STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968493	**04/08/2019**
NAME OF PROVIDER OR SUPPLIER **CLEON CORP FAMILY CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **10168 NW 128 TERRACE** **HIALEAH GARDENS, FL 33018**	

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

0000 - Initial Comments

A complaint (complaint #2019004048) investigation was conducted at Cleon Corp Family Care, Inc. from to . The facility had the following deficiencies identified at the time of survey:

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

Based on record review and interview, the facility failed to provide care and services to meet the needs of one of six sampled residents, (Resident #1). Resident #1, who had eight broken , received hospital care three days after expressing , .

Findings included:

Review of Resident #1's record showed the last health assessment dated had the following diagnoses of history of with no behavior, , , and , , . precautions and elopement risk. The resident needed supervision with ambulation, , and eating, and assistance with bathing and toileting. The resident required total care with grooming and transferring, and required 24 hour nursing or , care. Review of the facility's admission and discharge log showed Resident #1's admission date and discharge date to the hospital.

On , at 7:00 AM, Staff B stated, "Resident #1 never here. On , , she was well; she ate breakfast, took a bath; everything was fine. She sat on the recliner and asleep. Around 9:45 AM the resident started with the , , yelling and said she had , on the left side. I put her on the bed, removed her bra and made her comfortable; I called her daughter and the doctor and told them she had , ; we called 911 around 1:00 PM and the paramedics spoke to the daughter on the phone and she told them that she had , before. The paramedics did not take her to the hospital and told us to call an ambulance for her if we wanted to take her to the hospital but the daughter did not want us to and asked us to cancel the request. The next day on the fourth when she woke up, I tried to feed her breakfast but she did not take much; her doctor came and ordered a sonogram and test; we gave her soft food, soup and jello. That night Staff C had to stay with her all night; the doctor did not see anything wrong, that she had a lot of gases. On the sixth, the doctor said around 10:00 AM to 10:15 AM that she had , and I asked the doctor to speak to the daughter. The daughter took her to the hospital on the sixth; she did not want to call the ambulance." When Staff B was asked why the delay in calling 911, Staff B stated, "I was waiting for the daughter to come; I called 911 and the man said to call the regular ambulance to take the resident to the hospital. I called the ambulance but the daughter asked me to cancel it and said, 'If she needs to go to the hospital, I will take her.' Staff B further stated

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that they did rounds every 2 hours.

A review of hospital records showed Resident #1 was admitted on , . Hospital records showed the resident admitted to the emergency room on , an admission to the hospital and discharge date . CT abdomen and , with contrast exam showed that there was a discoid atelectasis at the left base (collapse). Trace , were present (fluid buildup between the and the wall). On the physician mentioned that showed minimal displaced of left from 4th to 7th and displaced right 6th to 9th, small , and at 4:44 PM- of - mildly displaced right 6th-9th . Small .

On , at 11:03 AM, the hospice nurse for another facility resident, who was present on , stated regarding Resident #1, "She was sitting on the recliner and she started complaining and holding her right side of her body and then the left side crying out in , from both sides. She stood up but she was still complaining and I told the staff to call the owners and let them know. I was with my patient, so I really do not know what happened after that."

On , at 11:25 AM, Staff C stated regarding Resident #1 "Everything was okay until the beginning of . I sleep here but I get up at night; when I hear the residents I will get up. That night I stayed awake all night with her because she had , ." At 1:30 PM, observed facility's video recording for the night before that showed the staff in the living room, sleeping, while a resident was walking on the hallway, the time was 11:30 PM. On , , at 4:37 PM, Staff C added, during a phone interview, "Resident #1 was complaining of , the entire day on Sunday , I took her to the bathroom and assisted her with a bath; after that, she laid down in the bed. She complained of , from Sunday to , ." Staff C was asked why the resident had a bed rail attached to the bed and stated that the resident never used it, that the rail was always down. She stated, "She was able to get in and out of bed by herself; she used to get up in the middle of the night by herself to go to the bathroom."

On , at 11:48 AM, Resident #1's daughter stated, "On , , Staff B called me to let me know that the doctor had ordered an ultra sound, test and . On Tuesday she called me again and said that my mom was doing better but she did not want to get out of bed and stated she had given her tea and did not complain of , . On , Staff B called me and told me that the doctor requested to take her to the hospital. At the hospital, they found high levels of CO 2 in her ; she had broken , four in each side, and a black . They took pictures and I did too."

On , at 2:30 PM, Resident #1's doctor stated, the resident had and , .

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The doctor added, "They told me that previous doctors said that she ; I do not remember if it was the facility or the daughter. I received a phone call from the owner on Sunday saying that the resident had a lot of . My assistant saw her on Monday for ; on Tuesday I received another phone call from Staff B stating that the daughter refused to have the resident transported to the hospital; the lab results showed she had problems with the ; I requested to take her to the emergency room as soon as possible. " On , at 10:00 AM, Resident #1's former physician who had been treating her from 2012 until her admission to the assisted living facility stated that the resident had no records of .

Review of the fire rescue report dated showed that resident had reduced mobility with no specific complaint, but a wellness check was requested. Upon assessment, paramedics were unable to determine the problem. The rescue offered the resident several times to transport the resident to the hospital for further medical evaluation but resident refused against medical advice. The Resident was advised to call 911 if anything changed or if she changed her mind.

Class II

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

Based on record review and interview the facility failed to submit an adverse incident report within one business day after the incident and within 15 days a full report of the incident to Agency for Health Care Administration (AHCA) for Resident #1. After experiencing three days of , Resident # 1 was transferred to the hospital on . Hospital records showed Resident #1 had displaced left 4th through 7th and right 6th-9th .

Findings included:

On at 4:29 PM, Resident # 1 was transferred to hospital. Hospital records showed resident had upper , with an elevated lipase (pancreatic) and admitted for acute pancreatic versus . On the hospital records showed Resident #1 had displaced left 4th through 7th and right 6th-9th .

A review of the Adverse Incident Report System showed that the facility did not file a report with the state the one business day after the incident or a 15 business day within the incident for Resident #1.

On at 7:35 AM, the Administrator acknowledged resident had , for several days before

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discharged to the hospital. He said, "I did not report the incident, Resident did not or injured at the facility."

Class III