STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922199	09/05/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Paradise Adult Care	14730 Sw 150 Street Miami, FL 33196	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0074 - 58a-5.019(3)(b) - Staffing Standards - Personnel File (bgs) S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced limited nursing services monitoring survey was conducted on . Paradise Adult Care had deficiencies at the time of the survey.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation, record review and interview the Assisted Living Facility failed to have a written doctor order for the use of half-bed rail as well as the consent of the resident or the resident's representative to the use of half-bed rail for one out of five sampled residents (#1).

Findings include:

1. Observation on at 10:15 a.m. revealed that resident #1 was lying on his bed with half-bed rail up.

2. Record review of resident's #1 file revealed that resident #1 was admitted to the facility on and did not have in the file a written doctor order for the use of half-bed rail and did not have a signed consent from resident or resident's representative to the use of half-bed rail.

3. Interview with administrator on at 11:45 a.m. revealed that resident #1's daughter informed her that her father needs to use half-bed rail, but facility did not have a doctor order for the use of half-bed rail or resident #1's daughter signed consent to the use of half-bed rail.

Class III

0074-Staffing Standards - Personnel File (BGS) 58A-5.019(3)(b)

Based on observation, record review and interview the Assisted Living Facility failed to the results of the employee screening conducted by the agencyfor 1 out of 2 sampled staff's personnel file.

Findings include:

1. Observation on at 10:10 a.m. revealed that caregiver_A was the only staff in the facility taking care of residents. On at 11:30 a.m. caregiver_A was found on # assisting resident #2 changing his brief.

2. Record review for caregiver_A's personnel file revealed that caregiver_A did not have in her personnel file results of the background screening.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922199	**09/05/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Paradise Adult Care	**14730 Sw 150 Street Miami, FL 33196**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

3. Interview with administrator on at 11:55 a.m. revealed that caregiver_A did not have time to bring her documentation to the facility.

Class III

0162-Records - Resident 58A-5.024(3) FAC

Based on record review and interview the Assisted Living Facility failed to have in resident records evidence of a health surrogate, guardian, or a power of attorney for one out of five sampled residents (#3).

Findings include:

1. Record review of resident #3's file revealed that resident #3's daughter-in-law signed her contract but the facility did not have any documentation that she was a health surrogate, guardian or had a power of attorney.

2. Interview with administrator on at 11:45 a.m. confirmed that resident #3's daughter-in-law signed the contract and other forms and the facility did not have the power of attorney from her.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Paradise Adult Care
14730 Sw 150 Street
Miami, FL 33196

Dear Administrator:

This letter reports the findings of a state Limited Nursing Services (LNS) Monitoring survey that was conducted on , 2013 by representative(s) 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 11/3/2013 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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100

Sincerely,

E Mayo-Davis for
Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121