AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965366	04/11/2016
NAME OF PROVIDER OR SUPPLIER **SLOAN HOME OF CENTRAL FL INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **307 S HIAWASSEE RD** **ORLANDO, FL 32835**	

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

0000 Initial Comments

The Abbreviated Relicensure Survey was conducted on / . Sloan Home of Central Fl Inc Assisted Living Facility had deficiencies at the time of the visit.

0010 Admissions - Continued Residency

Based on record review and interview the facility failed to obtain a new Health Assessment (AHCA form 1823) every three years for 1 of 1 sampled residents (#1).

Findings:

Record review for Resident #1 revealed the last AHCA form 1823 available for review was dated (due).

On / at 2 PM, the owner said she would have to get a new AHCA for 1823 completed for Resident #1.

Class

0025 Resident Care - Supervision

Based on record review and interview the facility failed to provide medications according to the health care providers orders, gave over the counter medication without the approval of the health care provider and did not contact the Health Care Provider when 1 of 1 sampled resident became ill (#1).

Findings:

During the tour of the facility on / at 9:15 AM, there was a strong odor in the Resident #1.
Staff D said on / at 9:AM that Resident #1 had last night and was sick. Staff D said she was just finishing up with cleaning of her .
On / at 11:15 AM, Resident #1 said she continued to have and had an accident while she slept.
Observations at 11:40 AM, revealed Staff D removed a box of Over the Counter Lopermide 2 milligrams tablet (Anti medication) and handed Resident #1 a pill and the resident was observed taking the medication.
On / at approximately 11:45 AM, the owner was asked if the health care provider had prescribed the Over the Counter Anti medication for Resident #1. The provider said the health care

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965366	04/11/2016
NAME OF PROVIDER OR SUPPLIER SLOAN HOME OF CENTRAL FL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 307 S HIAWASSEE RD ORLANDO, FL 32835	

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

provider had not been contacted and they kept the over the counter Anti medication for resident's if they needed it.
On / at 12:30 PM, the owner said she had just contacted the health care provider to make him aware of Resident #1 having with a very strong odor. She said the health care provider said he would send a prescription to the pharmacy but recommended the resident go to the hospital because of the number of times she had the episodes of and the strong odor. The resident said she did not want to go. She wanted to take the prescription medication.
Observations on / at 2:10 PM during Medication Pass revealed a prescription bottle of 100 Milligrams (mg) 3 times daily as needed for Pain. Staff D told resident #1 it was time to take her . The resident said she did not want to take it. Staff D told her she needed to take her medication and Staff D gave Resident #1 the . Review of the Medication Observation Record (MOR) revealed it noted 100 mg 3 times daily and the staff had initialed that the Medication was given 3 times daily at 8AM, 2 PM and 8 PM not as needed.
Record Review for Resident #1 revealed a Resident Health Assessment Form 1823 that was dated that health care provider noted 100 mg 3 times daily as needed for pain.
Staff D was informed at the time that the was only needed if the resident requested it for pain, Staff D stated she gave it three times daily as a routine medication.
On / / at 3 PM the owner was asked to call the health care provider for clarification of the order.
On / at 3 PM a telephone interview was conducted with Resident #1's health care provider, he said the 100 mg was to be given 3 times daily only if the resident was in pain and the order was correct.

Class III

0052 Medication - Assistance with Self-Admin

Based on observations and interview the facility failed to ensure when unlicensed staff provided assistance with the self-administration of medications, the staff followed the appropriate procedure at all times.

Findings:

Observations on / at 2:10 PM during Medication Pass revealed Staff D removed the medication for the medication Cart and told Resident #1 here is your . Staff D did not follow the proper procedure when providing assistance with the assistance of self-administration of medication. She did not in the presence of the resident, read the label, open the container, remove the prescribed amount of medication from the container and provide it to the resident.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965366	04/11/2016
NAME OF PROVIDER OR SUPPLIER **SLOAN HOME OF CENTRAL FL INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **307 S HIAWASSEE RD** **ORLANDO, FL 32835**	

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

On / / at 2:30 PM, Staff D said she did not read the label.

Class III

0054 Medication - Records

Based on review of the Medication Observation Record (MOR) and interview the facility failed to maintain an accurate and up to date MOR for 4 of 4 sampled residents (#1, #2, #3 and #4).

