Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969018	A. BUILDING: _____ B. WING _____	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGING HOME PARADISE LLC	110 ZACALO WAY KISSIMMEE, FL 34743

(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
CZ871	408.806(7)(d) FS Attempted Inspection (d) If a provider is not available when an inspection is attempted, the application shall be denied. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to be available when an inspection was attempted. Findings: On at 9:05am the agency representative arrived at the facility to conduct a re-licensure survey. The front door to the facility was answered by staff A, she said the administrator was not available. On at 9:20am the owner arrived. An entrance conference was conducted, and the purpose of the survey was discussed. She said she was not going to participate in a survey because she was not ready. She said she had not submitted an application because her password did not work. She also said she had to take a resident to the doctor. She said the administrator would not be available. Unclassified	CZ871		
A 000	Initial Comments A re-licensure survey was attempted on at Aging Home Paradise. A deficiency was identified at the time of survey.	A 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE