STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967353	R 11/15/2018
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 11/7/18 - 11/15/18. Calvinelle Adult Home, with limited mental health and limited nursing components (License #11422), had 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 facility failed to provide assistance with self administration of medication procedures as outlined by the state for seven of 13 sampled residents (1, 3, 7,9,14, 15 and 16). Medications were given more than one hour before the time identified on the Medication Observation Record (MOR)

Findings included:

Observation at 8:18 am revealed that Resident 16 and Resident 14 were sitting in the common area.

Record review revealed that the MOR for Residents 1, 3,7,9,14,15 and 16 reflected their daily medications at 9:00am.

Interview on at 8:27 am Staff C stated, "Residents 1, 3, 7,9,14 and 15 are at the Program. I assisted all the Residents with their medications, including Resident 16." In addition, Staff C stated, "I start at 7: 00 am - 7:30 am because some of them have to go to the Program; the bus came to pick them up at 7:30 am."

Uncorrected
Class III

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

Based on observation, record review and interview, the facility failed to correct the deficiency of following the outlined procedures regarding assistance with self-administration of medication. The facility also failed to provide documentation that a consultant licensed pharmacist or a licensed registered nurse provided onsite quarterly consultation until an inspection by the Agency's personnel determined that such consultation services were no longer required.

Findings:

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Observation and record review on , , and showed the facility did not follow the medication orders on the Medication Observation Record (MOR) to provide morning medication to the seven residents. The MOR indicated that Residents 1, 3, 7,9,14, 15 and 16 should have had their morning medications within one hour before or after 9:00 am. The medications were given on between 7: 00 - 7:30 am.

Record review revealed that the facility did not have documentation that a minimum of quarterly consultant services from a licensed pharmacist or a licensed registered nurse occurred.

On at 8:27 am Staff C stated, "Residents 1, 3, 7,9,14 and 15 are at the Program. I assisted all the Residents with their medications daily, including Resident 16." In addition, Staff C stated, "I start at 7: 00 am - 7:30 am because some of them have to go to their Program; the bus came to pick them up at 7:30 am."

On at 1:00 pm Staff B stated, "We have a Nurse for the LNS licensed, and she provided the consultation for us. However, we have no documentation of the visit or conclusion of the consultation."

Uncorrected
Class III

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

Based on observation and interview, the facility failed to maintain the environment clean and free of hazards.

Findings included:

Observation on at 8:15 am revealed that the facility had a fence (locked), and it was missing a bell, thus providing no way to access the property.

Observation on at 9:00 am revealed that (building #1) # 's ceiling paint was peeling over Resident #5's bed. The bathroom cabinet (next to #) did not close properly.

Observation on at 9:00 am revealed that the second floor (building #1) had six Residents 4, 7, 8, 9, and 13, and there were 21 bottles (of 5 gallons/closed) of emergency water on top of the kitchen counter (storage). There were two boxes full of debris in a corner of the dining area, the refrigerator was

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SUMMARY STATEMENT OF DEFICIENCIES
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empty, and there was no water available to drink.

On at 9:05 am Staff E stated, "The Residents that live here (Building #1 at second floor) have water downstairs, and all they need to eat or drink downstairs, too. They have a water fountain to drink water downstairs. We keep the refrigerator empty because we are preventing cockroach."

Observation on at 9:00 am revealed that building #2 (first floor) had a refrigerator that was not working, and two Residents, #1 and #5, were living in that area.

Observation on at 9:00 am revealed that the building #1 (second floor) behind the wall of Resident 7's bed had a bump (#). In addition, the closet door was not closing properly.

Interview on at 9:00 am regarding the wall and the closet door Staff C and E stated that they had no idea of how it happened. They also stated that it happened probably recently because they did not see it.

Observation on at 9:00 am, at the building #2 (first floor), Resident #1 room had unfinished ceiling paint. Resident #5's closet door in # was not closing properly.

Interview on at 10:00 am Staff B stated, " I do not have a bell because someone has been stealing it."

Uncorrected
Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to have an updated annual fire inspection.

Findings included:

Record review revealed that the facility had a fire inspection dated ( ).

On at 1:07 pm Staff B stated, "I requested the fire inspection, and I am waiting for them."

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Class III

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

Based on record review and interview the facility failed to have an accurate health assessment for one of 13 sampled residents (Resident #1).

Findings included:

Record review revealed that Resident #1's health assessment did not specify if Resident #1 needed 24 hour supervision.

On [redacted] at 1:00 pm, Staff B stated, "I did not notice that Resident #1's health assessment was missing that information."

Class III