

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/21/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EL PARAISO HOME, INC

**1540 SW 7TH STREET
MIAMI, FL 33135**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A COVID-19 Control, a Generator Monitoring, and a complaint (Complaint #2020016876) were conducted at Deficiencies were identified at the time of the survey.	A 000		
A 030 SS=L	59A-36.007(6) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 1 and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. _____ and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident _____, neglect, and _____; 6. Administrative and housekeeping schedules and requirements; 7. _____ control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 2 429.41(1)(k), F.S., the use of physical _____ by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical _____. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 3 (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 4 relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (1) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without _____, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, _____, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and, if applicable, _____ Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 5 complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: B Based on observation, record review, and interview, the facility failed to follow current control standards from the Centers for Control and Prevention (CDC) related to COVID-19 (Coronavirus 2019) and Florida Governor's emergency orders DEM Order	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 6 20-006, dated The facility placed fourteen residents at risk of exposure to COVID-19 (Residents # . . . #14) by allowing an employee to continue to work for three days after a confirmed positive COVID-19 test result. Eleven residents subsequently tested positive for COVID-19 (Residents #1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12) and two staff (The administrator and the Owner). Four residents were hospitalized (Resident #1, #2, #3, and #5), and one resident was put in a COVID-19 isolation area in a local hospital. Findings included: The COVID-19 is a transmissible that presents severe risk to persons who are aged, infirm, or suffer from co- including, but not limited to, system deficiency, , and See generally, Publications of the Centers for Control. On , the Governor of the State of Florida issued Executive Order 20-51 designating a Public Health Emergency as a result of COVID-19 and its impact. Pursuant to that authority, emergency orders have been issued by the Florida Division of Emergency Management to implement the protections necessary to assure the health, safety, and well-being of Florida's citizenry, including those most to the effects of Among those emergency orders was DEM Order 20-006, dated , delineating minimum screening standards for persons entering identified residential facilities. According to CDC guidelines, any person closely exposed (defined as being within six of the	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/21/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EL PARAISO HOME, INC

**1540 SW 7TH STREET
MIAMI, FL 33135**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 7 ) to a person with COVID-19 symptoms as early as 2 days before symptoms onset must self-..... for 14 days. Record review showed eleven residents tested positive after one staff tested positive for COVID-19 and failed to self-..... Observation on at 07:00 AM showed nine residents in the facility. Observation also revealed that Staff B, Staff E, and the Owner were at the facility caring for nine residents. Observed all three staff were wearing a surgical mask, a hair cover, and gloves. Observation at 08:00 AM showed 4 residents (Residents #8, #12, #13, and #14) sitting at the dining table with no covering, and 2 residents (Residents #7 and #9) sitting in the common area wearing no covering. Observation at 08:10 AM also revealed that Resident #6 walked out of her room, went to the common area, and continued to the patio. A review of the Admission and Discharge log showed the facility had a census of fourteen residents. On at 07:25 AM, Staff B stated the facility had 9 residents on-site and 5 residents in the hospital, including 2 confirmed COVID-19 positive residents (Residents #1 and #2). On at 08:27 AM, Staff B stated that 2 residents tested positive at a local hospital after showing symptoms in the facility. Staff B stated that Resident #1 had a high and a running on followed by Resident #2 with the same symptoms on Staff B then stated that the hospital called her on to report Resident #2 was positive for COVID-19.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/21/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EL PARAISO HOME, INC

