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
	AL11967941	A. BUILDING: _____ B. WING _____	C 06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROPICAL PARADISE	1593 BRICKYARD ROAD CHIPLEY, FL 32428

(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 An unannounced Biennial Licensure and Emergency Environmental Control survey was conducted at Tropical Paradise, an assisted living facility in Chipley, FL, on - . Deficient practice was identified at the time of the survey.	A 000		
A 078 SS=D	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	A 078		

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
	AL11967941	A. BUILDING: _____ B. WING _____	C 06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROPICAL PARADISE	1593 BRICKYARD ROAD CHIPLEY, FL 32428

(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 1 (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 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 staff interview, the facility failed to maintain documented evidence of an annual negative examination for 1 of 3 sampled employees.	A 078		

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
	AL11967941	A. BUILDING: _____ B. WING _____	C 06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROPICAL PARADISE	1593 BRICKYARD ROAD CHIPLEY, FL 32428

(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 2 The findings include: During a review of the Administrator's employee file (hire date) on , it was found that the most recent examination for the Administrator was dated . An interview was conducted with the Administrator on at 9:30 AM. She acknowledged the examination was expired. Class III .	A 078		
A 083 SS=G	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967941	A. BUILDING: _____ B. WING _____	C 06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROPICAL PARADISE	1593 BRICKYARD ROAD CHIPLEY, FL 32428

(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 083	Continued From page 3 requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a staff member who has completed an approved , , ( ) course was in the facility at all times for 3 of 3 sampled staff reviewed. (Staff A, B, and C) This failure has the potential to adversely affect all 10 residents residing at the assisted living facility at the time of the survey. The findings include: During a review of Staff A (Owner) and Staff B's (Administrator) employee files, it was found that both employees took an online-only course from the National Foundation on . A review of Employee C's (Caregiver) employee file revealed she also had an online-only course from the National Foundation on . A review of the National Foundation's webpage (https://nationalcprfoundation.com) and the Florida Department of Health's list of approved trainers on revealed that the National Foundation was not considered an approved trainer. An interview was conducted with the Administrator on at 10:11 AM. The Administrator stated she thought the provider was approved as she had been using them for about 4 years. She confirmed all of the facility staff were trained for through the National Foundation. Further interview was conducted with the Administrator on at 10:52 AM. She stated none of the 10 current residents had a signed . All 10 residents would require in the event of	A 083		

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
	AL11967941	A. BUILDING: _____ B. WING _____	C 06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROPICAL PARADISE	**1593 BRICKYARD ROAD CHIPLEY, FL 32428**

(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 083	Continued From page 4 Class II	A 083		