STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965890	10/09/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Tropical Heaven, Inc	14201 Sw 48 Lane Miami, FL 33175	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:
0162-Records - Resident-10/09/2014
L243-Lmh - Training-10/09/2014

Revisit New Tags:
0161-Records - Staff-58a-5.024(2) Fac

Specific Tag Findings:

0000-Initial Comments

A Standard Biennial survey revisit was conducted on 10-09-14. Tropical Heaven, Inc had deficiencies at the time of the survey.

0161-Records - Staff 58A-5.024(2) FAC

Based on observation, record review, and interview facility failed to have a copy of a employment application and level 2 background screening for 1 out of 1 sampled employee.

Findings included:

1. Arrived to the facility on at 11:00 am. found staff A in the facility caring for six residents. The employee was observed working alone with the residents until the administrator arrived to the facility.

2. Record review revealed staff A (caretaker) started on . . - . Record review revealed that the facility did not have a copy of the employment application with references and results of the level 2 background screening for the staff member.

3. Interviewed the administrator on - at 11:00 am she confirmed the findings and stated that she totally forgot to have the employee to fill one out at the time she was hired. She also confirmed the new employee did not have her level II background screening in the file at the time of the survey.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Tropical Heaven, Inc
14201 Sw 48 Lane
Miami, FL 33175

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2014by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than , 2014.

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

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