Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967551	A. BUILDING: _____ B. WING _____	05/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN JEAN FACILITY CARE, INC	815 24TH STREET ORLANDO, FL 32805

(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 Complaint investigations #2020007874 and #2020007875 were conducted at San Jean Facility Care on and . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel	A 025		

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A 025	Continued From page 1 independently in the community. (d) Contacting 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. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow a health care provider's order for 3 of 7 sampled residents (#2, 3 and 6.) Finding: 1. Resident #2's record revealed a facility admission date of . A current 1823 health assessment form, dated , indicated that her diagnoses include , , and . A health care provider's order, dated , indicated the resident was to have a , evaluation and treatment. However, review of the resident's entire record revealed there was no documentation to indicate this order was ever followed. (photographic evidence obtained) At 10 a.m. on , the director of staff said the resident did not have a payer source and	A 025		

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A 025	Continued From page 2 therefore could not receive . However, the resident's record did not contain documentation to indicate this or to indicate any attempts were made to assist the resident with receiving . In addition, there was no documentation to indicate the facility notified the health care provider when the order could not be followed. The director of staff confirmed the lack of documentation. 2. Resident #3's record revealed a facility admission date of . A current 1823, dated , indicated that his diagnoses include right Acromioclavicular , and . A health care provider's order, dated , indicated the resident was to have an of his right . However, review of the resident's entire record revealed there was no documentation to indicate he ever had the done. (photographic evidence obtained) At 10:17 a.m. on , the administrative assistant reviewed the resident's record and she too could not find any related documentation. In the presence of the surveyor, she phoned a mobile , company then placed the call on speaker phone. When she asked the representative for , results, the representative said an , was not performed on resident #3. Hospital discharge instructions, dated , indicated the resident was to have his checked four times a day. Review of the resident's entire record, including his Medication Observation Record (MOR,) revealed there was no documentation to indicate his was checked. (photographic evidence obtained)	A 025		

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A 025	Continued From page 3 At 11 a.m. on [illegible], the administrative assistant reviewed the resident's record and she too could not locate any related documentation. She retrieved two flow sheets from another location and provided them as evidence of the resident's [illegible] being tested. However, documentation of the [illegible] results did not start until [illegible] which was nearly a month after the initial order. (photographic evidence obtained) 3. Resident #6's record revealed a facility admission date of [illegible]. A current 1823, dated [illegible], indicated that his diagnoses include [illegible]. Additional diagnoses in his record include [illegible] and Major [illegible] with behavioral disturbances. Health care provider's orders, dated [illegible], [illegible] and [illegible], all indicated the resident's [illegible] and [illegible] levels were to be checked. However, review of the resident's entire record revealed there was no documentation to indicate they were checked. (photographic evidence obtained) At 10:15 a.m. on [illegible], in the presence of the surveyor and while on speaker phone, the administrative assistant phoned the lab to request the [illegible] levels however, the lab representative said the resident did not have labs performed for those dates. A health care provider's order, dated [illegible], indicated the resident was to have his right cleaned with normal [illegible] and [illegible] A&D was to be applied daily for 7 days. However, the resident's record, including his [illegible] and [illegible] MORs, did not contain	A 025		

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A 025	Continued From page 4 documentation to indicate the treatment was ever done. (photographic evidence obtained) At 11:42 a.m. on , the administrative assistant reviewed the resident's record and MORs and she too could not locate any documentation to indicate he received the treatment as prescribed. Class III	A 025		
A 027 SS=D	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , , , , , , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to facilitate resident access to health care by failing to assist 3 of 7 sampled residents (#1, 2 and 5) in making a medical , , , , , , , , . Findings: 1. Resident #1's record revealed a facility	A 027		

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A 027	Continued From page 5 admission date of . A current 1823 health assessment form, dated , indicated that his diagnoses include and . A health care provider's order, dated , indicated "please evaluate and manage vision complaints." (photographic evidence obtained) An , examination, dated , indicated that he was diagnosed with and with worsening in his left . He was referred to an ophthalmologist. However, review of the resident's entire record revealed there was no subsequent documentation to indicate he was seen by one. (photographic evidence obtained) At 9:50 a.m. on , the administrator said it would have been the responsibility of the resident's guardian to facilitate an with an ophthalmologist. However, the resident's record did not contain documentation to indicate the facility had any communication with the guardian regarding the necessary follow-up or any documentation to indicate the facility made any attempts on their own to facilitate an . At 9:53 a.m. on , the director of staff reviewed the resident's record and she too could not locate any related documentation. 2. Resident #2's record revealed a facility admission date of . A current 1823 health assessment form, dated , indicated that her diagnoses include and . A health care provider's note, dated ,	A 027		

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A 027	Continued From page 6	A 027		

indicated the resident had a large that was becoming uncomfortable and a discussion was had with the guardian to follow-up with a surgeon. (photographic evidence obtained)

A health care provider's order, dated , indicated the resident was to see an outpatient surgeon for a large and a related note indicated the was now so large that the resident was very uncomfortable, and her guardian wanted her taken to an outpatient surgeon. (photographic evidence obtained)

Review of the resident's entire record revealed there was no documentation to indicate she was ever seen by an outpatient surgeon, as ordered.

At 9:56 a.m. on , the director of staff said she and an assistant to the resident's previous guardian both took the resident to a surgeon and were told that as long as the resident did not complain of , then nothing needed to be done. However, the resident's record did not contain documentation to indicate this occurred and the staff director could not remember the date of the , or the surgeon's name.

3. Resident #5's record revealed a facility admission date of . A current 1823, dated , indicated that his diagnoses include .

A facility note, dated , indicated that he had a and was sent to the hospital. (photographic evidence obtained)

Hospital discharge instructions, dated , indicated that he was seen for after possible activity.

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A 027	Continued From page 7 Hospital discharge instructions, dated , indicated that he was to follow-up with a . However, review of the resident's entire record revealed there was no subsequent documentation to indicate he was seen by one. (photographic evidence obtained) At 11:32 a.m. on , the director of staff reviewed the resident's record and she too could not locate any related documentation to indicate the facility made any attempts to facilitate an with a . Class III	A 027		