**1540 SW 7TH STREET
MIAMI, FL 33135**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 8 and on the hospital called her again and informed her that Resident #1 was positive for COVID-19. A review of Resident #1's hospital record showed that Resident #1 was confirmed positive for COVID-19 two days after being tested on admission. Resident #1 had A review of Resident #2's hospital record showed that Resident #2 admitted in a local hospital on Resident #2's hospital record also showed that Resident #2 was tested positive for COVID-19 on admission. On at 08:35 AM, Staff B stated that she sent Residents # 3 and #5 to a local hospital on due to COVID-19 symptoms. She stated that Resident #3 had and , and Resident #5 had and a On at 11:26 AM when asked why the residents were not , Staff B stated that the roommates of Residents #1 and #2 were not because both residents tested positive at the hospital not in the facility. Staff B then stated that they cleaned the facility with bleach. Staff B also stated that no other residents showed symptoms of COVID-19. On when asked Staff B why the other Staff were not after being exposed to Staff C, Staff B stated that the staff did not because Staff C stopped working since However, both Staff C and Staff E stated that Staff C worked until On at 11:54 AM, Staff C stated that	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/21/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EL PARAISO HOME, INC

**1540 SW 7TH STREET
MIAMI, FL 33135**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 9 on she felt sick and had a runny She stated that she left the facility and went to her house. Staff C then stated that on she felt body aches, but she went to work anyway. Staff C further stated that she continued to work 8 hour shifts from to despite feeling sick. She stated on, she worked for 4 hours until she received her positive COVID-19 test result. On at 11:54 AM, when asked Staff C why she did not self-..... Staff C stated that she kept going to work because she thought it was just a and she was feeling fine. Staff C stated from to she worked with Staff B, Staff E and the owner. Staff C further stated that she worked 03:00 PM to 11:00 PM on 07:00 AM to 03:00 PM on 07:00 AM to 03:00 PM on 07:00 AM to 03:00 PM on and 03:00 PM to 11:00 PM on Staff C stated that she left at 07:00 PM after receiving the positive COVID-19 test result. A review of Staff C's COVID-19 test results on Staff B's cell phone showed that Staff C had two COVID-19 tests done on One test result showed positive on and the other one showed a positive result on On at 01:00 PM, Staff E stated that she remembered working with Staff C on and She then stated that she relieved Staff C from work on at around 10:40 PM after Staff C received a positive COVID-19 test result. A review of the facility's staffing schedule from	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 10 to showed Staff C was on the schedule for,, and On at 01:35 PM, the owner confirmed that Staff C showed COVID-19 symptoms while working in the facility. The owner stated that he thought staff C had the before because she had shiny, a runny, and trouble breathing 'a couple of days' prior to Staff C tested positive on, The owner stated this was the reason they sent Staff C to get tested. The owner stated that Staff C brought the positive results on, and she was told not to return to work anymore. On at around 01:35 PM, when asked why Staff C continued to work even after a positive COVID-19 test result, the owner stated that when he noticed Staff C had stuffy and shiny, he didn't do anything because he just assumed she had the, so that's why he told her to take the test. On, another stated agency reported that both Residents #3 and #5 tested positive for COVID-19 on admission. On, another state agency reported six other residents (Residents #6, #7, #8, #10, #11, and #12) were confirmed positive for COVID-19 after being tested at the facility on On Resident #9's health care provider reported that Resident #9 was admitted to the hospital on due to a, The health care provider further stated that Resident #9 was tested for COVID-19 on admission and received a positive COVID-19 test result on, The provider stated that	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 030	Continued From page 11 Resident #9 was then transferred to a COVID-19 isolation unit. On _____, another state Agency reported that Staff A and the owner tested positive for COVID-19. On _____ at around 01:35 PM, the Owner stated that he and the Administrator were at their house, self- _____. He stated that they both were positive for COVID-19. He further stated that he did not know how he _____ the _____. On _____ at 11:30 AM, during a telephone interview with another state agency's representative who was at the facility, she stated that she observed no social distance among the residents, and no residents were in isolation. She also stated that the facility's staff were not wearing proper personal protective equipment; staff were wearing no PPE at the time of the representative's arrival, then donned a surgical mask. On _____ at 11:33 AM, a representative from another state agency described the facility's environment as not in compliance with recommendations. The State Representative stated that the staff at the facility were not wearing proper personal protective equipment, and the residents were 'all over the place'. She also stated that the staff onsite said she was a nurse, but she did not know how to _____ the residents, nor the proper PPE to wear. A review of the state agency representative's report from this inspection of the facility on _____ noted, "I am unable to conduct a proper inspection due to the outbreak, 12 residents in an ALF with a capacity of 14. Upon entering the facility, [COVID-19] positive residents were seen in	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 12 common areas without the proper use of PPE's. The home aid and kitchen employee were also seen in a breach of PPE". Class I	A 030			
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 055	Continued From page 13 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 055	Continued From page 14 at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may be disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that medications were kept locked at all times. Findings included: Observation on ... at 7:25AM revealed an unlocked room (#) with a box full of medications. Observed medications for Resident #3, #4, #9, #10, and #11. During an interview on ... at 7:25AM, Staff B stated, "the medications are for the residents who have been hospitalized, I put them there, so I don't get ..." Record review revealed Resident #3 and #4 were hospitalized on ... Resident #9, #10, and #11 were observed in the facility on ... Class III	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 078	Continued From page 15	A 078			
A 078 SS=J	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 078	Continued From page 16 responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one out of six sampled staff (Staff C) had a written statement from a healthcare provider indicating that they do not constitute a risk of transmitting a communicable Staff C returned to work after testing positive for COVID-19. Findings Included: The COVID-19 . . . is a transmissible that presents severe risk to persons who	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/21/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EL PARAISO HOME, INC

