STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967253	**02/19/2018**
NAME OF PROVIDER OR SUPPLIER **LA PAZ HOME CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **12968 NW 9 TERRACE** **MIAMI, FL 33182**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on . . . . . La Paz Home Care Corp. with a Limited Mental Health component, license# 11300, had the following deficiencies found at the time of the survey:

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 treat three of six sampled residents with dignity and respect (#2, #3 and #6). Staff were sleeping in resident . . . . . .

Findings included:

On . . . . at 7:20 AM, observed Resident #2 sharing his . . Staff C. Resident #2 was a male and the caregiver was a female. Observed Residents # 3 and 6 sharing their Staff B.

On at 8:00 AM Staff B stated that she slept in # and Staff C slept in # with the residents.

On . . . . at 12:30 PM, the Administrator and the owner stated that the caregivers slept in the residents , now and then, but they usually slept on a futon that was in the living .

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview the facility failed to follow procedure outlined by state statues when assisting three out of six sampled residents with self-administration of medications (Residents #1, 4, and 3).

Findings included:

On . . . . . at 8:00 AM, observed Staff B take the medication out of the locked cabinet located in the kitchen. The medication was already pre-poured in a container labeled with resident's name . (Photographic evidence) The water was poured in a small cup. The resident was given tablets and some water, and swallowed the pill with some water. Staff already had initialed the medication book. Staff B failed to identify the medications for the resident.

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On at 8:30 AM staff B stated, "I put the medication in containers already so it will be easy."

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that Medication Observation Records (MORs)were completed as required. The MORS for three out of six sample residents were signed before medications were given (Residents #1, 4 and 3).

Findings included:

A review of Resident #1's MORs revealed that there was an order of 50 mg, 10 mg, 20 mg, 10 mg, 10 mg, 150 mg, Sertralin. Resident #4 had an order for, 325 mg, mg, 200 mg, 5 mg, 1 mg, 500 mg, Multiple 1 mg. Resident #3 had an order for 81 mg, 20 mg, 250 mg, 20 mg, 10 mg, Triperocaps daily.

On at 8:00 AM, observed that Staff B had already signed the MOR and she had not given the medication to the residents.

On at 8:00 AM staff B stated that she had signed the MOR already because she had put the medication already in the separate containers.

Class III