STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969016	02/20/2019
NAME OF PROVIDER OR SUPPLIER **LAS DELICIAS ALF 2**	STREET ADDRESS, CITY, STATE, ZIP CODE **3840 NW 184TH ST** **MIAMI GARDENS, FL 33055**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A Complaint (CCR#2018017798) Survey was conducted on and concluded on . Las Delicias Alf 2 had the following deficiencies identified at the time of the survey:

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

Based on interview and record review, the Assisted Living Facility failed to provide personal supervision to residents while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident for one out of five sampled residents (#1). Resident #1 in the facility and the hospital found the resident had a 20 days later. The facility failed to contact the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change for one out of five sampled residents (#1). Resident #1's family members were not inform in a timely manner about the . The facility failed to maintain an updated written record that reflected any significant changes that resulted in medical attention for one out of five sampled residents (#1). The facility did not document that Resident #1 .

Findings included:

Review of the facility's admission and discharge log showed that Resident #1's admission date was on and the discharge date was on . The reason for discharging the resident showed that "she need a lot take care" and was discharge to a nursing home. The special notes showed that she had and and was .

Review of Resident #1's record showed that there was a doctor's order for the use of half-bed rail signed on and included the diagnoses of , unsteady gait, poor balance, and high risk for . The health assessment (AHCA form 1823) completed on indicating that medical history and diagnoses were , idiopathic , sleep , with late onset, and or dependence. The resident had difficulty walking. The resident was alert but disoriented and with memory loss. She had precautions. The resident needed assistance with all activities of daily living (ambulation, bathing, , eating, self-care, toileting, transferring). There was no documentation that the resident's emergency contact or the primary physician were contacted regarding any .

On at 7:40 AM, the administrator revealed that none of the current or previous residents has in the facility. Resident #1 slipped in the facility but she did not ; she did not touch the floor. On

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further interview on at 9:27 AM, the administrator revealed that one day the resident was resting on bed after lunch; the staff left the room and the resident had closed. The staff was in the hallway, heard something and found the resident against the closet. She did not go the hospital because she did not hit herself and did not , she did not go to the floor. Like 20 days later, she started to refuse eating, walking and getting out of bed. The facility sent her to the hospital. The administrator called the resident's daughter who told her that the resident was improving and was discharged to a rehab. Then the resident's daughter told her that the resident had a , according to the hospital.

Review of Resident #1's progress notes showed that:
- On , the resident was better. She got out of bed very fast due to she had 's. She slipped but she did not hit the ground. The facility watched her. She ate well and slept all night. The facility did not send the resident to the hospital because she did not show any symptoms of , and slept all night. The facility continued watching her.
- On , the resident's family visited her and found her well. The staff continued observing her; she has always had poor ambulation but was better. The resident ate and slept all night.
- On (discrepancy on the date), "Today", the resident was very happy. She was better. She also walked better.
- On /8, "Today", she did not feel well. She could not open her . She went to the hospital.

On at 1:18 PM, the resident's doctor office revealed that she had X-ray done on and she did not any at that moment. The doctor saw the resident for last time on .

On at 4:26 PM, Resident #1's daughter revealed that her mother had an Advanced . Her mother used to go as day care participant and started to be a resident in the facility when she left to another country. She got ( ). They had two staff and provided good care. The resident's daughter called the facility every day. One of the staff informed her that the facility's owner reduced the staff working in the facility. Her mother used to stand out and required extra attention. On , around the 7th, she told one of the staff she preferred that they use a bed sheet to tie her mom because she was scare that her mother . On , she and her family went to the facility to celebrate the resident's birthday. The resident walked with no problems. She called the facility on and informed that was coming to visit her; staff informed that her mom the Monday while Staff D was working. The owner did not like to send the resident to the hospital because the hospital would report the facility. The administrator told her that her mother was ok and she applied ice. One of the resident in the facility informed the resident's daughter that her mother complained of , . By that moment, the facility put two staff on duty again. The facility told her that an oculist checked on the

