

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the _____ are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must 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. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic _____ submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; _____; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a new background screening for one out of four sampled staff (Staff C). Staff C had a break in service of more than 90 days from a position that requires screening. Findings included:	CZ814			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/10/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LA PAZ HOME CARE CORP

**12968 NW 9 TERRACE
MIAMI, FL 33182**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	Continued From page 1 Review of the facility's background screening clearinghouse showed Staff C was previously employed in another facility from _____ to _____. Further review of the facility's background screening clearinghouse showed Staff C was hired at the facility on _____ 329 days after her last employment. A review of Staff C's personnel records showed an employment application dated _____ and a copy of Staff C's latest background screening eligibility on _____. On _____ at 3:02 PM, the Owner acknowledged that Staff C had a break in service and stated that she would have the staff do her _____ again. Unclassified.	CZ814		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/10/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LA PAZ HOME CARE CORP

**12968 NW 9 TERRACE
MIAMI, FL 33182**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A biennial survey was conducted at La Paz Home Care, Corp on _____ through _____. The provider had deficiencies identified at the time of the visit.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____, _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being for one out of six sampled residents (Resident # 1). Resident #1 sustained a that caused her a on her left Also, the facility failed to maintain a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention. Findings included: On at 10:28 AM, observation showed	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 2 Resident #1 seated on a recliner in her room. Further observation showed the resident had a bandage and a metal fixator on her left On at 10:29 AM, Staff C (caregiver) stated the Resident #1 approximately a month earlier when she was walking . . . to her room after dinner. She further stated that the resident used a walker for ambulation, and she tripped. They called the ambulance, and the resident was transferred to the hospital. On at 10:34 AM, Resident #1 stated that she on the floor and hurt her arm. The resident explained that she had finished having dinner at the dining room and was walking with the walker . . . to her room and tripped. Then the staff called the ambulance and took her to the hospital. Resident #1 could not specify the date and time of the incident. On at 10:40 AM, the Owner stated that she was not present when Resident #1 . . . but came after the staff called her. The Owner explained that according to Staff C the resident was walking with the walker to her room and tripped. The Owner added that they called the ambulance, and the Resident #1 was transferred to the hospital. The resident was admitted and had surgery on her . . . , and they put on the fixators to prevent her to move the arm. Review of medical records received revealed that the resident presented to the emergency room on with complaint of . . . and injury to left The resident reported that she was walking with her walker when her walker slipped and she . . . , landing directly on her left Hospital records also indicated that Resident #1 stayed in the hospital until	A 025			

AHCA Form 3020-0001
STATE FORM

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 4 around or taking care of themselves. These health issues increase their risk for . Ultimately, each resident in the assisted living facility is unique with their own set of characteristics and conditions. The following procedures and guidelines are implemented at the [Assisted Living Facility] at all times to prevent . In the event of a , a more specific set of procedures may be applied to the resident to prevent future ." Class III	A 025			
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, record review and	A 034			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 034	Continued From page 5 interview, the facility failed to ensure that documentation of each device a resident used be included in the resident's record for one out of six sampled residents (Resident #1). Findings included: On at 10:28 AM, observation revealed that Resident #1 had half-bed rails attached to her bed. Review of Resident #1's record showed that the half-bed rail was not included in the assistive device policies and procedures completed On at 10:40 AM, the Owner stated regarding Resident #1 that she put the half-bed rail on the resident's bed so she could lean on it and help her sit or get out of bed, but there was no order. She said she would contact the doctor to obtain a prescription. On at 3:25 PM, the Owner acknowledged the half-bed rail was not included in the assistive device policies and procedures. Class III	A 034			
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number,	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 162	Continued From page 6 7. Medicaid and/or Medicare number, or name of other health insurance 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 7 (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____ (_____), CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 8 who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have an order and a consent for the use of half-bed rails for one out of six sampled residents (Resident #1). Findings included: On at 10:28 AM, observation showed	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 162	Continued From page 9 that Resident #1 had half-bed rails attached to her bed. Review of Resident #1's record showed no documentation of a prescription order for half-bed rails. Further review showed a consent to the use of bed rails signed by the resident on _____, however which type would be used, half-bed rails or full-bed rails, was not selected. On _____ at 10:40 AM, the Owner stated that she put the bed rails on the bed, so the resident could lean on it to seat or get out of bed. She further stated that there was no order on file, but she would contact the residents' physicians to obtain the prescription. Class III	A 162			
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements. - (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 165	Continued From page 10 resident's condition and results in: 1. _____; 2. _____ or _____ damage; 3. Permanent _____; 4. _____ or _____ of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) _____, neglect, or _____ must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 165	Continued From page 11 persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide, within 1 business day after the occurrence of an adverse incident a preliminary report, and within 15 days after the occurrence of a resident in the facility that resulted in admission to the hospital due to an injury	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 165	Continued From page 12 (Resident #1), a full report to the Agency for Health Care Administration that included the results of the facility's investigation into the adverse incident. Findings included: On _____ at 10:28 AM, observation showed Resident #1 seated on a recliner in her room. Further observation showed she had a bandage and a metal fixator on her left _____. On _____ at 10:29 AM, Staff C (caregiver) stated the Resident #1 _____ approximately a month earlier when she was walking _____ to her room after dinner. She further stated that the resident used a walker for ambulation, and she tripped. They called the ambulance, and the resident was transferred to the hospital. On _____ at 10:34 AM, Resident #1 stated that she _____ on the floor and hurt her arm. The resident explained that she had finished having dinner at the dining room and was walking with the walker _____ to her room and tripped. Then the staff called the ambulance and took her to the hospital. Resident #1 could not specify the date and time of the incident. On _____ at 10:40 AM, the Owner stated that she was not present when Resident #1 but came after the staff called her. The Owner explained that according to Staff C the resident was walking with the walker to her room and tripped. The Owner added that they called the ambulance, and the Resident #1 was transferred to the hospital. The resident was admitted and had surgery on her _____, and they put on the fixators to prevent her to move the arm.	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/10/2022
NAME OF PROVIDER OR SUPPLIER LA PAZ HOME CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12968 NW 9 TERRACE MIAMI, FL 33182		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 165	Continued From page 13 A review of the Incident Report System (AIRS) showed no documentation of any incident report related to the . . . and subsequently surgery of Resident #1. On . . . at 1:48 PM, during a telephone interview, the Administrator stated that if the consultant did not file the incident report was because she also had an emergency. Class III	A 165			