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
	AL11942793	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA MILAGROSA HOME	3341 SW 7 STREET MIAMI, FL 33135

(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 on at La Milagrosa Home. The provider had deficiencies at the time of the survey.	A 000		
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 interview, the facility failed to document an assistive device in Resident #2's record. The resident's use of a wheelchair was not listed.. Findings: Observation on at 10:00 AM Resident #2 was being wheeled from her room in a wheelchair by Staff B (Caregiver).	A 034		

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942793	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA MILAGROSA HOME	3341 SW 7 STREET MIAMI, FL 33135

(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 1 A review of Resident #2's records showed no documentation of the resident using a wheelchair. A review of Resident #2's health assessment showed Resident #2 needed assistance with ambulation, bathing, [illegible], grooming, toileting, transferring and supervision with eating. Interviewed on Resident #2 stated that the wheelchair belonged to her and that she brought there from another facility. Interviewed on at 12:15 PM the Administrator admitted that the wheelchair was not documented in the resident's records. Class III	A 034		
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	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
	AL11942793	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA MILAGROSA HOME	3341 SW 7 STREET MIAMI, FL 33135

(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 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 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 interview, the facility failed to ensure a safe and living environment, free from hazards; ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order for nine (#1, #2, #3, #4, #5, #6, #7, #8, #9) out of nine sampled residents. Findings: Observation on at 7:00 AM found a blue tarp covering the front of nailed to the soffit. According to 'How Stuff Works', "A soffit is any material that makes up the underside of a part of your house, including ceilings, stairs, and cornices." Photographic evidence obtained.	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942793	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA MILAGROSA HOME	3341 SW 7 STREET MIAMI, FL 33135

(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 3 Observation on . . . . . at 7:04 AM found several blue tarps covered at the center of the roof of the house with what appeared to be two sandbags apparently keeping it in place. Photographic evidence obtained. Observation on . . . . . at 7:01 AM found what appeared to be water stains inside the house in the popcorn-type ceiling. Photographic evidence obtained. Interviewed on at 7:45 AM when asked if there was a roof leak, the Administrator stated, "It was fixed." When asked if it was fixed and why the tarp remained, the Administrator never provided an answer or any contract that the repairs were completed. Observation on . . . . . at 7:10 AM the shower floor near the dining area appeared to have black spots between the grouts. Interviewed on . . . . . at 12:13 PM the Administrator stated that it was not mold. The Administrator stated further, "We tried cleaning between the grout, and it does not come out." Class III	A 152		