

Agency for Health Care Administration

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967551</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/07/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAN JEAN FACILITY CARE, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>815 24TH STREET<br/>ORLANDO, FL 32805</b>                                    |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                                  | Initial Comments<br><br>A Complaint Investigation #2022006311 was conducted at San Jean Facility Care, Inc. Assisted Living Facility with Limited Mental Health (LMH) on . . . . . The facility had a deficiency at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | A 000                                                                          |                                                                                                                          |  |                                                        |
| CZ821<br>SS=D                                                          | 59A-35.110( ) FAC Reporting Requirements; Electronic Submission<br><br>59A-35.110 Reporting Requirements; Electronic Submission.<br>(1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including:<br>(a) Insurance coverage renewal;<br>(b) Bond renewal;<br>(c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider;<br>(d) Annual sanitation inspections;<br>(e) Fire inspections.<br>(2) Electronic submission of information.<br>(a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at <a href="https://apps.ahca.myflorida.com/SingleSignOnPortal">https://apps.ahca.myflorida.com/SingleSignOnPortal</a> :<br>1. Nursing homes:<br>Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , which is hereby incorporated by | CZ821                                                                          |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967551</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/07/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAN JEAN FACILITY CARE, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>815 24TH STREET<br/>ORLANDO, FL 32805</b>                                    |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| CZ821                                                                  | Continued From page 1<br><br>reference and available at:<br><a href="https://www.flrules.org/Gateway/reference.asp?No=Ref-08777">https://www.flrules.org/Gateway/reference.asp?No=Ref-08777</a> , and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at:<br><a href="https://apps.ahca.myflorida.com/SingleSignOnPortal">https://apps.ahca.myflorida.com/SingleSignOnPortal</a> .<br><br>2. Assisted living facilities:<br>Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, _____, which is hereby incorporated by reference and available at:<br><a href="https://www.flrules.org/Gateway/reference.asp?No=Ref-08778">https://www.flrules.org/Gateway/reference.asp?No=Ref-08778</a> , and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at:<br><a href="https://apps.ahca.myflorida.com/SingleSignOnPortal">https://apps.ahca.myflorida.com/SingleSignOnPortal</a> .<br><br>3. Hospitals:<br>Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, _____, which is hereby incorporated by reference and available at:<br><a href="https://www.flrules.org/Gateway/reference.asp?No=Ref-08779">https://www.flrules.org/Gateway/reference.asp?No=Ref-08779</a> , and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at:<br><a href="https://apps.ahca.myflorida.com/SingleSignOnPortal">https://apps.ahca.myflorida.com/SingleSignOnPortal</a> . | CZ821                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967551</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/07/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAN JEAN FACILITY CARE, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>815 24TH STREET<br/>ORLANDO, FL 32805</b>                                    |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| CZ821                                                                  | <p>Continued From page 2</p> <p>4. Ambulatory Surgical Centers:<br/>Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, _____, which is hereby incorporated by reference and available at:<br/><a href="https://www.flrules.org/Gateway/reference.asp?No=Ref-08780">https://www.flrules.org/Gateway/reference.asp?No=Ref-08780</a>, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at:<br/><a href="https://apps.ahca.myflorida.com/SingleSignOnPortal">https://apps.ahca.myflorida.com/SingleSignOnPortal</a>.</p> <p>5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, _____, which is hereby incorporated by reference and available at:<br/><a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-12123">http://www.flrules.org/Gateway/reference.asp?No=Ref-12123</a>, and through the Agency's Single Sign On Portal located at:<br/><a href="https://apps.ahca.myflorida.com/SingleSignOnPortal">https://apps.ahca.myflorida.com/SingleSignOnPortal</a>.</p> <p>6. For the purposes of this rule, the following applies for submitting adverse incident reports:</p> <p>a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S.</p> <p>b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident.</p> <p>c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident.</p> | CZ821                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967551</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/07/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAN JEAN FACILITY CARE, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>815 24TH STREET<br/>ORLANDO, FL 32805</b>                                    |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| CZ821                                                                  | <p>Continued From page 3</p> <p>d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later.</p> <p>e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to \$50 per day late not to exceed \$500.</p> <p>(b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission.</p> <p>(c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored.</p> <p>This Statute or Rule is not met as evidenced by: Based on facility record review, resident record review and interview, the facility failed to submit electronically the 15-day Adverse Incident report #575331 as required to the Agency for Health Care Administration (AHCA) after the occurrence of the incident and the 1-day Adverse Incident report was submitted.</p> <p>Findings:</p> <p>Resident #1's record review revealed admission date . . . . . His last 1823 Health Assessment dated . . . . . listed medical history of . . . . . type 1, and . . . . . He needed assistance with Activities of Daily Living (ADLs) with . . . . . grooming, and transferring as well as he needed assistance with self-administration of medication.</p> | CZ821                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967551</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/07/2022</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**SAN JEAN FACILITY CARE, INC**

**815 24TH STREET  
ORLANDO, FL 32805**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| CZ821                    | <p>Continued From page 4</p> <p>On ..... at approximately 7 AM, resident #1 slipped and ..... on the ground at the facility by accident, resulting in a ..... injury.</p> <p>A facility note documented on ..... that when resident #1 was asked what happened? He stated that he tripped and ..... The facility called 911 and resident #1 was transported to the hospital, and the legal Guardian and physician were notified immediately.</p> <p>On ..... at 3:28 PM, the 1-day Adverse Incident report #575331 was electronically submitted and accepted by the agency.</p> <p>(Photographic Evidence Obtained)</p> <p>A facility note documented on ..... at 10 AM, the legal Guardian called the facility informing that resident #1 will need surgery and rehabilitation with a higher level of care in a nursing home. Resident #1 will not be returning to the facility.</p> <p>There was no evidence that the 15-day Adverse Incident report #575331 was electronically submitted to the agency timely and required.</p> <p>On ..... at 2 PM, an interview with the Assistant Administrator confirmed the finding.</p> <p>Unclassified</p> | CZ821               |                                                                                                                          |                          |