STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922199	04/29/2014
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 - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments

A visit for a Change of Ownership (CHOW) survey was made on . Paradise Adult Care had the following deficiencies at the time of the visit.

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observation and interview the facility failed to follow the correct procedure when assisting with self administration of medications.

Findings as follow:

On at about 8:00 a.m. staff #1 (facility administrator) was observed administering resident #1 medications and assisting with self administration of medications to resident #2. Staff #1 did not prompt medications to residents.

On at at about 8:00 a.m. staff #1 (facility administrator) stated failed to verbally prompting medications to residents #1 and #2.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC

Based on observation, record review and interview the facility failed to have a licensed staff member who administered medications to 2 of 2 (#1 and #2) facility sample residents.

Findings as follow:

On at about 8:00 a.m. it was observed staff #1 (facility administrator) administering 8:00 am medications to resident #1 as follow:
Staff #1 placed resident's #1 medications in a cup with water and thickener then proceed to administered the melted medications, to resident using an spoon. Resident #1 did not assist in the process of taking medications.
Record review (assessment date:) documented resident #1 needed medication administration.

On at about 8:05 a.m. it was observed staff #1 (facility administrator) assisting resident #2 with self administration of medications as follow:
Staff #1 placed resident #2's medications in a cup and gave the cup to resident who took it with right hand and proceeded to take the medications.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922199	**04/29/2014**
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)		

Record review (assessment date: documented resident #2 needed medication administration.

On at about 8:15 a.m. staff #1 (facility administrator) stated residents #1 and #2 were prescribed medication administration and stated administered medications to resident #1 and assisted with medication administration to resident #2 .

Staff #1 stated she was not licensed to administered medications to residents #1 and #2 who where prescribed administration of medications.

Class III

0160-Records - Facility 58A-5.024(1) FAC

Based on record review and interview the facility failed to perform to elopement drills per year.

Findings as follow:

Record review documented the facility last elopement drill was performed on .
On at about 11:00 a.m. the facility administrator (#1) stated had not performed any elopement drill since .

Class III

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

Based on observation, record review and interview the facility failed to have orders for medications and diet for 2 of 2 (#1, #2) facility residents.

Findings as follow:

On at about 8:00 a.m. it was observed staff #1 (facility administrator) administering medications to resident #1 as follow:
Staff #1 placed 8:00 a.m. medications in a cup with thickener and water, medications melted. and then staff #1 proceed to administer the medication to resident #1 with a spoon.

On at about 8:05 a.m. it was observed staff #1 (facility administrator) assisting resident #2 with self administration of medications as follow:
Staff #1 placed resident #2's medications in a cup and gave the cup to resident who took it with right hand and proceeded to take the medications.

Record review (assessment date:) documented residents #1 and #2 were prescribed medication administration and resident #1 had no orders for the use of thickener with medications.
On at about 8:10 a.m. staff #1 (administrator) stated was given medications with thickener to resident #1 because resident could swallow it better and stated the prescription was misplaced.

On at bout 8:00 a.m. observed staff #1 (facility administrator) assisting residents #1 and #2 at

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922199	**04/29/2014**
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)		

breakfast time, staff #1 gave both residents only an ensure can (in a cup) for breakfast to each resident.
Record review documented resident #1 and #2 had a regular diet with low salt.
On at about 8:15 a.m. staff #1 stated was given ensure to residents #1 and #2 everyday as breakfast due to it was nutritious and also stated had no order for it.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

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

Dear Administrator:

This letter reports the findings of a state Change of Ownership (CHOW) survey that was conducted on , 29, 2014 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 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,

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