

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 09/06/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965890	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER TROPICAL HEAVEN, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 14201 SW 48 LANE MIAMI, FL 33175	

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

0000 Initial Comments

A Limited Mental Health Licensure Expansion Revisit survey was conducted on 08/02/2016. Tropical Heaven, Inc. had the following deficiencies at the time of the survey:

0079 Staffing Standards - Levels

Based on observation, record review, and interview the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period.

Findings as follow:

Observation on at 10:00 AM showed Staff B and E were in care of the residents and providing personal services to them.
Review of facility records found no written work schedule.

Interview on at 2:00 PM, the Administrator stated that there was not a written work schedule for the staff that reflected the 24 hour staffing pattern.

Class III
Uncorrected Deficiency.

Z814 Background Screening Clearinghouse

Based on observation, record review, and interview the facility failed to register 1 out of 4 (Staff B) sampled staff with the clearinghouse and maintain the employment status of all employees within the clearinghouse.

Findings as follow:

Facility visit on / at 10:10 AM showed that Staff B was in care of the residents.

Observation made during the course of the survey on showed that Staff B was providing personal services to residents.
Staff B record review revealed that she was hired on

The background screening website revealed that Staff B was no registered on the facility's clearinghouse roster.

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Interview conducted on at 2:30 PM, the facility's Administrator acknowledged the findings. Unclassified		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11965890	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y2	Y3
NAME OF FACILITY TROPICAL HEAVEN, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 14201 SW 48 LANE MIAMI, FL 33175	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0084	Correction	ID Prefix AZ815	Correction	ID Prefix	Correction
Reg. # 58A-5.0191(5) FAC	Completed	Reg. # 408.809, 435.02(2), 435.06	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>UG</i>	DATE 9/6/14	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/20/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

February 2, 2016

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

Dear Administrator:

This letter reports the findings of a Limited Mental Health Licensure Expansion Revisit survey conducted on February 2, 2016 by 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.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than February 2, 2016.**

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

