

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967941	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER TROPICAL PARADISE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 On _____ an unannounced follow survey was conducted at Tropical Paradise Assisted Living Facility in Chiply Florida. Discernable deficiencies were identified during the survey. The facility was not in compliance at this time.	(A 000)			
(A 026) SS=D	58A-5.0182(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility shall provide an ongoing activities program. The program shall provide diversified individual and group activities in keeping with each resident ' s needs, abilities, and interests. (b) The facility shall consult with the residents in selecting, planning, and scheduling activities. The facility shall demonstrate residents ' participation through one or more of the following methods: resident meetings, committees, a resident council, suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities shall be available at least six (6) days a week for a total of not less than twelve (12) hours per week. Watching television shall not be considered an activity for the purpose of meeting the twelve (12) hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required twelve (12) hours per week of scheduled	(A 026)			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

YSQ612

If continuation sheet 1 of 4

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967941	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER TROPICAL PARADISE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 026}	Continued From page 1 activities. An activities calendar shall be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to three (3) hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observations and interviews the facility failed to provide a minimum 12 hours of social leisure activities per week. Findings: On : at approximately 9:30 AM an interview was conducted with residents #1, #2, and #3 about social leisure activities in the facility. When the three residents were asked what activities are offered in the facility Monday-Saturday none of the three residents could say. Resident #1&2 stated "we create our own activities". Resident #3 said there were no activities. On : at approximately 9:45 AM a record review was conducted of the facilities activities calendar. The calendar showed there were activities Monday-Saturday for a total of 9.5 hours and not the required minimum of 12 hours. On : at approximately 10:10 AM an interview was conducted with resident #4 in reference to scheduled leisure activities. Resident #4 said Monday-Saturday they have board games only. On : at approximately 12:00 AM an interview was conducted with the Administrator in reference to only having 9.5 hours of scheduled	{A 026}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967941	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER TROPICAL PARADISE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 026}	Continued From page 2 social leisure activities per week. The Administrator stated that the facility does more activities with the residents than what is on the calendar. She said during Halloween they had a party which lasted at least 3 hours. When asked why it was not on the calendar she stated it just wasn't. Class III		{A 026}		
{A 057} SS=D	58A-5.0185(8) FAC Medication - Over The Counter (OTC) Products (8) OVER THE COUNTER (OTC) PRODUCTS. For purposes of this subsection, the term OTC includes, but is not limited to, OTC medications, _____, nutritional supplements and nutraceuticals, hereafter referred to as OTC products, which can be sold without a prescription. (a) A stock supply of OTC products for multiple resident use is not permitted in any facility. (b) OTC products, including those prescribed by a licensed health care provider, must be labeled with the resident ' s name and the manufacturer ' s label with directions for use, or the licensed health care provider ' s directions for use. No other labeling requirements are necessary nor should be required. (c) Residents or their representatives may purchase OTC products from an establishment of their choice. (d) A facility cannot require a licensed health care provider ' s order for all OTC products when a resident self-administers his or her own medications, or when staff provides assistance with self-administration of medications pursuant to Section 429.256, F.S. A licensed health care provider ' s order is required when a licensed nurse provides assistance with self-administration		{A 057}		

Agency for Health Care Administration

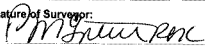
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967941	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER TROPICAL PARADISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1593 BRICKYARD 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 057}	Continued From page 3 or administration of medications, which includes OTC products. When such an order for an OTC product exists, only the requirements of paragraphs (b) and (c) of this subsection are required. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility did not have properly labeled over the counter medication for 1 of 5 residents, resident #4. Findings: On _____ at approximately 9:37 AM it was observed in resident #4's _____ bottle of 1 A Day _____, a bottle of Coarison Extra Strength (_____), a bottle of CVS _____ Liquid, and a bottle of _____. None of the OTC's had the residents name on the containers. On _____ at approximately 12:00 PM during an interview with the administrator, she stated that the resident was told to write his name on the OTC bottles. Class III	{A 057}			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967941	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/
Name of Facility TROPICAL PARADISE		Street Address, City, State, Zip Code 1593 BRICKYARD ROAD CHIPLEY, FL 32428

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0152</u> Reg. # <u>58A-5.023(3) FAC</u> LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: 	Date: <u>11/14/12</u>
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____				

Followup to Survey Completed on: _____

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

..., 2012

Administrator
Tropical Paradise
1593 Brickyard Road
Chipley, FL 32428

Dear Administrator:

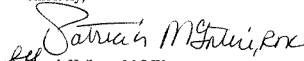
This letter reports the findings of a revisit survey conducted on ..., 2012 by representatives of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies, identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than ..., 2012.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at 850-412-4540.

Sincerely,


Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure

BB17

