STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968166	04/07/2016
NAME OF PROVIDER OR SUPPLIER **PARADISE RETREAT ASSISTED LIVING FACILITY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5626 SOUTEL DR** **JACKSONVILLE, FL 32219**	

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

0000 Initial Comments

On , 2016 a biennial relicensure survey with Limited Mental Health license was conducted for Paradise Retreat Assisted Living. Deficient practice was identified during the surveys.

0083 Training - First Aid and

Based on employee record review and staff interview the facility failed to ensure that staff who are left alone with residents have current First Aid and ( ) that is offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Association, or National Safety Council; or a provider approved by the Department of Health for 3 of 3 employees (Employees A, B, C).

The findings include:

The personnel record for Employee A was reviewed for First Aid and certification. A certificate was found from an online training course that is not an approved provider.

The personnel record for Employee B was reviewed for First Aid and certification. A certificate was found from an online training course that is not an approved provider.

The personnel record for Employee C was reviewed for First Aid and certification. A certificate was found from an online training course that is not an approved provider.

During an interview with the Administrator on at 2:15 PM she agreed that all the previous training for and First Aid for Employees A, B & C was from an online course. She said she was not aware courses must be offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Association, or National Safety Council; or a provider approved by the Department of Health.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968166	**04/07/2016**
NAME OF PROVIDER OR SUPPLIER **PARADISE RETREAT ASSISTED LIVING FACILITY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5626 SOUTEL DR** **JACKSONVILLE, FL 32219**	

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

L243 LMH - Training

Based on record review and staff interview the facility failed to provide evidence of limited mental health training 2 of 3 employee files reviewed (Employees B, C).

A review of the personnel file for Employee B with a hire date of revealed no evidence of limited mental health training that is required within six months of hire.

A review of the personnel file for Employee C with a hire date of revealed no evidence of limited mental health training that is required within six months of hire.

During an interview with the Administrator on at 2:00 PM she acknowledged the file of Employees B & C did not contain any evidence of limited mental health training.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Paradise Retreat Assisted Living Facility, LLC
5626 Soutel Drive
Jacksonville, FL 32219

Dear Administrator:

This letter reports the findings of a state biennial licensure with Limited Mental Health survey that was conducted on , 2016 by a representative 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. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JS/JM/sm
Enclosure
XG90

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