Findings:

During the Medication Pass on / / at 2:10 PM, Staff D after giving Resident #1 her medication was observed signing the MOR for the date of . Staff D was asked at the time why did she sign the MOR for and the date was / . Staff D stated at the time she thought the date was and begin initialing the blank spaces on the MOR.
Review of the MOR's for Resident's #1, #2, #3, #4 and #5 revealed the spaces were left blank on the MOR and there was no explanation why as follows:

Resident #1
100 Milligrams (mg)-1- 3 times at 8AM, 2 PM and 8 PM was left blank on / At 8AM, 2 PM and 8 PM and at 8 AM on / /
100 mg 1 a day was left blank at 6 AM on
The medications below were all left blank on / at 8 AM
15 mg 1 daily, 5 mg 1 daily
1 daily
1 daily
30 mg 1 daily

Resident #2
/ / at 8 PM for the following medications were left blank:
30 mg PO, 1 tab at bedtime
150 mg 1 tab at bedtime
500 mg 1 cap twice a day
75 mg 1 tab daily
Diskus, 1 puff twice daily
Metroprolol 100 mg, 1 tab twice daily

/ at 8AM for the following medications were left blank:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965366	04/11/2016
NAME OF PROVIDER OR SUPPLIER **SLOAN HOME OF CENTRAL FL INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **307 S HIAWASSEE RD** **ORLANDO, FL 32835**	

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

Hydrochlorot/ 25 mg/125 mg, 1 tab daily
25 mg, 1 tab daily for itching
500 mg 1 cap twice daily for seven days
Cabonate ER 300 mg, 1 tab daily
Diskus 1 puff twice daily
100 mg, 1 tab twice daily

Resident #3
at 8 PM were left blank-Vesicare 5 mg 1 twice daily, Tabs 8.6 mg 2 daily; 80 mg 1 at bedtime
/ / at 8 AM these medications were left blank Vesicare 5 mg 1 twice daily; ER 20 MEQ 1 daily, 50 1 daily,
300 mg 1 3 times daily

Resident #4
/ 8 PM medications all left blank- 160 mcg/4.5 mcg 2 puff daily 0.25 mg 1 twice daily and 0.5 mg twice daily was also left blank at 2 PM
/ / at 8 AM-Divalporex DR 125 mg 125 MG 1 twice daily at 8 am was left blank only the 8AM dosages were on the MOR the second dosages were not listed on the MOR.

On / / at 2:30 PM, Staff D said the residents did receive their medications on and and she did not sign the MOR. She said Resident #4 did get the second Dosage of Divalporex and she did not list it on the MOR. She provided the package of Divalporex for the second dosage that was marked night and it was given.

Class III

0055 Medication - Storage and Disposal

Based on observations, medication review and interview the facility did not make sure all medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times, out of sight of all residents and did not disposed of abandoned, expired medications.

Findings:

Observations during the tour on / at 9:15 AM, revealed in # there was a bottle of +D 600 mg, E-100 IU and all 30 Senior with Lutein and Lycopene and medicated chest rub sitting on a table in the , the door was unlocked and the resident was not in his .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965366	04/11/2016
NAME OF PROVIDER OR SUPPLIER SLOAN HOME OF CENTRAL FL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 307 S HIAWASSEE RD ORLANDO, FL 32835	

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

Review of the Medications that were in the bottom of the medication cart on / at 11:30 AM revealed there was expired medications as follows:
5- 2-pill packages of 200 mg-2 of the packs had expired on ; 2 of the packs had expired and 1 expired ;
4 packs of - 2- pill pack all expired on
Bayer extra strength 500 mg 2 pill pack expired
2 boxes of 3% that had expired / /
In the top drawer was Advanced relief eye drops expire in
There were 3 bottles of 5 mg that did not have prescription labels

On / at 12 PM, the owner said the medications were removed from Resident #2's she was not aware that the medications had expired. She said the Bottles of 5 mg belonged to a resident who was

Class III

0056 Medication - Labeling and Orders

Based on observations and interviews the facility failed to maintain a label Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., for sample or complimentary prescription drugs that are dispensed by a health care provider.

Findings:

Observation on / at 11:30 AM revealed in the bottom drawer of the medication cart there were 2 complimentary boxes of 75 Milligrams (mg) with 14 tablets in each and 3 bottles of 5 mg that did not have prescription labels or a labels containing:
1. Practitioner's name;
2. Resident's name;
3. Date dispensed;
4. Name and strength of the drug;
5. Directions for use; and
6. Expiration date.

