

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966845	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER CASA DE PAZ ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9360 SW 24 STREET MIAMI, FL 33165		
(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 Generator Monitoring was conducted at Casa De Paz, Inc on . Deficiencies were identified during time of the survey.	A 000			
A 182 SS=D	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that two out of two (Staff A & B) direct care staff were trained in their duties and would be responsible for implementing the emergency management plan. Staff A and B did not know how to operate the alternate power source (generator) that would be used to maintain room temperature at or below 81 degrees Fahrenheit in the event of a loss of primary power. Findings included: On at 10:15 AM observed outside in the backyard was an encasement with a Firman portable generator with a 15 gallons tank of gasoline and a 50 gallon propane tank. On at 10:17 AM Staff A was observed as she attempted to crank the portable generator	A 182			

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966845	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER CASA DE PAZ ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9360 SW 24 STREET MIAMI, FL 33165		
(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 182	Continued From page 1 unsuccessfully and then try to connect portable generator with extension cord to fuel tank unsuccessfully. In an interview on _____ at 10:45 AM Staff A stated, "I started in _____ this year. I have been train from the facility I came from on how to turn on the generator. I have not been trained yet on how to turn on the generator here." In an interview on _____ at 10:52 AM Staff B stated, "I do not know how to turn it on. I don't remember." Review of the facility's employee roster in the background screening database revealed that Staff A was _____ and Staff B was hired on _____. Class III	A 182			