

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 10/21/2016
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

An Abbreviated Biennial Revisit Survey was conducted on 10/13/16. Tropical Heaven Inc., license number #10216 had a deficiency found at the time of the survey.

0080 Training - Core & Competency Test

Based on record review and interview the facility failed to have an Administrator who successfully completed the assisted living facility core training requirement within 3 months of becoming facility's Administrator.

Findings included:

On at 9:00 AM record review showed the facility's Administrator was hired on .
Record review showed the facility did not have documentation of the successful completion of the CORE course.

On at 10:02 AM during an phone interview with the administrator she stated that she had taken the 26/hours training in and she had programmed the test for and that she was going to send me the information.

On at 12:04 PM a receipt of the test schedule was sent and on the receipt it showed that she paid it on at 11:52 AM.

Class III

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 A0025	Correction	ID Prefix A0030	Correction	ID Prefix A0152	Correction
Reg. # 429.26(7) FS; 58A-5.0182(1) FAC	Completed	Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS	Completed	Reg. # 58A-5.023(3) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0160	Correction	ID Prefix AZ828	Correction	ID Prefix	Correction
Reg. # 58A-5.024(1) FAC	Completed	Reg. # 408.813(3)	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>CL</i>	DATE <i>10/2/16</i>	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/2/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

1, 2016

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

Dear Administrator:

This letter reports the findings of an Abbreviated Biennial revisit survey conducted on 14, 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 1, 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