On / at 12 PM, the owner said the health care provider brought in the 75 mg tablets to the facility and she did not know who they belonged to. She said the 5 mg belonged to a resident who was .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965366	04/11/2016
NAME OF PROVIDER OR SUPPLIER SLOAN HOME OF CENTRAL FL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 307 S HIAWASSEE RD ORLANDO, FL 32835	

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

Class III

0057 Medication - Over The Counter (OTC) Products

Based on observations and interview the facility maintained Over the Counter (OTC) products in a stock supply for multiple residents use which is not permitted in the facility.

Findings:

Observations at 11:40 AM, revealed Staff D removed a box of Over the Counter Lopermide 2 milligrams (mg) tablet (Anti medication) and handed a pill to Resident and the resident was observed taking the medication.
Observation of the centrally stored medication cart revealed in the top drawer there was two boxes of Lopermide tablets-2 mg Anti- medication and a bottle of Tables that did not have any resident's name on them.
Further Observations of the medication Cart revealed there was other OTC medications that did not have a Resident's name on the container in the cart as follows:
Mucus Relief
Stress Formula
Baby Rub soothing ointment.
Night time sleep aid 50 mg

On / / at 12 PM, the owner said the above medications were purchased for residents if they needed them, they did not belong to any resident. She said the Night Time Sleep Aid 50 mg belonged to Staff D.

Class III

0078 Staffing Standards - Staff

Based on personnel record review and interview the facility failed to obtain an annual statement from a health care provider documenting freedom from ( ) for 1 of 4 sampled staff (D).

Findings:

Personnel Record review for Staff D hired in , revealed the last documentation to confirm she was free from was dated / (due / and).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965366	04/11/2016
NAME OF PROVIDER OR SUPPLIER SLOAN HOME OF CENTRAL FL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 307 S HIAWASSEE RD ORLANDO, FL 32835	

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

On / at 3:46 PM, the owner said Staff D had her test conducted and she did not have it with her. She was given the opportunity to provide it to the agency and it was not received.

Class III

0083 Training - First Aid and

Based on personnel record review and interview, the facility failed to have one staff member who held a currently valid card that documented the completion of courses in First Aid and was in the facility at all times.

Findings:

On / at 9 AM, Staff D was observed working alone with the Residents.
Personnel Record review for Staff D revealed her First Aid Card expired on .

On / at 3:44 PM, the owner said she knew that Staff D's First Aid Card had expired on 4/3.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on personnel record review and interview, the facility failed to have evidence that 2 of 4 sampled unlicensed staff (C and D), who provided assistance with the resident's medications received the initial 4 hours training in providing assistance with self-administration of medications and safe medication practices in an Assisted Living Facility (ALF).

Findings:

On / / at 10:45 AM during a telephone interview Staff C said she assisted with the Self-Administration of the Resident's Medications.
On / at 11 AM Staff D was observed Assisting with the Self-Administration of a Resident's medication.
Personnel Record review for Staff C and D revealed there was no documentation to confirm they had received the initial 4 hours training in providing assistance with self-administration of medications and safe medication practices in an Assisted Living Facility (ALF).
The owner provided a certificate titled "Medication Technician training" for 4 hours dated / .
On / at 3:40 PM, the owner said Staff C did have the training and she did not bring her the paper

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965366	04/11/2016
NAME OF PROVIDER OR SUPPLIER SLOAN HOME OF CENTRAL FL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 307 S HIAWASSEE RD ORLANDO, FL 32835	

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

work and she thought the "Medication Technician" training was the correct training.

Class III

0093 Food Service - Dietary Standards

Based on menu review, observations and interview, the facility did not maintain dated menus as served, did not maintain non-perishable milk and Fruits to be used in the event of an emergency for the 4 residents of the facility.

Findings:

Review of the menus revealed there were no menus available for review for the following dates:
25 Through /
/ and /
27 through /
24 through /
28 and /
27 through /
Further review of the Menus at the top noted the Month on each one
On / at 12:45 PM-the owner said the facility used 4 cycled menus. She said she did not know that at the end of the month she could start over and use the cycle 1 menu and then go use cycle 2 even though it was the first week of the month. She thought the cycled menus meant the week of the month and the menus had to be used according to the monthly calendar. She said if it was the first week of the month she used cycle 1, if it was the second week she used cycle 2, if it was the 3rd week of the month she used cycle 3 and if it was the 4th week of the month she used cycle 4. She said because there was no cycle 5 menu for months having 5 weeks, she would use cycle 1 for the few days remaining at the end of the previous month and when the 1st week of the month would begin she would use the same cycle 1 menu again for the first week because it was the first week of the month. This meant the cycle 1 menu was used twice in one week. for the above dates that were missing.

