STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969018	R 12/13/2018
NAME OF PROVIDER OR SUPPLIER **AGING HOME PARADISE LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **110 ZACALO WAY** **KISSIMMEE, FL 34743**	

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

0000 - Initial Comments

A revisit to complaint investigation #2018009221 was conducted on . . . . . Aging Home Paradise, license #2865, had a deficiency at the time of the visit.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on resident record review and interview, the facility did not obtain a complete and accurate Resident Health Assessment form (AHCA form 1823) for 2 of 2 sampled residents (#5 and #6).

Findings:

1) Review of the record for resident #5, admitted . . . . , revealed a health assessment dated . . . . . The form documented the resident was independent with eating, but required medication administration.

On , resident #5 was observed seated in a wheelchair in her room, independently eating her lunch. When greeted, she responded. She was later observed self-propelling herself around the facility in her wheelchair.

On at 1:30 PM, the administrator stated resident #5 can assist with her medications, she said they put the pill in a small cup, or in her . . , and the resident puts it in her . . and swallows it with a glass of water. She stated she had been having trouble communicating with the resident's physician about the form.

2) Review of the record for resident # 6, admitted . . . . , revealed a health assessment that was not dated. The report listed diagnoses of left , , , and . According to the health assessment she required total assistance with ambulation, toileting and transferring, and was bedridden. The form documented she required administration of medications.

On , resident #6 was observed seated in a wheelchair at the dining table, independently eating her lunch. When greeted, she responded appropriately. She was later observed self-propelling herself around the facility in her wheelchair.

On at 1:30 PM, the administrator stated resident #6 can assist with her medications, she said the resident puts her own pills in her . . . and swallows them with a glass of water. She stated she had did not realize the form needed to be corrected.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969018	R **12/13/2018**
NAME OF PROVIDER OR SUPPLIER **AGING HOME PARADISE LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **110 ZACALO WAY** **KISSIMMEE, FL 34743**	

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

Class III