STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969056	R 09/06/2018
NAME OF PROVIDER OR SUPPLIER **CALVINELLE WEST ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2045 NW 26 ST** **MIAMI, FL 33142**	

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

0000 - Initial Comments

A Standard Biennial Survey Revisit was conducted on 6th, 2018. Calvinelle West ALF Inc. with limited mental health and limited nursing components (License #12908) had deficiencies identified at the time of the survey:

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that residents had ordered medications for one out of 14 sampled residents (#10) . Residents #14 did not have medications for unknown days.

Findings included:

Review of Resident #10's MORs showed that there were orders for 10 mg, and 50 mg. 10 mg was scheduled at 7 AM and 50 mg was scheduled at 7 PM.

Reconciliation of medications for Resident #10's showed that there were medications cards with orders for 10 mg, and 50 mg. 10 mg's label showed 10 mg tablet- take one tablet by mouth every day. 50 mg's label showed 50 mg tablet- take one tablet by mouth every day. and medication cards were empty.

On at 10:25 AM, Staff B revealed that the facility did not document when they ordered the medication from the pharmacy.

On at 10:25 AM, Staff K revealed that she ordered the medications 3 days ago and last time that took the was the night before ( ) and was today in the morning ( ). She further stated she was not aware that there was a change in the dose, and said it probably was an error from the pharmacy.

Observed medications arrive on at 12:34 PM.

Class III

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

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

Based on interview and record review, the Assisted Living Facility failed to follow doctor's orders for one out of 14 sampled residents (#3). The facility also failed to have the correct medication dose for one out of 14 sampled residents (#10).

Findings included:

1. Review of Resident #3's Medication Observation Record (MOR) showed that there was an order for , 600 mg tab- take one tablet by mouth every 8 hours. It was scheduled at 7 AM, 1 PM, and 8 PM.

Reconciliation of medications for Resident #3 showed that there were three medication cards labeled for , 600 mg tab- take one tablet by mouth every 8 hours.

2. Review of Resident #10's MORs showed that there was an order for , 5 mg; it was scheduled at 7 AM.

Reconciliation of medications for Resident #10 showed that there were medications card Trihexyphenudyl 2 mg's label showed Thrihexyphenidyl 2 mg tablet- take one tablet by mouth every day.

On at 11:12 AM, Staff K revealed that the pharmacy informed her that the resident changed doctors and the new doctor changed the dosage from 2 mg to 5 mg. Staff K further stated that the paper preceded the medication, and that when the medication arrived, it would show the new dose.

Uncorrected
Class III