

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 Assisted Living Facility complaint inspection (CCR# 2013000379) was conducted on Paradise Care Cottage had licensure deficiencies found at the time of the visit.	A 000			
A 025 SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident 's whereabouts. The resident may travel independently in the community. (d) Contacting the resident 's health care provider and other appropriate party such as the resident 's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident 's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6899

CE1111

If continuation sheet 1 of 14

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 025	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide care and services as physician order, for 1 out of 8 sampled residents (Resident #4). The findings include: Resident #4 was admitted to the facility on _____ with pertinent diagnosis of _____ Review of her medical examination (AHCA Form 1823) dated _____, documented she requires assistance with self-administration of medications. On _____ at 10:20 AM, Resident #4 was interviewed in her _____. An open box containing five _____ pre-filled injectable _____ "flex pens" were observed on a shelf next to her bed. She displayed a box of lancets on her nightstand that were used to draw _____ for _____ glucose (sugar) testing. She stated she kept the _____ and lancets in her _____; she checks her _____ sugar every evening and injects the _____ herself, the amount based on the _____ sugar reading; neither of these items was secured as required. Instructions printed on the box containing the _____ pens called for them to be stored at 36-45 degrees before opening; the prescription label on the box documented it was filled on _____, 18 days earlier. The box had a label that appeared to have been placed there by the pharmacy which disclosed, "After Opening, Use by _____," but no date was written in. This was observed and acknowledged by a Caregiver on _____ at 12:45 PM.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 025	Continued From page 2 In an interview conducted on _____ at 12:55 PM, the Administrator confirmed aforementioned. She stated she believed there was a written health care provider order in Resident #4's file stating "the resident self-administer her _____ and perform the _____. However, upon request of aforementioned physician order; no documentation was provided for review. Class III	A 025			
A 030 SS=D	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (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 Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for 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 address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida Hotline " 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility's policies with respect to such issues, for example, as resident responsibilities, the facility's and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall 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 shall not prohibit 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 shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be 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 achieve the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 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 _____, 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) Access to adequate and appropriate health care 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 relocation shall be set forth in writing. 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. (l) 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952			
(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 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. This Statute or Rule is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to establish a grievance procedure that honored residents' right to present grievances. There was lack of a cohesive written policy, an on-going missing suggestion box and lack of documentation demonstrating facility response to grievances received. The findings include: In an interview conducted00 AM, the facility's Administrator was asked to present resident council meeting minutes and/or documentation of complaints or grievances received in the past six months. She stated they did not have a resident council nor did they hold resident meetings. When asked for records documenting complaints or grievances they received from residents, families, or other parties, she stated they would not document the grievance if it was considered minor. She stated other grievances would be documented in individual resident observation notes but was not able to provide any examples. In an interview conducted 52 PM, the Administrator stated anyone can complain to facility staff. She stated they also use a	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 "suggestion box" as a means to receive complaints; she added the box repeatedly goes missing and was missing at this time. She confirmed they received multiple complaints from Resident #4's family members, but did not have any documentation showing facility response (or resolution) to those complaints. She confirmed they did not have a written internal policy related to receiving, investigating, resolving, responding to complainants, and documenting grievances. Written facility policies and procedures and related notices were requested at that time, the following items were received: 1) Page five of their standard resident admission agreement; a section titled Complaints disclosed, "Residents of the facility are encouraged to register complaints at any time. A "suggestion box" has been installed in the living , for the purpose of registering complaints anonymously if desired. (Please note, throughout the survey conducted interviews were conducted with five alert and oriented residents. Three residents had knowledge of a suggestion box but had not seen it in a long time; two residents stated they had never seen a suggestion box in the facility). 2) A framed letter-sized document was posted on a wall in the facility according to the Administrator. It listed the facility's name, address, telephone and fax numbers and disclosed. A. Complaints regarding house rules are handled with a weekly group meeting. B. Complaints on a personal level are handled one on one. C. Complaints of a more serious nature than cannot be handled on the house level will be	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 discussed with the Administrator and handled accordingly. D. All suggestions are considered and discussed at a weekly group meeting. E. Results of complaint investigations will be provided to the resident within five days. On _____ at 3:45 PM, the Administrator acknowledged these two documents and a missing suggestion box did not represent an adequate written grievance procedure per facility's policy. She acknowledged there was an inadequate system established to adhere to the facility's grievance policy and to ensure receipt and resolution of the complaints. Class III	A 030			