Observations of the emergency food supply on / at 12:15 PM revealed there was only 192 ounces of non-perishable milk sources and 288 were required (24 ounces a day x 3 days' x 4 residents).
There was only 68 ounces of non-perishable Fruit and 192 ounces were required (16 ounces a day x 3 days' x 4 residents).
On / at 12:30 PM the owner said she would have to purchase more milk and fruit.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965366	04/11/2016
NAME OF PROVIDER OR SUPPLIER **SLOAN HOME OF CENTRAL FL INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **307 S HIAWASSEE RD** **ORLANDO, FL 32835**	

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

0152 Phvsical Plant - Safe Living Environ/Other

Based on observations and interviews, the facility failed to provide and maintain a home-like and decent environment in which to provide for the safe care of the residents.

Findings:

Observations during the tour on / at 9:15 AM, revealed # had peeling wallpaper, the to # had paint peeling behind the commode. A black substance on the ceiling and wall next to the commode and wall paper was peeling.
Bed # had a broken mini next to the bed that was on the left, there was a black substance that covered the window panes and the mini blinds on both windows that were in the .
On / at 10:45 AM, the owner said she had just replaced the roof and was working on other repairs.

Class III

0160 Records - Facility

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

Findings:

During an interview with Staff D on / / at 9 AM, she said there were 5 residents who resided at the facility and 1 of the residents was in a Rehabilitation center. Staff D provided the names of the Residents.
Review of the Admission and Discharge log revealed there were residents listed who were no longer residing in the facility. Resident #4 was not listed nor was the resident who was currently in the Rehabilitation Center.
On / at 9:55 AM, the owner said the Admission and Discharge Log was not accurate and there were residents who no longer lived at the facility listed. She confirmed two current residents were not listed also.

Class

0161 Records - Staff

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965366	04/11/2016
NAME OF PROVIDER OR SUPPLIER **SLOAN HOME OF CENTRAL FL INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **307 S HIAWASSEE RD** **ORLANDO, FL 32835**	

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

Based on personnel record review and interview, the facility failed to obtain a copy of the employment application with references for 2 of 4 sampled staff (C and D).

Findings:

Personnel record review for Staff C hired , revealed there was no employment application with references available for review. Personnel record review for Staff D hired in revealed there were no reference listed on her application.
On / at 3:46 PM, the owner confirmed the above findings.
Class III

Z814 Background Screening Clearinghouse

Based on the personnel record review, the Agency's Background Screening Website and interview, the facility did not initiate all Criminal history checks through the clearinghouse before employment and failed to report changes within 10 business days.

Findings:

On / / at 1 PM, the owner said there were 4 employees that worked at the facility.
Review of the Agency's Background Screening website on / at 3:20 PM revealed there were 4 employees listed on the facility's Employee's Roster that were no longer employed at the facility. Staff C and D were not listed.

On / at 4 PM, the owner reviewed the Background Screening Clearinghouse Employee Roster and said Staff C and Staff D were no listed and confirmed the 4 employees that were listed were no longer employed and the Roster was not updated.

Unclassified

Z815 Background Screening: Prohibited Offenses

Based on personnel record review and interview, the facility failed to ensure that 2 of 4 sampled staff (C and D) were in compliance with background screening requirements.

Findings:

Personnel record review for Staff C hired revealed there was no Level II background screening

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965366	04/11/2016
NAME OF PROVIDER OR SUPPLIER **SLOAN HOME OF CENTRAL FL INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **307 S HIAWASSEE RD** **ORLANDO, FL 32835**	

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

found in her record.
Review of the Agency's Background Screening website on / / at 3:20 PM revealed for Staff C it noted "Screening in Process Finger; Prints rejected."
Personnel Record review for Staff D revealed her last background screening results were dated / / (More than 5 years)
Review of the Agency's Background Screening website on / / at 3:20 PM revealed for Staff D it noted "New Screening Required."
On / / at 4 PM, the owner said she was not aware the screenings were not done.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2016

Administrator
Sloan Home Of Central Fl Inc
307 S Hiawassee Rd
Orlando, FL 32835

RE: Abbreviated Re-licensure

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,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

XG90

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com