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resident. The facility informed her that the doctor ordered . The resident's daughter noticed during her visit to the facility that the staff put her under armpits and placed her mother on the bath chair. Before the staff gave her the and assisted to transfer, the resident ambulated with her . The resident's daughter did not take her mother to the hospital because the facility told her the doctor already checked on her. She called on around 11 in the morning and the staff told her that the resident refused to eat breakfast. She called again around 2 pm and the staff informed her that her mother ate lunch but was down. She called the facility the following day around 10 AM, the other staff told her that her mother was in bed but she was quiet. She received a called around 11 AM from Staff E who told her that she called -1, sent her mother to the hospital and then informed Staff A because Staff A did not let the staff to call 911. The resident's family met the resident in the hospital. One of the staff told her that her mother had on the for two days but she slept with that under her . When the resident's daughter arrived to the hospital Sunday, the doctor told her that her mom was not a for surgery. The doctor explained to her that the did not happen that day, it happened days before. The doctor told her the following Tuesday that her mother was going to be discharge with hospice services because she needed to receive . She called the facility and the facility told her that the resident could not return to the facility because the facility did not have license for that service.

Photographic evidence provided by Resident #1's daughter showed the resident had a . It was a bump to the right side of the forehead with a small opening. There was skin discoloration covering the right side of forehead and the upper and right side of the right . The discoloration showed that the area was purplish, yellowish and greenish.

Review of Resident #1's hospital record showed that the admission date to the hospital was on and discharged on . The chief complaint description in the demographic sheet showed: of of right , Rhabdomyolysis. History and physical/admission notes showed that the resident was admitted for decline in function. She was not eating or drinking in the ALF. The resident had a right and right at the time of admission. The resident's daughter informed the hospital by phone that the resident had a at the ALF two weeks ago. The resident's grandson was at the bedside and informed the hospital that he was out of town but was notified a week ago that the resident at her ALF. When he returned the day before and went to visit her, he found that the resident had on the right side of her , a right , significantly weak, and had some right . She was mute and did not speak, also was bedridden. The of the right and the completed on showed that there was a no acute traversing the right . The was displaced. There was soft tissue . Discharge diagnoses were , intracapsular of the right , , rhabdomyolysis, , status post

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localized , occlusion and of carotid .

On at 1:43 PM, Staff D revealed that Resident #1 one day while she was on duty at lunch. The resident got out of bed with her cover, hit her forehead and had a bump. The resident did not lose . That incident happened 20 days before she went to the hospital. The incident happened between the 20th and . The administrator sent the resident to the hospital because she did not want to eat or drink. During the resident's last days at the facility, she made some expressions. It looked like something bother the resident but she could not talk. The daughter called three days later after it happened. The other staff informed the daughter who lived in another country.

Class III

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

Based on interview and record review, the Assisted Living Facility (ALF) failed to assist out of five sampled residents with arranging for health care services (#1). Resident #1 at the facility and as a result, she had a black , a injury, and a . The resident did not receive medical attention for 20 days.

Findings included:

Review of Resident #1's record showed that there was a doctor's order for the use of half-bed rail signed on . The resident had diagnoses of , , unsteady gait, poor balance, and high risk for . The health assessment (AHCA form 1823) dated showed medical history and diagnoses of , idiopathic , sleep , with late onset, and , or dependence. The resident had difficulty walking. The resident was alert but disoriented and with memory loss. She needed precautions. The resident also needed assistance with all activities of daily living (ambulation, bathing, , eating, self-care, toileting, transferring). There was no documentation that the resident received medical care or saw the Primary Care Physician after the in .

On at 7:40 AM, the Administrator revealed that Resident #1 slipped in the facility but stated that the resident did not ; she did not touch the floor. On further interview, the Administrator stated that one day the resident was resting in bed after lunch; the staff left the room and the resident had her closed. The staff was in the hallway, heard something, and found the resident against the closet. The Administrator reiterated that Resident #1 did not go the hospital because she did not hit herself and did

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not , she did not go to the floor. She said that 20 days later, Resident #1 started refusing to eat, walk, or getting out of bed. She said facility staff sent the resident to the hospital. Later, the Administrator called the resident's daughter who told her that the resident was improving and was discharged to a rehab. Then the resident's daughter told her that the resident, according to the hospital, had a ,

.

On at 1:18 PM, Resident #1's doctor office revealed that she had X-ray done on and she did not have any at that moment. The doctor saw the resident for last time on .

