Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968509	A. BUILDING: _____ B. WING _____	R 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS TRES MILAGROS II, LLC	15431 SW 159 STREET MIAMI, FL 33187

(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 second revisit survey was conducted at Los Tres Milagros II Assisted Living Facility on . Deficiencies were identified at the time of the survey.	{A 000}		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968509	A. BUILDING: _____ B. WING _____	R 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS TRES MILAGROS II, LLC	15431 SW 159 STREET MIAMI, FL 33187

(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 152	Continued From page 1 use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, record review and interviewed, the facility failed to provide a safe and living environment for six (#1, 2, 3, 4, 5, 6) out ix sampled residents. Findings: Observation on at 8:20AM found Residents #3, #4, #5, and #6 in the common area and at dining table. Observation on at 8:20AM found a drawer in the kitchen next to the medication cabinet without a lock and unsecured with the following over-the counter-medications in: 1 bottle 200 MG 500 Tablets, 1 bottle 500MG 100 Tablets, 1 box Effervescent & Relief 36 Tablets, Relief Subsalicylate 262 MG 30 Tablets, 1 tube Gel, 1%, 1 bottle Health Dietary Supplements 500 MG 100 Caplets, 1 bottle 8Hr Relief Extended-Release Tablets 600 MG, 1 Medicated Rub Net 3.53 OZ., HBr Suppressant 8 FL OZ., Liquid 400 MG, 400 MG 12 FL OZ., 24 Tablets, and 2 bottles of 325 MG 100 tablets. Photographic evidence obtained. Interviewed on at 8:29AM Staff B (Caretaker) stated that she used the medications	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968509	A. BUILDING: _____ B. WING _____	R 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS TRES MILAGROS II, LLC	15431 SW 159 STREET MIAMI, FL 33187

(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 152	Continued From page 2 for her own emergency for . . . . . and pains. Interviewed on at 9:08AM the Administrator stated that she was just at the facility on to make sure everything was current, and she acknowledged the problem and if she was fined, she would take it out of the employee's (Staff B (Caregiver) check. A review of the facility policy on the Central Storage Medication Policy states the following: "The regulations specify requirements for medication management, including proper storage of medications. The medication storage area is maintained with the safety of the residents in mind at all times." Class III	A 152		