Findings included:

On at 7:21 AM, Staff C assisted with self-administration of medication to Resident #1. After the staff prepared medications, Resident #1 walked to the med . Staff C handed a cup with medications inside to the resident. Medications were tablets and capsules. The resident put medications in her hands and walked away from the staff. Staff did not read aloud medications' labels. Staff initialed

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the Medication Observation Record for Resident #1.

Review of Resident #1's MORs at 7:22 AM revealed Staff C initialed that all medications for at 9 AM. Medications were:
- Low 81 mg tab- take one tablet by mouth daily.
- 30 mg cap- take one capsule by mouth daily.
- 20 mg tab- take one tablet by mouth daily.
- 100 mg cap- take one capsule by mouth every morning.
- 20 mg tab- take one tablet by mouth once daily.
- 500 mg tab- take one tablet by mouth once daily.
- 25 mg tab- take one tablet by mouth once daily.
- 100 mg softgel- give 2 capsule by mouth per day.
- MAPAP ER 650 mg tab- take one tablet by mouth per day.
- D3 2000 units tab- take one tablet by mouth once daily.
- 0.25mg tab- take one tablet by mouth in the morning and at bedtime.
- 10gm/15 ml- give 30 ml per mouth once daily.
- Eye Drops- instill one drop on each eye once daily.
- Prop 50 mcg spray- inhale 2 sprays by intranasal route in both nostrils once daily.
- 160-4.5 mcg inhaler- inhale 2 puffs by inhalation route two times a day.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, interview and record review, the Assisted Living Facility failed to keep medications locked at all times.

Findings included:

On at 8:16 AM observed that there was a medication on top of a table in Resident #1's . Medication had the label with Resident #1's name and it was Prop 50 mcg spray.

On at 8:16 AM Staff B stated, "She has to keep it in case that she gets ."

Review of Resident #1's record showed that health assessment completed on . It showed that the resident needs assistance with self-administration of medication.

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Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the Assisted Living Facility failed to contact the health care provider and obtain clarification for medications ordered as needed for one out of 10 sampled residents (#1) . The facility also failed to ensure that one out of nine sampled residents had medications on hand (#2). Resident #2 did not take medications for four days.

Findings included:

1)

Review of Resident #1's MORs at 7:22 AM revealed Staff C initialed that all medications for were 'as needed'. Medications were:

- Iprat- Albut 0.5-3(2.5)mg/3 ml- inhale 3 ml (1 UD) by nebulation route every 6 hours as needed.
- HFA 90 mcg inhaler- inhale 1 puff by inhalation route every 6 hours as needed.

There was no documentation of what conditions might lead the resident to need the medications.

On at 3:26 PM the Administrator revealed that none of the staff that assisted with self-administration of medications were licensed staff.

2)

On at 7:47 AM, Resident #2 revealed that she did not take some of her medications for four days.

On at 7:50 AM observed that medication bottles for Resident #2 were empty. Empty medications bottles were:

- tab 50 mg- take one tablet by mouth at bedtime.
- tab 50 mg - take one tablet by mouth once daily.
- tab 20 mg- take one tablet by mouth in the morning.

Review of Resident #2's Medication Observation Record (MOR) were signed by staff with letter "O" on , , and . There was no documentation on .

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On at 10:45 AM Resident #2's medications arrived. The medications were:
- tab 50 mg- take one tablet by mouth at bedtime.
- tab 50 mg - take one tablet by mouth once daily.
- tab 20 mg- take one tablet by mouth in the morning.

Review of Resident #2's record revealed that health assessment completed on . It showed the medical diagnosis of and stated that the resident needed assistance with self-administration of medication. There was no documentation that the doctor was notified about the resident not having sufficient medication on hand.

According to medlineplus.gov:
- is used to treat . It can also be used to treat and and .
- is used to treat , Post- Stress , and Premenstrual Pysphoric .
- is used to treat the symptoms of , episodes of or mixed episodes of and that happen together, (- ; a that causes episodes of , episodes of , and other abnormal moods) and .

According to mayoclinic.org, is alsoknown as . It is a mental health condition. People that suffer this condition can have extreme mood swings. People with can have thoughts and behaviors. Stopping the treatment or reducing the dose of the medication without medical supervision can cause withdrawal effects or worsening of the symptoms.

On at 3:18 PM the Administrator revealed that when the resident did not receive the medication, the staff was supposed to document it.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation and record review, the Assisted Living Facility failed to keep an accurate staffing schedule.

Findings included:

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On at 7:13 AM, observed that Staff C was the only staff on duty.
Staff D arrived on at 7:24 AM.
Staff B arrived on at 7:47 AM.
Staff E arrived on at 8:37 AM.
The administrator arrived on at 8:48 AM.

A review of the staffing pattern for 2018 showed that the Administrator, Staff B and D worked on from 7 AM to 7 PM.
Staff H worked on from 7 PM to 7 AM .

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and record review, the Assisted Living Facility failed to note menu substitutions before or when the meal was served.

Findings included:

On at 12:16 PM Staff B served lunch to residents. Lunch was two slices of bread with ham, cheese, and tomato, mango, juice (citrus).

Review of the menu showed that for the planned lunch was: soup Du Jour (6 oz.), ham and cheese (3 oz.) on bread (2 slices), lettuce and tomato (1 cup) and peaches (1/2 cup). There was no documentation for the substitution.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the Assisted Living Facility failed to maintain the facility clean and the required furniture in good working order.

Findings included:

On at 8:11 AM observed that Residents #4 and #7's not have a night table and the closet was missing one door.

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On at 8:11 AM Staff O stated that they would fix it.

On at 8:13 AM observed one of the bed with a green disposable underpad on Residents #5 and #6's . There was a strong smell.

On at 3:43 PM the Administrator stated that the staff informed him Resident #5 just in the morning before the tour of Resident #5 and #6's .

Class III

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Z824 - Right of Inspection; Inspection Reports - 408.811 FS; 59A-35.120 FAC

Based on observation and interview, the Assisted Living Facility failed to provide timely access to the facility for an unannounced compliance inspection.

Findings included:

During the tour of the facility on at 8:05 AM, the facility did not give access to tour the second floor of the second building (1601 NW 62nd Terrace, Miami, FL).

On at 8:28 AM Staff B, revealed that the second floor on the second building (1601 NW 62nd Terrace, Miami, FL) was an office. The staff did not have key therefore the area could not be checked. The staff would see if she could get the key.

On at 4:43 PM, the Administrator revealed that the second floor was not part of the ALF, just the first floor was part of the ALF. The second floor was the administrator's apartment.

Review of the floor plan submitted for the facility's licensure showed that the upper floor was included.

Unclassified