STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922199	04/12/2016
NAME OF PROVIDER OR SUPPLIER **PARADISE ADULT CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **14730 SW 150 STREET** **MIAMI, FL 33196**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An Abbreviated Biennial Survey was conducted on , 2016. Paradise Adult Care with Limited Nursing Services components had the following deficiency identified at the time of the survey:

0032 Resident Care - Elopement Standards

Based on record review and interview, the Assisted Living Facility failed to complete two elopement response drills per year.

Findings included:

Review of facility's record revealed that last elopement drill was on / . The Assisted Living Facility failed to complete two elopement response drills per year.

In an interview on / at 10:12 AM the Administrator revealed that 2015 was a bad year; something had to be missed.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of an Abbreviated Biennial licensure survey that was conducted on , 2016 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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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