On at 4:26 PM, Resident #1's daughter revealed that her mother had Advanced 's . She further stated one of the staff informed her that the facility's owner reduced the amount staff working in the facility. She called the facility on and staff informed that her mom the previous Monday while Staff D was working. She stated the owner did not like to send the residents to the hospital because the hospital would report the facility. She said the Administrator told her that her mother was ok, and that she had applied ice. Resident #1's daughter stated one of the other residents told her that her mother complained of , . The facility staff told in the resident's daughter that an oculist (according to Merriam Webster dictionary, an oculist is an ,) checked on the resident, and that the doctor ordered , to treat Resident #1. She noticed during her visit to the facility that the staff put their under Resident #1's armpits and placed her on the bath chair. The resident's daughter did not take her mother to the hospital because the facility told her the doctor already checked on her. She called on around 11 in the morning and the staff told her that her mother refused to eat breakfast. She called again around 2 PM and the staff informed her that her mother ate lunch but was laying down. She called the facility the following day around 10 AM, the other staff told her that her mother was in bed but she was quiet. She received a called around 11 AM from Staff E who told her that she called 911, sent her mother to the hospital and then informed Staff A because Staff A did not let the staff to call 911. One of the staff told her that her mother had , on the for two days but she slept with that under her , . When the resident's daughter arrived to the hospital on Sunday, the doctor told her that her mom was not a for surgery. The doctor explained to her that the did not happen the day of the examination, but that it happened days before. The doctor told her the following Tuesday that her mother was going to be discharged with hospice services because she needed to receive , . She called the facility and was told Resident #1 could not return to the facility because the facility did not have license for that service.

Photographic evidence provided by Resident #1's daughter showed the resident had : a large bump on the right side of the forehead with a small opening. There was skin discoloration covering the right side of forehead and the upper and right side of the right , . The discoloration showed that the area was purplish, yellowish and greenish.

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On at 1:43 PM, Staff D revealed that Resident #1 one day while Staff D was on duty at lunch. The resident got out of bed with her cover, hit her forehead and had a bump. The resident did not lose . That incident happened 20 days before she went to the hospital. The incident happened between the 20th and . The administrator finally sent the resident to the hospital because she did not want to eat or drink. During the resident's last days at the facility, although she was unable to speak, she made some expressions. It looked like something bothered the resident, but she could not talk.

Review of Resident #1's hospital record showed that the admission date to the hospital was . The chief complaint description in the demographic sheet showed: , , , of , of right , , Rhabdomyolysis (according to Merriam Webster dictionary, the medical definition of Rhabdomyolysis is the destruction or of tissue (as from injury, excessive exertion, or) that is accompanied by the release of cell contents (as myoglobin and ,) into the bloodstream resulting in , , hyperkalemia, and sometimes acute failure) . The resident arrived at 1:40 PM via ambulance and the paramedics provided the information to the hospital. History and physical/admission notes showed that the resident was admitted for a decline in function; she was not eating or drinking in the ALF. The resident had a right and right , , at the time of admission. According to the record, the resident's daughter informed the hospital by phone that the resident had a at the ALF two weeks prior to arrival to the hospital. The resident's grandson was at the bedside and informed the hospital that he was notified a week ago that the resident at her ALF. When he went to visit her, he found that the resident had on the right side of her , a right , was significantly weak, and had some right , . Assessment completed on at the time of admission to the emergency department showed right and warm to touch. Resident #1 was mute and did not speak, and was bedridden. The of the right , and the , completed on showed that there was a traversing the right . The was , displaced. There was soft tissue . The resident's discharge date from the hospital was on to the hospice facility. Discharge diagnoses were , intracapsular of the right , , Rhabdomyolysis, , status post , , , localized , occlusion and of carotid , . The resident was not a for surgery; physicians and family members agreed for conservative treatment and , -free management.

Class I

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

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Based on interview and record review, the Assisted Living Facility (ALF) failed to provide a safe and decent living environment, free from neglect for one of five sampled residents (Resident #1). Resident #1 at the facility and as a result, she had a black , a injury, and a , . She did not receive medical attention for 20 days, despite her family's inquiries about the on her body. Once the resident refused to eat and get out of bed, she was sent to the hospital where the , was found.

