STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965825	R 05/18/2018
NAME OF PROVIDER OR SUPPLIER **DE' BLANCA HOME II**	STREET ADDRESS, CITY, STATE, ZIP CODE **2520 SW 102 AVENUE** **MIAMI, FL 33165**	

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

0000 - Initial Comments

A Standard Biennial Survey revisit was conducted on [redacted] to [redacted]. De' Blanca Home II, License #10154, with a Limited Mental Health (LMH) component had the following deficiencies found at the time of the survey:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview, and record review, the facility failed to adequately provide care and services appropriate to meet the needs of the residents by not properly assessing, monitoring, and supervising the safety and physical well-being of one out of six sampled residents (Residents #3). Resident #3 [redacted] in the facility resulting in hospitalization with [redacted] and a [redacted] nasal bone [redacted] a [redacted] and [redacted] nasal [redacted]. Resident #5 had an open [redacted] on her left arm without receiving professional care.

Findings included:

On [redacted] at 10:25 AM, observed Resident #5, who had a personal bed with plastic rails attached at one side and at the edge of the bed. On [redacted] at 10:30 AM, Caretaker B, stated "I don't know why she has those rails." Caretaker B, called Caretaker C who stated, "her grandson place the rails to her bed and she is using."

On [redacted] at 10:26 AM, observed Resident #5 with an open skin [redacted] on her left arm. Caretaker B stated at 10:40 AM, that the resident had sensitive skin and she hurt herself today. Observed that Resident #5 had a box of tissue in her lap, and was using the tissues to dry body liquid [redacted].

On [redacted] at 10:46 AM, Caretaker B stated, "The Administrator is not here, because she is off today. I did not contact any person yet to inform that Resident #5 had open skin."

On [redacted] at 10:50 AM, asked Caretaker B again, if she informed the resident's condition to administrator or contacted a doctor, she stated "no." Observed that Staff B went to the office to get the resident file, placed it on the kitchen counter and contacted a person over the phone and informed them of Resident #5's condition, staff stated they are going to send nurse.

On [redacted] at 11:22 AM, Resident # 5, pointing to her arm said, stated," I had this for a while. It is painful and sometimes it bleeds. Nobody is healing me, the staff is put cream on it."

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Resident #5's (admitted on), health assessment dated showed the following diagnoses: Type II, ( ), and History of and had precautions. Further review of the health assessment revealed it had no indication if the individual needed supervision or assistance with activities of daily living (ADLs). Resident #3's file contained a half bed rails order by a physician dated and a consent to have a bed rails was signed on . There was also a " diet" order. The facility's progress notes did not contain documentation that resident had an incident.

Resident #3's progress note written by the Administrator showed on , "Today resident was sleeping, caretaker heard a noise and found resident on the floor, she said she , down no complaining at the morning she went to a medical office, from there came to the facility and transferred to the hospital and returned from the hospital on she came weakened, alert and oriented, she complained of head pain." After seven days, on progress note showed that resident was sleeping and down again hitting her face specifically nose and mouth, rescue was called immediately, she was transferred to a hospital.

Hospital record of Resident #3' revealed that on , 94 years female was admitted for ground level at home. Patient does not recalled and denies . The family report history of and, per chart patient also demonstrated history of , most recently admitted with (ICH) on after a . Per Emergency Medical Service ( ) initially complaining of left forehead pain and LLQ Pain. Hospital record showed that patient chart had diagnoses of , ( ), , non- -dependent ( ), / , The resident was recently discharge on after being treated of right SHA, Small and Nasal Bone after sustaining a GLF. The assisted Living Facility (ALF) was contacted and Caretaker B provided list of events, Resident #3's was found on the floor ,never seen falling from bed and no signs of .

The discharge plan showed that Resident #3 was back to ALF as discussed with family, patient and caretaker were advised to follow up with physician care provider (PCP) in 1 week. Her record did not have documentation that follow up care was scheduled or done.

Resident #3's (admitted on) health assessment done on revealed the following diagnoses: , ( ), , Hematoma, ( ), , A-fib, ( ), the resident had precautions, , and , precaution. The resident are independent with eating, and needed assistances with ambulation, bathing, dressing, self-care, toileting, and transferring. Special diet instruction Mechanical Soft, ground, no added salt (NAS), no concentrated

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sweets (NCS), nectar thickened liquids. The health assessment showed that resident did not have any pressure sores. Resident needed administration of medications. New health assessment dated showed the following diagnoses: , , , , Chronic Kidney ( ) , Type II, Memory Loss, Recruitment , Two Recent Head with Hematoma and Nasal Bone . The health assessment showed that resident need nursing/treatment/ , that required Precautions and half bed rails. The resident file contained a consent to the use of bed rails dated , signed by the power of attorney.

On at 12:25 PM, Caretaker B reviewed Resident #3's health assessment, she acknowledged that resident had a physician order for half bed rails.

On at 12:25 PM, interview Resident #3 Power of Attorney and he stated, "She down here twice and on the second she broke her nose. I did put the rails on her bed to prevent , and she cannot remove it and with the rails no more problems."

On at 12:36 PM, Caretaker B stated, "we do not have the bed rails, we suggested her grandson to get another bed to place the appropriate rails so we are going to have less worries."

On at 1:09 PM, Caretaker B stated, 'We could not prevent Resident #3's , the resident recently after she was admitted. Maybe because resident was not used to or adapted to live in the house, it never happen again. ' No other interventions were identified

On at 1:10 PM, Caretaker C gave her personal phone cellular to Caretaker B and stated, "I text the administrator and she said that you can have her cellular phone number but if you want to called her now she is not going to be able to answer you because she is in a meeting.

Class II

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation, interview and record review, the facility failed to have a complete and accurate health assessment for two of five sampled residents (# 3 and #5).

Findings included:

Observation on at 10:25 AM showed Residents #3 and #5 sitting in a common area. Further observation during lunch at 11:45 PM observed Caretaker B and C assisting three female Residents #3,

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#4 and #5 with transferring and toileting before they went to the dining table for lunch.

Record review showed Resident #3's (admitted on) health assessment dated did not have documentation of the individual 's needed supervision or assistance with activities of daily living (ADL). Further record review showed Resident #5's health assessment done on identified that the resident needed administration of medication.

On at 1:14 PM, Caretaker B, acknowledged that health assessment of Residents #3 and 5 were not accurate.

Class III