STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967353	R 09/05/2018
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 Revisit was conducted on [redacted] 5th, 2018 and concluded on [redacted] 14th, 2018. Calvinelle Adult Home, with limited mental health and limited nursing components (License #11422), had the following deficiencies identified at the time of the survey:

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 one out of one sampled resident (#5). The facility also failed to ensure that the medication was given within one hour before or one hour after the time prescribed. Medication was given two hours and twenty minutes before the prescribed time.

Findings included:

On [redacted] at 6:40 AM, Staff C assisted Resident #5 with self-administration of medication. After the staff prepared medications, Resident #5 walked to the dining table. Staff C pushed the medications out of the [redacted] pack into her bare hand, and inserted the medication into a small plastic container. Staff C then handed the plastic container 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 #5 for 9:00 am medications.

Reconciliation of Resident #5's medications on [redacted] at 6:45 AM revealed that 9 AM medications showed that the resident took:
- [redacted] 2.5 MG,
- [redacted] 81 MG,
-Prezcodix 800 MG,
-Tendfovir Disop Fum 300 MG,
- [redacted] 1,000 MG,
-Ducusate [redacted] 100 MG twice a day,
-Isentress 400 MG twice a day,
- [redacted] twice a day,
- [redacted] 1 MG twice a day

Uncorrected
Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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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 out of 1 sampled residents (#5).

Findings included:

On at 6:40 AM, Staff C assisted Resident #5 with self-administration of medication. Staff initialed the Medication Observation Record for Resident #5 for 9:00 am medications.

Reconciliation of Resident #5's medications on at 6:45 AM revealed that 9 AM medications showed that the resident took:
- 2.5 MG,
- 81 MG,
-Prezcodix 800 MG,
-Tendfovir Disop Fum 300 MG,
- 1,000 MG,
-Ducusate 100 MG twice a day,
-Isentress 400 MG twice a day,
- twice a day,
- 1 MG twice a day

Uncorrected
Class III

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

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

Findings included:

On at 10:00 am observed resident medications in a unlocked desk drawer located inside the Administrator's office:
- 2.5 MG,
- 81 MG,
-Prezcodix 800 MG,

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

-Tendfovir Disop Fum 300 MG,
- 1,000 MG,
- 100 MG,
-Isentress 400 MG,
-
- 1 MG
Observed that the door to the Administrator's office was unlocked and ajar.

On at 10:00 am Staff C stated, "Resident #5's medications does not fit in the Residents medication cabinet."

Uncorrected
Class III

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

Based on observation and interview, the Assisted Living Facility failed to properly store and label over the counter medication.

Findings included:

On at 7:00 am, observed various unlabeled medication scattered alongside resident medication located in the medication cabinet: and 2MG gum.

On at 7:02 am Staff C stated those over the counter medications are for everyone and not for one specific resident.

Uncorrected
Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observation, interview and record review, the facility failed to correct deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration during a survey. The facility is required to employ the consultant services of a licensed pharmacist or a licensed registered nurse who will, at a minimum, provide onsite quarterly consultation until an inspection by the Agency's personnel determines that such consultation services are no longer required.

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

Findings:

On and , the facility was found to have deficient practice in the areas of: Assistance with Self administration of medication; medication records; medication storage and disposal, medication labeling and orders.

During a revisit inspection ending on , the facility was found to have uncorrected deficient practice in the areas of: Assistance with self-administration of medication; medication storage and disposal; medication labeling and orders.

Class III

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

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

Findings included:

On at 5:51 am, observed Staff C was the only staff on duty. Staff C stated she was the only staff on the premises at the moment due to Staff I leaving to his home. Staff C stated the facility currently had a census of 14 residents. Staff C stated Staff I would be returning shortly.

On at 6:07 am, observed Staff I return to the facility.

On at 6:08 am, Staff I stated he left to his home nearby to check on his family before leaving to school.

A review of the staffing schedule for 2018 showed that Staff (C and I) worked on from 7 pm to 7 am.

Uncorrected
Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on observation, interview and record review the Assisted Living Facility failed to ensure one of one sampled employee (Staff C) who held a valid First Aid and ( )

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

certification (accredited by the American Red Cross, American Association, National Safety Council; or a provider approved by the Department of Health) remained in the facility at all times.

Findings included:

On at 5:51 am, observed Staff C was the only staff on duty. Staff C stated she was the only staff on the premises at that moment due to Staff I leaving to his home. Staff C stated the facility currently had a census of 14 residents. Staff C stated Staff I would be returning shortly.

A review of Staff C's employee file revealed the Certification was not accredited by the American Red Cross, American Association, National Safety Council; or a provider approved by the Department of Health.

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 8:30 am Staff C served Breakfast to residents. Breakfast was two pancakes, one (1) egg, one (1) teaspoon of Margarine, syrup, milk (eight ounces) and once cup (eight ounces) of coffee.

Review of the menu showed that for the planned breakfast was: two pancakes, one (1) egg, one (1) teaspoon of Margarine, syrup, assorted juices (4 ounces) and Milk (8 ounces). There was no documentation of the substitution.

Uncorrected
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 free of environmental hazards.

Findings included:

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On . . . . . at 6:00 AM observed in the backyard of Building 1 of the facility, various window shutters on the ground. Observed debris located in the backyard of Building 2 of the facility on the ground.

On at 10:30 am Administrator stated he understands the debris and window shutters should be cleaned up and stored away properly and that he would have it cleared.

Uncorrected
Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review, and interview, the Assisted Living Facility failed to have an accurate health assessment for one out of one sampled residents (Resident #5).

Findings included:

A review of Resident #2's health assessment showed there was no date documented and did not indicate the resident is an elopement risk although the resident eloped from the facility on . . . . .

On . . . . . at 1:00 pm Administrator stated that the day program provider was Resident #5's primary care provider. Administrator stated he would ask the doctor to complete a new health assessment to indicate Resident #5's elopement risk.

Class III