Findings included:

On at 7:40 AM, the Administrator revealed that Resident #1 slipped in the facility but she did not ; she did not touch the floor. On further interview on at 9:27 AM, the Administrator revealed that one day the resident was resting on bed after lunch; the staff left the room and the resident had , closed. The staff was in the hallway, heard something and found the resident against the closet. The Administrator stated the resident did not go the hospital because she did not hit herself and did not , she did not go to the floor. Around 20 days later, she started to refuse eating, walking and getting out of bed. The facility finally sent her to the hospital.

Review of personnel records showed that all staff had received training regarding resident and neglect.

Review of Resident #1's record showed no documentation that the resident was monitored for , , or that she received assistance for the black , and she acquired during the (photo). Photographic evidence provided by Resident #1's daughter showed the resident had : a large bump on the right side of the forehead with a small opening. There was skin discoloration covering the right side of forehead and the upper and right side of the right , . The discoloration showed that the area was purplish, yellowish and greenish.

On at 4:26 PM, Resident #1's daughter revealed that the facility staff told in the resident's daughter that an oculist checked on the resident, and that the doctor ordered , to treat Resident #1 (according to Merriam Webster dictionary, an oculist is an ,), however there was no documentation of this care from an oculist in the resident's record.

On at 1:18 PM, Resident #1's doctor office revealed that she had X-ray done on and she had no at that time. The doctor saw the resident for last time on .

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Photographic evidence provided by Resident #1's daughter showed the resident had a . It was a bump to the right side of the forehead with a small opening. There was skin discoloration covering the right side of forehead and the upper and right side of the right . The discoloration showed that the area was purplish, yellowish and greenish.

On at 1:43 PM, Staff D revealed that Resident #1 one day while she was on duty at lunch. The resident got out of bed with her cover, hit her forehead and had a bump. The resident did not lose . That incident happened 20 days before she went to the hospital. The incident happened between the 20th and . The administrator sent the resident to the hospital because she did not want to eat or drink. During the resident's last days at the facility, Resident #1, who was unable to speak and could therefore not verbally express , made some expressions. It looked like something bothered the resident but she could not talk.

Review of Resident #1's hospital record showed that the resident had a right and right , at the time of admission. According to the record, the resident's daughter informed the hospital by phone that the resident had a at the ALF two weeks prior to arrival to the hospital. The resident's grandson was at the bedside and informed the hospital that he was notified a week ago that the resident at her ALF. When he went to visit her, he found that the resident had on the right side of her , a right , was significantly weak, and had some right , . Assessment completed on at the time of admission to the emergency department showed right and warm to touch. Resident #1 was mute and did not speak, and was bedridden. The of the right , and the , completed on showed that there was a traversing the right . The was , displaced. There was soft tissue . The resident's discharge date from the hospital was on to the hospice facility. Discharge diagnoses were , , intracapsular of the right , , Rhabdomyolysis, , status post , , , , localized , occlusion and of carotid , . Review of Resident #1's hospital record showed that the resident was not a for surgery to repair the broken bone; physicians and family members agreed that she would need to receive , for the duration of her stay in hospice to manage the , .

Class I

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation and record review, the Assisted Living Facility failed follow the right procedures during self-administration of medication in accordance with in accordance with the procedures outlined by the state for two out of five sampled residents (#3 and #5).

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Findings included:

On . . . . . at 6:54 AM, Staff C went in the kitchen and took the medications out of the medication cards. She placed the medications in three different cups that had the residents' names labeled.

On at 7:07 AM, Staff C took a cup labeled with Resident #3's name with medications inside and placed them at the top of dining table in the living-dining area.

On . . . . . at 7:20 AM, Resident #3 sat in the living-dining area with a cup with milk and coffee and , cake. The staff was not present while the resident took her morning medications.

Review of Resident #3's record showed that the health assessment completed on indicating the resident needed assistance with self-administration of medications.

On . . . . . at 8:23 AM, the Staff C stood next to Resident #5 in the living-dining area. Staff C took Resident #5's previous dispensed in a cup and put them on her . The staff did not wear gloves. She took one medication at the time with other and passed it to the resident. The staff did not read the medications' labels aloud and did not initial the Medication Observation Records when the resident took her medications.

Review of Resident #5's record showed that the health assessment completed on . . . . indicating the resident needed assistance with self-administration of medications.

Class III

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

Based on observation, interview and record review, the Assisted Living Facility failed to immediately update Medication Observation Records (MORs) each time the medication was offered or administered for three out of five sampled residents (#3, #4 and #5). The facility failed to ensure that MORs included the name, strength, and directions for use of each medication for three out of five sampled residents (#3, #4 and #5).