**1540 SW 7TH STREET
MIAMI, FL 33135**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 078	Continued From page 17 are aged, infirm, or suffer from co- _____ including, but not limited to, _____ system deficiency, _____ and _____ . See generally, Publications of the Centers for _____ Control and Prevention (CDC). The Centers for _____ Control and Prevention referred to Assisted Living Facility's high risk of COVID-19 spread to residents and stated: "Given their congregate nature and population served, assisted living facilities (ALF) are at high risk of COVID-19 spreading and affecting their residents. If _____ with SARS-CoV-2(Severe Acute _____ Coronavirus 2), the _____ that causes COVID-19, assisted living residents-often older adults with underlying _____ medical conditions-are at increased risk of serious illness." During an interview on _____ at 8:05AM, Staff B stated, "Staff C's last day of work was on _____ because she was feeling weird and had a _____." Record review revealed Staff C tested positive for COVID-19 on _____ and _____ Staff C reported to work from _____ through _____. During an interview on _____ at 11:54 AM, Staff C stated, "I went to work on _____ feeling like I had a _____, on _____ I had body aches, and I worked until _____ when I got a positive result for COVID-19." Staff C further stated she worked with Staff B, E, and F during this time. According to the Centers for _____ Control and Prevention (CDC) on _____, guidelines for people suspected of having the _____, "Properly manage anyone with suspected or confirmed	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 078	Continued From page 18 SARS-CoV-2 or who has had contact with someone with suspected or confirmed SARS-CoV-2 : Healthcare personnel (HCP) should be excluded from work and should notify occupational health services to arrange for further evaluation, to return to work." Regarding the criteria for return to work, the Centers for Control and Prevention (CDC) on guidelines for healthcare professionals "healthcare professionals who are not severely and were throughout their may return to work when at least 10 days have passed since the date of their first positive diagnostic test." During an interview on at 12:40PM, Staff E stated she worked with Staff C from Staff E further stated she relieved Staff C from work on at 10:40PM because she was positive for COVID-19. During an interview on at 1:28 PM, the owner stated Staff C's last day of work was on after she tested positive for COVID-19. The owner further stated he felt Staff C was positive prior to that day because she had shiny , runny , and trouble breathing. During an interview on at 11:54 AM, Staff C stated she worked from 3PM-11PM, from 7AM-3PM, from 7AM-3PM, from 7AM-3PM, and from 3PM-7PM. A review of the personnel record showed no evidence of a written statement from a health care provider documenting that Staff C did not constitute a risk of transmitting a communicable	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER EL PARAISO HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SW 7TH STREET MIAMI, FL 33135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 078	Continued From page 19 Class I	A 078			