A 055 SS=D	58A-5.0185(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; or in their _____ or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the _____ or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request;	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 9 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 6. The facility 's rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C. (b) Centrally stored medications must be: 1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and 4. Kept separately from the medications of other residents and properly closed or sealed. (c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident 's representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident 's request. If centrally stored by the	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 10 facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care provider. (d) When a resident ' s stay in the facility has ended, the administrator shall 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 at least 15 days, the resident ' s medications are still at the facility, the medications shall be considered abandoned and may disposed of in accordance with paragraph (e). (e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall 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. (f) 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 observations, interviews and record review, the facility failed to ensure resident medications were properly stored, for 1 out of 8 sampled residents (Resident #4). The findings include: Resident #4 was admitted to the facility on _____ with pertinent diagnosis of _____ Review of her medical examination (AHCA Form	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 11 1823) dated _____, documented she requires assistance with self-administration of medications. On _____ at 10:20 AM, Resident #4 was interviewed in her _____. An open box containing five _____ pre-filled injectable _____ "flex pens" were observed on a shelf next to her bed. She displayed a box of lancets on her nightstand that were used to draw _____ for _____ glucose (sugar) testing. She stated she kept the _____ and lancets in her _____; she checks her _____ sugar every evening and injects the insulin _____ the amount based on the blood _____ reading; neither of these items was secured as required. She also confirmed that she had a roommate. _____ printed on the box containing the insulin _____ called for them to be stored at 36-45 degrees before opening; the prescription label on the box documented it was filled on 02/1 _____ days earlier. The box had a label that appeared to have been placed there by the pharmacy which disclosed, "After Opening, Use by _____," but no date was written in. This was observed and acknowledged by a Caregiver on _____ 12:45 PM. In an interview conducted on 03/0 _____ 12:55 PM, the Administrator confirmed aforementioned and that Resident #4's roommate _____ confused _____ forgetful. She stated she believed there was a written health care provider order in Resident #4's file stating "the resident self-administer her insulin _____ perform the accuchecks". _____ upon request of aforementioned physician order; no documentation was provided for review.	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952		
(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 12 Class III	A 055			
A 092 SS=D	58A-5.020(1) FAC Food Service - General Responsibilities Food Service Standards. (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall: (a) Be responsible for total food services and the day to day supervision of food services staff. (b) Perform his/her duties in a safe and sanitary manner. (c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident ' s health care provider for resident ' s who require special diets. (d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure safe food service operations were performed and that the facility's food service designee (FSD) maintained required continuing education. As evident of the facility's failure to maintain written records food temperatures were not taken or recorded, and the FSD failed to obtain annual training by a qualified person. The findings include: On _____ around 11:30 AM, the lunch meal service was observed. At 11:48 AM, the facility's main cook and FSD stated, he did not have a	A 092			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PARADISE CARE COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952			
(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 092	Continued From page 13 food thermometer to take food temperatures, did not take food temperatures and did not maintain records related to food temperatures taken. He further stated, he had not received the required two-hour annual training related to nutrition and food service in an Assisted Living Facility by either a Certified Food Manager, licensed Dietician, registered dietary technician or health department sanitarian. This was discussed and acknowledged by the Administrator on _____ at 3:33 PM. Class III	A 092			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Paradise Care Cottage
2277 S.E. Lennard Road
Port Saint Lucie, FL 34952

RE: CCR #2013000379

Dear Administrator:

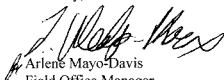
This letter reports the findings of a complaint survey that was conducted on . 2013 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after . 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,



Arlene Mayo-Davis
Field Office Manager

AMD/ls
Enclosure