Findings included:

1. On . . . . . at 7:06 AM, Staff C sat at the table in the staff area. She started to initial the MORs.

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On at 7:07 AM, Staff C stated, "I finished so tired. I did not sign the book but I gave them the medicines; I gave them all."

Review of Resident #3's MORs on at 10:35 AM showed that there was an order for Tears (Lubricant) 0.5 fl oz. It was scheduled four times a day at 8 AM, 12 AM, 4 PM, and 8 PM. The staff initialed it at 8 AM and 8 PM on .

Review of Resident #5's MORs on at 10:35 AM showed that there was an order for , 0.5 mg. It was scheduled three times a day at 8 AM, 5:30 PM, and 8 PM. The staff did not initial it on . There was an order for D3 2000 units. It was scheduled at 8 AM. The staff did not initial it on .

Review of Resident #4's MORs on at 10:35 AM showed that the staff did not initial any of the medications scheduled at 8 AM on .

2. Review of MORs Residents #3, #4, and #5 showed that they did not contain the directions for use of each medication.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, record review and interview, the Assisted Living Facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern.

Findings included:

On at 6:49 AM, Staff C was on duty. She revealed that was the only staff on duty; she lived in five days, and had one day off.

Review of staff schedule showed that it covered from to . Staff D was listed as being on vacation. Staff A worked from 7 AM to 7 PM. Staff B worked from Monday to Friday (-) from 7:30 AM to 11 AM and from 11:30 AM to 3 PM. There was a note expressing that staff accompanied the residents from 8 PM to 6 AM. The schedule did not include Staff C.

Review of background screening database showed that Staff D's end date was on . Staff E's

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end date was on .

On at 7:46 AM, the Administrator revealed that there were some changes with the staffing. The administrator brought at that moment the new schedule with her.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that the unlicensed staff involved with the management of medications and assisting with the self-administration of medications complete a minimum of 6 hours of training cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities provided by a registered nurse or licensed pharmacist for Staff C.

Findings included:

On at 6:54 AM, Staff C went in the kitchen and took the medications out of the medication cards. She placed the medications in three different cups that had the residents' names labeled.

On at 7:06 AM, Staff C sat in the table on the staff area. She started to initial the MORs.

On at 7:07 AM, Staff C stated, "I finished so tired. I did not sign the book but I gave them the medicines; I gave them all."

On at 7:07 AM, Staff C took a cup labeled with Resident #3's name with medications inside and placed them at the top of dining table in the living-dining area.

On at 7:20 AM, Resident #3 sat in the living-dining area with a cup with milk and coffee and cake. The staff was not present while the resident took her morning medications.

On at 8:23 AM, the Staff C stood next to Resident #5 in the living-dining area. Staff C took Resident #5's previous dispensed in a cup and put them on her . The staff did not wear gloves. She took one medication at the time with other and passed it to the resident. The staff did not read the medications' labels aloud and did not initial the Medication Observation Records when the resident took her medications.

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Review of Staff C's personnel record showed that there was no evidence that she completed a minimum of 6 hours of training provided by a registered nurse or licensed regarding state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities.

On [redacted] at 7:54 AM, the Administrator stated that the staff had another medication training.

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(7) FAC

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that staff responsible for food service and the day-to-day supervision of food service obtained a minimum of 2 hours of training in topics pertinent to nutrition and food service in an assisted living facility for one of four sampled staff (Staff C).

Findings included:

On [redacted] at 6:49 AM, Staff C was on duty. She revealed that she was the only staff on duty; she lived in five days and was one day off.

On [redacted] at 7:20 AM, Resident #3 sat in the living-dining area with a cup with milk and coffee and [redacted] cake.

On [redacted] at 7:39 AM, the Administrator and Staff B arrived.

Review of Staff C's personnel record showed that there was no evidence that she completed a minimum of 2 hours of training in topics pertinent to nutrition and food service in an assisted living facility.

