STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965608	10/20/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Paradise Assisted Living Facility Inc	9605 Sw 144 Place Miami, FL 33186	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0127 - 58a-5.021(4) Fac - Fiscal - Liability Insurance S-S= D
St - A - 0181 - 58a-5.026(2) Fac - Emergency Mgmt - Plan Approval S-S= D
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Specific Tag Findings:

0000-Initial Comments

A Change of Ownership (CHOW) survey was conducted on . Paradise Assisted Living Facility Inc had the following deficiencies at the time of the survey:

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC

Based on record review and interview the facility failed to have 1 of 4 (#1) facility staff trained in 4 hours of assisting with self administration of medications.

Findings as followed:

Record review showed the facility failed to have staff #1 (administrator, hired on /) trained in 4 hours of assisting residents with self administration of medications.

On at 11:40 a.m. the facility's owner acknowledged the facility failed to have staff #1 trained in assisting residents with self administration of medications.

Class III

0127-Fiscal - Liability Insurance 58A-5.021(4) FAC

Based on record review and interview the facility failed to maintain a liability insurance coverage all the timed.

Findings as followed:

Record review showed the facility's liability insurance expired on .

On at 11:00 a.m. the facility's owner acknowledged the facility liability insurance was expired on .

Class III

0181-Emergency Mgmt - Plan Approval 58A-5.026(2) FAC

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965608	**10/20/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Paradise Assisted Living Facility Inc	**9605 Sw 144 Place Miami, FL 33186**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Based on record review and interview the facility whose ownership has been transferred failed to submit an emergency management plan within 30 days after obtaining a license.

Findings as followed:

Record review showed the facility's emergency management plan was last review and approved by the local emergency management agency on . . . . I/ . . Record review showed the facility's had a new owner since . . . . . Record review found the facility did not have documentation that the plan was submitted to the local agency.

On at 11:20 a.m. the facility's owner acknowledged the facility's management plan was last approved on I/ by the local agency.

Class III

L243-LMH - Training 58A-5.0191(8) FAC

Based on record review and interview the facility failed to have 1 of 4 (Staff D) trained in working with limited mental health (LMH) residents. The facility failed to ensure that staff D received at least 6 hours of LMH training by an approved Department of Children and Families trainer.

Findings as followed:

Record review showed the facility held a standard license with Limited Mental Health component. Record review documented the facility failed to have staff D (hired on I/) trained in working with Limited mental health residents with six months of employment.

On at 11:00 a.m. the facility's owner acknowledged the facility failed to have staff D trained in working with Limited Mental Health residents.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Paradise Assisted Living Facility Inc
9605 Sw 144 Place
Miami, FL 33186

Dear Administrator:

This letter reports the findings of a Change of Ownership survey that was conducted on , 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure
XG90

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