STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966057	01/05/2017
NAME OF PROVIDER OR SUPPLIER **RESIDENTIAL PARADISE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **9041 SW 142 COURT** **MIAMI, FL 33186**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on I/ . Residential Paradise, Inc with limited mental health component, license #10320 has the following deficiency at the time of survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review, and interview, the facility failed to conduct as part of the continued residency criteria for residents face-to-face medical examinations by a health care provider after a significant change for 2 out of 6 sampled residents (#1 and #2) sampled residents.
Findings included:
Observation on I/ / at 08:50 a.m. found Resident #1 and Resident #2 sitting in a recliner chair; Resident #1 had what appeared to contracted hands and feet. On I/ at 10:52 a.m. Staff C (caregiver) was observed feeding Resident #1.
During an interview on I/ / at 10:54 A.M., the facility Administrator stated that Resident #1 and Resident #2 had crushed medication orders. She stated that staff at the facility administered medications to residents in the following manner: We crushed her medication, mixed up with pudding and feed her with the spoon. She cannot hold spoon or takes pill with her hands. Resident #1 need total assistance.
Record review showed Resident #1's health assessment (AHCA form 1823) dated I/ / had a diagnosis of , the resident needed assistance with all activities of daily living (ADLs) and needed assistance with self-administration of medication.
Further review found Resident #2's health assessment dated I/ / showed diagnoses ( ) and ; the resident need supervision with ambulation and eating and assistance with bathing, dressing, self-care, toileting and transferring.
During an interview on I/ / at 1:25 p.m. the facility administrator acknowledged that health assessment were not accurate for Residents #1 and #2. She acknowledged that Resident #1 did not meet the continued resident criteria because she needed total assistance with ADLs.
Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, record review, and interview, the facility failed to ensure that licensed personnel administer medications to 2 out of 6 sampled residents (#1 and #2) sampled residents.
Findings included:
Observation on I/ / at 08:50 a.m. found Resident #1 and Resident #2 sitting in a recliner chair; Resident #1 had what appeared to contracted hands and feet. On I/ / at 10:52 a.m. Staff C (caregiver) was observed feeding Resident #1.
During an interview on I/ at 10:54 A.M., the facility Administrator stated that Resident #1 and

AGENCY FOR HEALTH CARE ADMINISTRATION

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Resident #2 had crushed medication orders. She stated that staff at the facility administered medications to residents in the following manner: We crushed her medication, mixed up with pudding and feed her with the spoon. She cannot hold spoon or takes pill with her hands. Resident #1 need total assistance.
Record review showed Resident #1's health assessment (AHCA form 1823) dated / / had a diagnosis of , the resident needed assistance with all activities of daily living (ADLs) and needed assistance with self-administration of medication.
Further review found Resident #2's health assessment dated / / showed diagnoses ( ) and ; the resident need supervision with ambulation and eating and assistance with bathing, dressing, self-care, toileting and transferring.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Residential Paradise, Inc
9041 Sw 142 Court
Miami, FL 33186

Dear Administrator:

This letter reports the findings of a Standard Biennial licensure survey that was conducted on , 2017 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 , 2017.** 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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