

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966057	(X3) DATE SURVEY COMPLETED 12/08/2014
NAME OF PROVIDER OR SUPPLIER Residencia Paradise, Inc	STREET ADDRESS, CITY, STATE, ZIP CODE 9041 Sw 142 Court Miami, FL 33186	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments

A Standard Biennial Survey was conducted on . Residencia Paradise, Inc has the following deficiencies:

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

Based on observation and interview the facility failed to dining in good repair.

Findings as followed:

On at 9:00 a.m. observed a chair on the dining missing its back part.

On the facility's administrator acknowledged the finding and added we will fix the chair soon.

Class III

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

Based on record review and interview the facility failed to have the evidence of a power of attorney, guardianship, or health surrogate for 1 of 2 (#1) facility residents.

Findings as followed:

Record review showed the contract between facility and resident #1 was signed by a family member.
Record review found the facility failed to have the evidence power of attorney, guardianship, or health surrogate for resident #1

On at 12:10 p.m. the facility's administrator acknowledged the facility failed to have the power of attorney for resident #1.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Residencia Paradise, Inc
9041 Sw 142 Court
Miami, FL 33186

Dear Administrator:

This letter reports the findings of a Standard Biennial licensure survey that was conducted on , 2014 by representative(s) of this office.

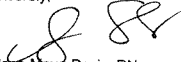
Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved 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

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