STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967551	09/06/2016
NAME OF PROVIDER OR SUPPLIER SAN JEAN FACILITY CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 815 24TH STREET ORLANDO, FL 32805	

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

0000 Initial Comments

On a biennial re-licensure survey including Limited Mental Health was conducted at San Jean Facility Care, Inc. Assisted Living Facility License Number 11563. Deficient Practice was identified during the survey.

0008 Admissions - Health Assessment

Based on record review and interview, the facility did not ensure the Health Assessment (form 1823) was accurate and fully completed by the health care provider for 1 of 3 sampled records (#1).

Findings:

Review of the Health Assessment/1823 for resident #1 dated revealed that the resident was bedridden and required total care for ambulation and toileting. The resident is not receiving Hospice services. His previous 1823 dated / , which was used to admit him to the facility omitted the type of assistance needed for medications, type of diet required, if he was an elopement risk, and did not indicate if his needs could be met in an assisted living facility. Neither Health Assessment was complete or accurate.

Observation of Resident #1 on / revealed a resident seated in the lounge in a wheelchair, dressed and wearing sunglasses. Staff do wheel him around the facility due to his . In an interview with the resident at 10:55AM on / , through caregiver translator, he stated that he can do everything for himself, but the staff does give him his medicines. Caregiver told me she was always impressed that, in spite of being , his clothes always match. At 12:15 pm, the resident was observed eating lunch without assistance.

In an interview with the administrator on at 3:45pm, he stated he was not aware there was incorrect or missing information on this resident ' s health assessment form.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observations and interview, the facility did not treat the residents with consideration, individuality and due recognition of personal dignity by locking residents who were not elopement risk and/or inside of the facility without providing an access card to enter or exit.

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Findings:

Observations on / at 9:15 AM, the entrance of the facility had a gate to enter and exit the premises, a staff would have to open the gate for entry into the facility premises. Further observations revealed the facility had two buildings on the property. Both buildings were secured, all entrance and exit doors remained locked and would require a staff with an access card to unlock the doors.

During interviews with Residents on / at 9:30 AM, it was revealed that some felt that they were in jail, because they would have to ask staff at all times to let them outside of the building and when they were ready to return inside they would have to wait for a staff to let them back in the building.

On at 3 PM the administrator said, there were residents who would wander around the parking lot and may not know they needed to move when cars entered. He said the facility needed the locks on the door also, because there were residents who would try to leave. The administrator identified only 2 elopement risk residents. The other 48 residents who resided at the facility were not identified as elopement risk. There were no resident's identified by the administrator as being Limited Mental Health residents or . The administrator said there were only two residents who he felt were capable of having an access card because they signed themselves in the facility. The administrator said the Local Fire Marshal was aware that the locks were placed on the door.
Review of the fire inspection report dated / revealed the facility received a violation that noted the following:
Provide permit for Controlled Access Doors (Mag Locks) Apply for permit at the office of the Fire Marshal (the address was listed). Provide approval from the Fire Marshal Office.
On / at 8:15 AM a telephone call was made to the Fire Marshal's office and the representative said the facility was told they were required to remove the locks on the doors because they did not receive a permit for the locks. She said she would be going back on / to see if the locks were removed.
A review of the fire inspection report dated / at 9:35 AM noted: Provide permit for Controlled Access Doors (Mag Locks) Apply for permit at the office of the Fire Marshal (the address was listed). Provide approval from the Fire Marshall Office.
Remove mag locks immediately, until permit for locks are approved by the Fire Marshal's office.
Class III

0054 Medication - Records

Based on Medication Observation Record (MOR) review and interview, the facility failed to maintain an accurate MOR's for 1 of 2 sampled residents (#2).

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Findings:

On / at 11 AM, resident #2 said she had been out of her for 5 days.

Review of the MOR for for resident #2 revealed there were staff initials on the MOR on / through / at 8 AM and 8 PM and at 8 AM for 8 milligrams 2 mg film dissolve 1/2 film twice a day.

On / at 12:30 PM, the administrator ' s assistant said she was responsible for ordering the medication, she said the resident was out of the medication and it was going to be delivered in the evening. She said the medication was late because it was not ordered until Saturday and Monday was a holiday. The administrator ' s assistant reviewed the MOR that was initialed daily and said she did not know why the staff initialed the MOR when the medication was not given.

On / at 12:35 PM resident #2 was present and said she was not out of medication for 5 days like she originally said. She further stated she had been out since / .

On / at 2 PM staff F reviewed the MOR and said his initials were on the MOR for / at 8 AM, He said he did not give the medication and made a mistake by initialing the MOR when the medication was not given.

