

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 10/27/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965890	(X3) DATE SURVEY COMPLETED R 10/25/2016
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 Second Revisit survey was conducted on 10/13/16. Tropical Heaven, Inc. license number 10216 had a deficiency found 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 included:

On 10/25/16 at 6:30 AM observed Staff B in care of the residents and providing personal services to them.

On 10/25/16 at 7:00 AM the Administrator arrived at the facility.

Review of facility records found on the staff schedule listed Staff A, B, and C to work at 7:00 AM.

Further observations on 10/25/16 found Staff C or another staff member was not at the facility.

On 10/25/16 at 12:17 PM phone interview with the Administrator, explained that the facility was going to be cited for not maintaining the schedule.

Uncorrected 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 AZ814	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 435.12(2)(b-d), FS	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	
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>[Signature]</i>	DATE 10/27/10	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

JUSTIN M. SENIOR
INTERIM SECRETARY

-----, 2016

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

Dear Administrator:

This letter reports the findings of a second Limited Mental Health component expansion licensure revisit survey conducted on -----, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

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 -----, 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(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

YOSF

