STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967941	09/24/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Tropical Paradise	1593 Brickyard Road Chipley, FL 32428	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0000-Initial Comments

On , 2013, at Tropical Paradise Assisted Living Facility, an unannounced monitoring visit survey was conducted. The survey continued on , 2013. There were a deficiency found at the time of the visit.

L240-LMH - Licensing 58A-5.029(1) FAC

Based on observations, interviews and record reviews, it was determined the Assisted Living Facility (ALF) exceeded allowable standard licensure requirements. The ALF has 5 of 7 Limited Mental Health (LMH) residents that are receiving personal care and services but does not hold a Limited Mental Health License. (#3, #4, #5, #6, #7)

Findings include:

On at approximately 6:48 AM, a tour of the facility begin along with staff member B. The following LMH residents were observed at the facility. Resident #3 was observed in his in his bed. Resident #4 was observed watching TV in the TV . Resident #5 was observed walking into the TV . Residents #6 and #7 were observed in the the left of the front entrance of the facility. Staff member B identified each resident, #6 and #7 in the beds by pointing at them and stating their names. Staff member B confirmed resident #6 and #7 are staying with her and her husband (staff member A) at the facility.

A record review of the LMH resident's records revealed the following:

A. Resident #3's treatment plan dated indicated resident is receiving services with Life Management Center (LMC) for diagnosis of . A Community Living Support Plan dated indicated resident will receive 1 day per week for 6 months. Resident #3's AHCA Health assessment form (1823) dated indicated a diagnosis of .

B. Resident #4's AHCA Health assessment form dated / indicated resident diagnosis of . Resident #4's last treatment plan dated indicated resident received services with LMC for diagnoses of and . On at 1:58 PM an interview was conducted with resident #4 ' s former case manager. She confirmed resident #4 had received case management services in the recent past and was still active with LMC and could start back receiving case management services and services at any time because she meets the LMH criteria.

C. Resident #5's ( ) form indicated part three (to be completed only for Mental Health resident residing in ALF) was completed and signed by a Mental Health Professional on indicating the resident had a mental health diagnosis and was eligible for .

D. Resident #6's treatment plan dated / indicated resident is receiving services with LMC for diagnoses of .

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E. Resident #7's treatment plan dated / indicated resident is receiving services with LMC for diagnoses of and Mental .

On at approximately 7:10 AM, investigators from the Office of Attorney General-Medicaid Fraud Control Unit observed resident's #6 and #7's medications in a black medication box located in the kitchen. Resident #6 medication revealed: ( ) 500 mg Expire: Take 1 tablet twice daily for 10 daily for 10 days Quantity (Qty) 20 and resident #7 medication revealed: ( ) 20 mg Expire: Take 1 tablet daily Quantity (Qty) 60.

At approximately 9:35 AM an interview was conducted with staff member A. He reported residents #6 and #7 lives with him and his wife (staff member B). He stated he was in charge of the facility while the Administrator and Owner were out of town and he confirmed resident #6 and #7 had been sleeping at the ALF.

At approximately 11:35 AM an interview was conducted with the Owner. He stated he and the Administrator have been out of the facility since . He stated he left staff member A and B in charge of the facility. He stated he was aware that residents #6 and #7 were at the facility with staff member B and confirmed residents #6 and #7 received breakfast, lunch, and dinner at the facility.

On at approximately 12:54 PM, an interview was conducted with the Case Manager at Life Management Center (LMC). She confirmed residents #6 and #7 are her mental health clients and she visits them monthly at the Life Management Center. She reported both residents #6 and #7 are receiving services from an Advanced Registered Nurse Practitioners (ARNP) at LMC. She also confirmed that residents #3 and #4 are a receiving case management services with LMC and provided the names of their case managers.

On On at approximately 7:35 AM, an interview was conducted with resident #5. She stated resident # 6 and #7 has been staying at the facility because staff member A and B is working at the facility while the Owner and Administrator are out of town.

On at approximately 7:48 AM, and interview was conducted with Resident #3 and he confirmed residents #6 and #7 were sleeping in the facility since the owners went to a conference. He stated staff member B drop resident #6 and #7 off every day at the facility because she has a new dress shop.

On at approximately 2:19 PM, an interview was conducted with resident #1. Resident #1 confirmed residents #6 and #7 stayed overnight at the facility on Monday ( ), Tuesday ( ), and Wednesday (/).

A review of the facility's client billing spreadsheet provided by the Office of Attorney General-Medicaid Fraud Control Unit revealed the facility is billing Medicaid Assistive Care Services for residents #3, #4, and #5 under Primary diagnosis code 29530 and a Decription of .

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Tropical Paradise
1593 Brickyard Road
Chipley, FL 32428

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 12 and 24, 2013 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) 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 surveyor(s). Should you have any questions please call me at (850) 412-4540.

Sincerely,

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

Field Office Manager
Enclosure
XG90

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