Class III

0056 Medication - Labeling and Orders

Based on the medication observation record (MOR) review, record review and interviews the facility did not make every reasonable effort to ensure that prescriptions were refilled in a timely manner for 1 of 2 (#2) sampled residents who received assistance with self-administration of medications.

Findings:

On at 11 AM, resident #2 said she had been out of her for 5 days.

Review of the MOR for for resident #2 revealed there were staff initials on the MOR on / through / at 8 AM and 8 PM, and / at 8 AM for 8 milligrams 2 mg film dissolve 1/2 film twice a day. There was no documentation that the resident was out of the medications.

On / at 12:30 PM, the administrator ' s assistant said she was responsible for ordering the

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medication, she said resident #2 was out of the medication and it was going to be delivered in the evening. She said the medication was late because it was not ordered until Saturday and Monday was a holiday. She said the facility policy was to order the medications 3 days before it was to run out and the staff did not notify her that the medication was out. The administrator ' s assistant reviewed the MOR that was initialed daily and said she did not know why the staff initialed the MOR when the medication was not given.

On / at 12:35 PM Resident #2 was present and said she was not out of medication for 5 days like she originally said she said she had been out since / .

on / at 2 PM-Staff F said resident #2 was out of the medication, he said the medication was a film and it was hard to determine when the medications were out until it was the last film, because there were other papers in the container with the film.

Class III

0078 Staffing Standards - Staff

Based on personnel record review and interview, the facility failed to obtain for 4 of 4 staff (B, C, D and E) a statement from his health care provider documenting freedom from ( ) annually and an accurate Freedom from Communicable Statement for 1 of 4 staff (D).

Findings:

Personnel record review for staff E (the administrator), revealed the last documentation to confirm he was free from was dated / (due 2/1/6).

On / at 4 PM, staff E confirm he did not have his annual statement.

Staff B's date of hire and the personnel record review revealed that the annual examination was last completed on (due).

Staff C's date of hire / and the personnel record review revealed that the last annual examination was on / (due / /).

Staff D's date of hire on and the personnel record review revealed no evidence of a written physician statement that staff was free from signs & symptoms of communicable . Furthermore, the review revealed no evidence that annual examination was completed.

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An interview on at 2 PM with the administrator who confirmed the findings.

Class III

0079 Staffing Standards - Levels

Based on the facility's staff work schedule, personnel record review, and interview, the facility failed to ensure that 1 of 5 sampled staff (D) holds a current card of completion for First Aid and ( ) who works alone on the overnight shift hours of 5pm to 7am in one of the two facility buildings.

Findings:

Facility's staff work scheduled dated week of revealed that staff D works the overnight shift (3rd) from 7pm to 7am for 6 days alone in one of the two buildings.

Staff D's personnel record review revealed no documentation that the First Aid and was completed.

An interview on at 2 PM with the administrator who confirmed that he was not aware that staff D did not have First Aid and and was working alone on 3rd shift.

Class III

0081 Training - Staff In-Service

Based on personnel record review and interview, the facility failed to ensure staff completed the required in-service training within 30 days of employment.

Findings:

Staff A's date of hire was on , and the personnel record review revealed no documentation that staff in-service training was completed by the administrator within 30 days of hire for the following trainings listed below:

1-hour emergency preparedness & evacuation training; reporting major & adverse incidents; and nutritional & safe food handling.

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An interview on at 2 PM with the administrator who confirmed the findings.

Class

0082 Training -

Based on personnel record review and interview, the facility failed to ensure that 3 of 5 sampled staff (A, B, and C) completed the one-time education course in (/).

Findings:

Personnel record review for staff A, B, and C revealed no evidence or documentation that the one-time education course on and was completed.

An interview on at 2 PM with the administrator who confirmed the findings.

Class III

0090 Training -

Based on personnel record review and interview, the facility failed to ensure that 1 of 5 sampled staff (A) completed 1-hour of the ( ) training within 30 days after employment.

Findings:

Staff A's date of hire was on , and the personnel record review revealed no documentation on file that 1-hour training was completed within 30 days of hire .

An interview on at 2 PM with the administrator who confirmed the findings.

Class

0160 Records - Facility

Based on review of the Admission and Discharge Log and interview, the facility did not maintain an accurate and up to date Log.

Findings:

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Review of the Admission and Discharge log revealed there were residents listed who were no longer residing he the facility.

In an interview with the administrator on at 3:45 pm, he stated the two residents in question no longer resided at the facility. He was unsure of what dates they left.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
San Jean Facility Care, Inc
815 24th Street
Orlando, FL 32805

RE: Re-licensure w/LMH

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Théresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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