STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965416	**03/29/2017**
NAME OF PROVIDER OR SUPPLIER **NEW PARADISE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2001 SW 80 COURT** **MIAMI, FL 33155**	

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

0000 - Initial Comments

A Complaint (CCR #2017001225) Survey was conducted on . New Paradise Inc, license #9810, had the following deficiencies at the time of survey:

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on observation, record review, and interview, the facility failed to have an accurate health assessments for 1 out of 6 (#3) sampled residents.

Findings included:

Observation on at 8:45 A.M. revealed Resident #3 was sitting in the common area on a sofa.

Record review found Resident #3's health assessment (AHCA form 1823) dated documented the resident required total care with bathing and dressing and needed medication administration.

In an interview on at 11:20 A.M. the Administrator acknowledged that health assessment was not accurate for Resident #3.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review, and interview, the facility failed to limit physical to half (1/2) bed rails for 2 out of 6 (#1 and #5) sampled residents. The facility failed to have a doctor's orders or consent forms for the use of half bed rails for 3 out of 6 (#2, and #3) sampled residents.

Findings included:

Observations on at 8:45 A.M. during the tour revealed Resident ##1 and #5 had full bed rail attached to the bed. Further observations showed Residents #1, #2, and #3 had bed rails attached to their beds.

A review of Residents #1, #2, and #3's files found the facility did not have physician's order for the use of half bed rails or consents to half-bed rails.

During an interview at 11:20 A.M., the Administrator acknowledged the facility did not have doctors' orders or signed consents for the residents. She stated Resident #5's full bed rail was place on

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the bed without an order.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview, the facility failed to ensure that 1 out of 6 (#2) sampled residents were assessed for elopement and put interventions in place.

Findings included:

Resident #2's file revealed the health assessment (AHCA form 1823) dated had the following diagnosis: . The resident was also identified as an elopement risk.

During an interview on at 11:20 A.M. the Administrator stated that she did not assess resident at the time of the admission. At 11:27 A.M. the Administrator stated, "we had one elope last year. Resident #2 did eloped from the facility and the police brought her back to the facility. This incident happened on around 12:00 p.m. we documented it. I did not file an incident report with the agency." On at 11:40 A.M., the Administrator stated they did not assess Resident #2 after the incident occurred.

During an interview on at 12:01 P.M. Staff D stated, "I'm working here for 2 years. She stated we had an incident that Resident #2 left the facility, that incident happened last year. On that day (I do not remembered) I was working and left the facility for a personal issue, my daughter was going to travel from Italy to here. I left the facility and one staff member remain here, she was careering for the six residents. I did not remember her last name. She stated the staff looked and told me that Resident #2 was not at the facility, I returned to the facility fast. We inform the administrator and the owner came here to look for her. Administrator implemented a new alarm to the entrance door but it did not do not have battery."

Interview on at 12:07 P.M. the Owner acknowledged that that door alarm battery was not working at the moment.

Class III

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

Based on observation, interview, and record review, the failed to have a licensed staff member administer medications to 1 out of 6 (Residents #1) sampled residents.

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Findings included:

Review of Resident #1's file revealed the health assessment (AHCA form 1823) dated documented the resident needed administration of medication

Medication pass observations on at 9:18 A.M. found Staff D and Staff C, Resident #1 was in his bed. Resident #1 sat in bed. Staff C took the cup that Staff D handed to her and place it into the resident's mouth. Staff got cup of water and also placed it into the resident's mouth.

Review of the medication observation records (MORs) of Resident #1 showed that staff initialed the MOR. Resident #1's list of medications were , 5 mg, 1 mg, 0.4 mg, , 500 mg, 100 mg, , 50-200 mg, , , 10 mg , , 20 mg, and , 20 mg.

During an interview on at 9:36 A.M., the Administrator stated that Staff C was not a nurse. She acknowledged that staff administered the medications to Resident #1.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observations and interview, the facility failed to ensure that medications were kept locked at all times.

Findings included:

Observation on at 9:25 A.M., the Administrator left medication unattended in the family residents where sitting.

On at 9:27 A.M. the Administrator stated, "I went to get the key and I let the medication there."

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

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. The facility also failed to have staff to meet the scheduled and unscheduled needs of the residents (census of 6).

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Findings included:

On at 8:40 A.M. upon arrival at the facility a family member of Resident #1 answered the facility's door. He stated let me call the caregiver, she is helping another resident. Staff D stated wait for me I needed to help the residents now. Observed that Staff D was alone at the facility caring for 6 residents.

On at 8:51 A.M. Staff D stated, "I'm waiting for the other staff." Staff D joined the facility tour. Observation during tour found # occupied by Resident #1 had strong odor of . Resident #1 in bed wearing an adult brief.

Review Resident #1's file revealed health assessment (AHCA form 1823) dated with diagnoses: Parkinson's , Moderate , , incontinence, hearing loss, , spinal . Resident needed assistance with activities of daily living (ADLs) as the following: ambulation (assure the resident has proper ambulation around the facility, promote physical activities. Bathing (Remind resident bathing time and assuring resident has the necessary items for a full bath in order to maintain adequate body hygiene). Dressing (support resident's ability to make appropriated clothing decision and physically dress oneself). Self-care (assure resident is maintaining adequately personnel hygiene, adequately , including nails, hairs and oral care). Toileting (assure resident to adequately maintain hygiene body function using). Transferring (assure resident appropriately moves from seated to standing position and gets in and out of bed.

On at 9:00 A.M. Staff C arrived at the facility. She stated, "I went to the school to drop off my son."

Record review of the staffing schedule posted showed that following 2017: Staff B from 7:00 A.M. to 7:00 P.M., Staff C from 7:00 A.M. to 7:00 P.M., Administrator from 7:00 p.m. to 7:00 a.m., and Staff D (on Call).

On at 9:15 A.M. the Administrator arrived to the facility, she acknowledged that upon arrival at the facility only was staff was caring for 6 residents.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview the facility failed to provide a safe and clean environment for

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residents living at the facility.

Findings included:

Observations on at 8:45 A.M. revealed the facility had a broken outlet plug in # and ceiling had peeling paint, missing light bulbs in the common . The facility's door and fire alarm did not have batteries. # had a strong smell.

Interview on at 12:07 P.M. the Owner acknowledged that that door alarm and fire alarm batteries were not working at this moment. He stated that I'm working with an alarm company to do it at whole house. He acknowledged deficiencies found.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to file an adverse incident report for 1 out of 6 (#2) sampled residents who eloped from the facility.

Findings Included:

A review of Resident #2's record revealed the health assessment (AHCA form 1823) dated documented the resident as an elopement risk. Resident #2's observation log dated stated the staff notified to the administration that Resident #2 was not at the facility. The staff did not know in what moment the resident went out of the house, at the moment that administration was inform and the family member contacted the facility to inform that the police found the Resident#2 three blocks away from the facility and they will returned her to the facility.

During an interview on at 11:27 A.M. the Administrator stated we had one elope last year. Resident #2 eloped from the facility and the police brought her back to the facility. This incident happened on around 12:00 P.M. "I did not file an incident report with the agency."

Class III

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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on observation, record review, and interview, the facility failed to register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days.

Findings included:

Observation on revealed that Administrator, Owner, Staff C and D were at the facility during survey.

Review of background screening for providers revealed that facility's employee roster did have any staff names listed.

During an interview on at 1:10 P.M., the Administrator and the Owner acknowledged that staff were not registered at the agency background screening roster..

Unclassified