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
	AL11965366	A. BUILDING: _____ B. WING _____	R-C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLOAN HOME OF CENTRAL FL INC	307 S HIAWASSEE RD ORLANDO, FL 32835

(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 A revisit survey for complaint investigation #2023018324 was conducted at Sloan Home of Central FL on . The facility had uncorrected deficiencies at the time of the survey.	{A 000}		
{A 032} SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary.	{A 032}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 032}	Continued From page 1 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to make a daily effort to ensure 1of 1 sampled residents who was identified as being at risk for elopement had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#1); the facility failed to have documentation that 4 of 4 sampled staff participated in a minimum of two resident	{A 032}		

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{A 032}	Continued From page 2 elopement drills each year (A, C, Owner, Administrator). Findings: 1. Review of Resident #1 record review revealed a Health Assessment Form (1823) indentified the resident as an elopement risk. A review of Resident #1's Progress Notes and Medication Observation Records did not reveal a daily effort was made to ensure the resident had Identification on his person. On at 2:30pm the Owner stated, " no, we did not put an ID on him or make a daily effort." 2. Review of personnel records revealed Unlicensed Caregiver A was hired on , Unlicensed Caregiver C was hired on , the Owner on , and Administrator on . Review of the , , and resident elopement drills revealed no documentation the Owner or Administrator participated. The Owner was asked if any drills were conducted in 2023 or after the event of Resident #1 elopement on ? On at 12:45pm, the Owner stated, " I haven't done any for 2024 and did not do any drills when Resident #1 got out. The facility's undated Elopement Policy and Procedures states, "Communicate elopement risk	{A 032}		

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{A 032}	Continued From page 3 to the care giving staff upon hire and conduct in-services and drills 2 times a year regarding policy/procedures in recognizing and preventing elopement." On at 1:35pm upon reviewing the facility's undated Elopement Policy with the Owner, she stated as she mumbled, "yea, I know the policy." On at 2:30pm the Owner confirmed the findings and provided no additional drills. Class III	{A 032}		
{A 161} SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable:	{A 161}		

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{A 161}	Continued From page 4 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ⌄ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure the record for 1 of 2 sampled staff contained a copy of the employment application, with references furnished. (C) Findings:	{A 161}		

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{A 161}	Continued From page 5 Review of Caregiver C's record, revealed a hire date on . . . . . , revealed the record did not contain an employment application and references. A review of the , staff schedule revealed a name other than the documentation provided. Caregiver C was contacted via phone to verify employment and her name as it appears on the background roster. On at 1:20pm the Owner stated, "no, I don't have an application with references for Caregiver C. I ran out of the applications and the store did not have any. I haven't had a chance to get any. Yes, that is Caregiver C's nickname on the schedule. On . . . . . at 1:30pm Caregiver C stated the name on schedule is my nickname, but the name listed on my trainings is my legal name. Caregiver C confirmed the findings and stated, "No I did not complete a job application with references. On at 2:30pm the Owner confirmed the findings. Class III	{A 161}		