STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967551	03/21/2017
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

Complaint Investigation #2017001778 was conducted on , , and . San Jean Facility Care, Inc. with Limited Mental Health (LMH), License #11563, had deficiencies at the time of the visit.

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on observation, record review and interview, the facility failed to ensure appropriate supervision and care for high risk elopement residents for 1 of 6 sampled residents (#2), failed to assess all 3 high risk elopement residents for daily identification for (#1, 3 & 6), and failed to file a 1-Day and 15-Day Adverse Report for 1 of 6 sampled residents (#2).

Findings:

1. Resident #2's record revealed a dated AHCA Health Assessment form reflecting special precautions of "Risk for Elopement", and the need for assistance with self-administration of medications.

Resident #2's notes reflected the resident eloped on at 11:30 PM, and returned to the facility by local police on the morning of . The resident did not take medication for 3 days while away from the facility. A second elopement occurred on at 1 PM.

The 1-Day Adverse Incident report, filed on by the administrator, read, "The resident right after lunch step out with the other residents and went to the back of the building and jumped over the 6 ft (foot) metal fence. I already call law enforcement and also spoke to his daughter at 12:15 PM the same day and I make sure the resident when he return to the facility will not be able to step out the door with out proper supervision at the time."

The 15-Day Adverse Incident report filed on by the administrator read, "The resident right after lunch step out with the other residents and went to the back of the building and jumped over the 6 ft metal fence. I already call law enforcement and also spoke to his daughter at 12:15 PM the same day and I make sure the resident when he return to the facility will not be able to step out the door with out proper supervision at the time. I already put in place more supervision specially for elopement risk one like (resident #2). I already talked to the staffs and make sure we all on the same page."

For the second elopement, 3 weeks after the first elopement on at 1 PM, there was no documentation of the 1-Day and 15-Day Adverse incident report or supporting documentation in the resident's record as being submitted and filed to AHCA as required by 429.23 (3) and (4), Florida Statute

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and 58A-5.0241, Florida Administrative Code.

Review of the facility's Elopement Policy and Procedures revealed that for all identified high elopement risk residents, the facility must ensure each elopement risk resident has identification on their person, including their name, and the facility's name, address, and telephone number.

2. On at 1 PM, residents #1, #3, and #6, identified as high risk elopement residents, did not have any identification on them, and no identification was found their .

On at 2:20 PM, the administrator confirmed all the findings.

Class II

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

Based on the admission and discharge log and interview, the facility failed to ensure that 2 of 6 sampled residents were listed and updated on the log (#4 & 5).

Findings:

Review of the facility's admission and discharge log on revealed that resident #4 and resident #5 were not listed and unknown of admission dates and discharge dates.

On at 12:30 PM, caregiver A confirmed that resident #4 and #5 were not listed on the admission and discharge log.

On at 2:20 PM, the administrator confirmed the findings.

Class III

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

Based on record review and interview, the facility failed to submit a 1-Day and 15-Day Adverse Incident Report as required by 429.23 (3) (4) Florida Statute and 58A-5.0241 Florida Administrative Code for 1 of 6 sampled residents (#2).

Findings:

Resident #2's record's observation notes reflected that an elopement occurred on at 1 PM,

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resulting in local police being called and resident #2 being . Documentation for the 1-Day and 15-Day required Adverse Incident Report was found in the resident's record.

On at 11:30 AM, administrator's assistant F and registered nurse E confirmed that they were unable to locate the Adverse Incident Report for .

On at 2:20 PM, the administrator confirmed the finding.

Unclassified