On [redacted] at 7:54 AM, the Administrator revealed that Staff C did not have the nutrition training.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the Assisted Living Facility failed to identify in the admission and discharge log the facility to which the resident was discharged for two out of five sampled residents (#1 and #2).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969016	**02/20/2019**
NAME OF PROVIDER OR SUPPLIER **LAS DELICIAS ALF 2**	STREET ADDRESS, CITY, STATE, ZIP CODE **3840 NW 184TH ST MIAMI GARDENS, FL 33055**	

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

Findings included:

Review of the admission and discharge log showed that Resident #1's discharge date from the facility was on . The place of discharge to showed "Nursing Center".

Review of the admission and discharge log showed that Resident #2's discharge date from the facility was on . The place of discharge to showed "She is in Nursing Center".

On at 7:42 AM, the Administrator revealed that those residents (#1 and #2) did not live in the facility. She said that they needed more care and she could not keep them.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on observation, record review and interview, the Assisted Living Facility failed to maintain an employment application in the personnel record for one of four sampled staff (Staff C).

Finding included:

Review of Staff C's personnel record showed that it did not have an employment application, with references.

On at 7:46 AM, the Administrator revealed that she had some changes with the staffing. Staff C worked in the facility since .

On at 7:54 AM, the Administrator revealed that she did not have job application for Staff C.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on interview and record review, the Assisted Living Facility (ALF) failed to file an initial adverse incident report with the agency within 1 business day and a full adverse incident report within 15 days of the incident for one out of five sampled residents (#1).

Findings included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969016	**02/20/2019**
NAME OF PROVIDER OR SUPPLIER **LAS DELICIAS ALF 2**	STREET ADDRESS, CITY, STATE, ZIP CODE **3840 NW 184TH ST MIAMI GARDENS, FL 33055**	

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

On at 7:40 AM, the Administrator revealed that none of the current or previous residents has in the facility. Resident #1 slipped in the facility but she did not ; she did not touch the floor. On further interview on at 9:27 AM, the Administrator revealed that one day the resident was resting on bed after lunch; the staff left the room and the resident had closed. The staff was in the hallway, heard something and found the resident against the closet. She did not go the hospital because she did not hit herself and did not , she did not go to the floor. Like 20 days later, she started to refuse eating, walking and getting out of bed. The facility sent her to the hospital. The Administrator called the resident's daughter who told her that the resident was improving and was discharged to a rehab. Then the resident's daughter told her that the resident had a according to the hospital.

Review of Resident #1's progress notes showed that:
- On , the resident was better. She got out of bed very fast 'because she had 's'. She slipped but she did not hit the ground. The facility watched her. She ate well and slept all night. The facility did not send the resident to the hospital because she did not show any symptoms of and slept all night. The facility continued watching her.
- On , "Today", she did not feel well. She could not open her . She went to the hospital.

Photographic evidence provided by Resident #1's daughter showed the resident had a . It was a bump to the right side of the forehead with a small opening. There was skin discoloration covering the right side of Resident #1's forehead and the upper and right side of the right . The discoloration showed that the area was purplish, yellowish and greenish.

Review of Resident #1's hospital record showed that the admission date to the hospital was on and she was discharged to a nursing home under hospice care on . The chief complaint description included of and of right . The resident had a right and right at the time of admission. The resident's daughter informed the hospital by phone that the resident had a at the ALF two weeks ago. The resident's grandson was at the bedside and informed the hospital that he was out of town but was notified a week ago that the resident at her ALF. When he returned and went to visit her, he found that the resident had on the right side of her , a right , was significantly weak, and had some right . She was mute and did not speak, also was bedridden. The of the right and the completed on showed that there was a no acute traversing the right . The was displaced. There was soft tissue . Discharge diagnoses included intracapsular of the right .

On at 1:43 PM, Staff D revealed that Resident #1 one day while she was on duty at lunch.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969016	**02/20/2019**
NAME OF PROVIDER OR SUPPLIER **LAS DELICIAS ALF 2**	STREET ADDRESS, CITY, STATE, ZIP CODE **3840 NW 184TH ST** **MIAMI GARDENS, FL 33055**	

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

The resident got out of bed with her cover, hit her forehead and had a bump. The resident did not lose . That incident happened 20 days before she went to the hospital. The incident happened between the 20th and . The Administrator sent the resident to the hospital because she did not want to eat or drink. During the resident's last days at the facility, she made some expressions. It looked like something bother the resident but she could not talk.

Review of the adverse incident report database showed that the facility did not file any adverse incident report with the agency.

Class III