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
	AL11969198	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE AT OAKLEAF	417 OAKLEAF PLANTATION PKWY JACKSONVILLE, FL 32222

(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 complaint survey (complaint number 2022002049) was conducted at Benton House at Oakleaf on - . Deficiencies were identified at the time of the survey, including a Class I related to .	A 000		
A 076 SS=K	59A-36.009 FAC ( ) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No	A 076		

AHCA Form 3020-0001

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A 076	Continued From page 2 two unresponsive residents who did not have an executed ( ) (Resident #1 and Resident #2). The staff's failure to immediately initiate , ( ) placed the remaining 46 residents who did not have an executed at risk, should they be found responsive. The findings include: 1. Resident #1's clinical record showed she was admitted on and expired on . Diagnoses included: , Mild , history of , and . She was listed as full code An incident report progress note dated authored by Employee B, LPN, stated she went to Resident #1's room "around 8 am" where the resident was observed sitting "on left side of the bed with down in bed. No heartbeat or , present. Notified the Administrator and Resident Service Director ( ) and asked them the protocol of what to do. They stated to do nothing until they arrive. Both of them arrived and took over the situation." Photographic evidence obtained. In an interview on at 9:45 am, Employee C, Medical Technician, stated her certification was current. Her training in and was completed online. When asked how to identify residents with an executed , she explained there was a red dot next to the resident's name on the door to indicate their status. She stated that the information was also available in the computer. If she found a resident unresponsive who did not have a red dot (indicating they were full code and wanted performed), she would then contact the nurse	A 076		

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A 076	Continued From page 3 (instead of initiating herself.) When asked if the nurse is available in the facility at night, she said no. In an interview on at 9:50 am, Employee D, Resident Assistant ( ), stated that in case of an emergency, she would contact the med tech or the nurse and follow the direction. When asked if she had an active certification, she stated yes, she mentioned that all staff received training online at the facility during a group session. She denied receiving recent inservice training on emergency response or the policy. She mentioned that there were some trainings she received online through Relias upon hire. Facility records showed she was hired . When asked where the information was found, she said "at the resident's door next to their name, there is a red dot beside resident's name." In an interview on at 9:55 am, Employee E, Care Coordinator, stated that she was hired in and her work duties included coordinating activities for memory care residents and working as an as needed. She mentioned that she had an active certification received through the facility's online course. When asked what she would do if she found a resident unresponsive, she stated, "I had not thought about that," and she would summon the nurse or the Administrator. When asked how to identify a resident's code status, she said she didn't know. She said she would ask the front office. When asked if she has had any recent inservice training about responding to emergencies, she stated no. Employee F, , was interviewed on at 10:05 am. She stated that she received an in service approximately weeks ago regarding	A 076		

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A 076	Continued From page 4 response to emergencies. She was familiar with the facility practice of placing a red dot by the name on the door of residents with an executed and confirmed she was certified. When asked what do when a resident is found unresponsive, she stated she would call the med tech or the nurse and wait for directions. In an interview on at 10:30 am, Employee G, LPN, stated that during an emergency the nurse's responsibility was to assess the resident and contact the responsible parties (the Resident Service Director, Administrator, family, and physician) and document the event. When asked her responsibility when a resident is unresponsive, she stated she would call the , and 911. She added, "You know this is an assisted living and we don't do much." She continued to state that she would obtain the information while with the resident and page for assistance. She confirmed having active certification provided online through the facility. She denied receiving any recent inservice on the facility's policy and procedure on 's. Facility records show she was hired on . The Job Description of the LPN stated they were to serve as the "responsible person" in the absence of the Executive Director or Assistant Executive Director. They were expected to follow all policies and procedures of the community. Photographic evidence obtained. In a phone interview on at 3:30 pm, Employee B stated she was summoned to Resident #1's room as the resident was no responsive. Upon assessment, the resident had no , and was . She contacted that regarding the facility's protocol in pronouncing	A 076		

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A 076	Continued From page 5 resident [redacted], and she was informed not to do anything. She stated that she had worked as needed (PRN) at the facility and she was not trained on the protocol. She confirmed she didn't receive any training or inservice on the protocol for emergency response following the incident with Resident #1. She confirmed that Resident #1 was a full code (she had not executed a [redacted]) and did not perform [redacted] as resident appeared [redacted]. Facility records showed Employee B was hired [redacted]. 2. Resident #2's clinical record indicated she was admitted to the facility on [redacted] and expired on [redacted]. Diagnoses included [redacted], lower [redacted], and [redacted]. She was listed as full code. An incident report progress note authored by Employee H dated [redacted] at 12:30 am read, "I entered in residents' room for a 2-hour check, I found resident leaned over her walker in the bathroom. I called for other staff to assist me as I called EMT. EMT came and pronounced her [redacted]. I then called [the Administrator] to explain to her the situation, she followed all the steps that needed to take place. At 3:00 AM funeral home arrived. Her room was locked up to secure her belonging. Family also notified." Photographic evidence obtained. In a phone interview on [redacted] at 2:25 pm, Employee H, Medical Technician, stated that she had reported to work on [redacted] at 11:00 pm and while doing her rounds, she found Resident #2 on the bathroom floor. She described Resident #2 as unresponsive, with no [redacted], to touch, and stiff. She stated she panicked, and she summoned other staff for help and	A 076		

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A 076	Continued From page 6 proceeded to call 911. She stated that was not initiated as the resident seemed like she had transitioned. She added that paramedics arrived shortly after and pronounced the resident . When asked if she had received training on emergency response, she said "no" but she did have online training after the incident. Records showed Employee H was hired . The Administrator confirmed on at 11:45 am that she was in the facility and that was not done for Resident #1 since, "the event happened so quickly, and Emergency Medical Technician (EMT) arrived within minutes." When asked about Resident #2, she stated that was initiated by Employee H. After revealing the notes from the staff to indicate had not in fact been conducted, she stated she had not seen the note and she received information through staff interview. The Administrator was then asked to explain the corrective actions the facility has taken since Resident #1's code status was not honored when she was found unresponsive in , . She stated, "all staff members are trained on what to do in this situation, as to procedure to call family, medics and staff. We have an emergency book located in several places in the building. In our , inservice meeting we reviewed person in charge (PIC) duties and how to handle emergencies efficiently and effectively". She added that not all staff were trained on where to find the emergency book. Only handpicked staff were designated as the PIC, and those individuals were trained. When asked how the training was conducted, she stated that all staff were informed they would be enrolled to the training class through the facility. She stated that	A 076		

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A 076	Continued From page 7 the training was provided online by Emergency Educational Institute NF, LLC- aligned with American Association. Review of the facility's policy and procedure titled: "Policies regarding ( ) orders effective 11/15/2013, read " Resident does not have a : if a resident experiences a , staff trained in , ( ), or a licensed health care provider present in the community, will administer ." Photographic evidence obtained. The Job Description of the PIC was reviewed and explained they were to act as the "responsible person" or "in-charge" person in the absence of the Executive Director. The listed "major tasks, duties, and responsibilities" mandated this individual "be prepared for, and manage emergency situations including disasters, fire, and no-show employees" and qualifications included evidence of first aid and certification. The PIC also needed to be "fully in state regulations and company policies relative to resident care." Photographic evidence obtained. The Administrator continued to explain in the interview that they were in the process of auditing the resident's status. When asked what the facility protocol was during an emergency, she stated that staff should call the person in charge (PIC) and 911 depending on the situation. When asked how staff obtained the information, she said it was on the resident's door beside their resident name and in the resident chart. She added that she was in the process of reviewing the accuracy of the red dots.	A 076		

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A 076	Continued From page 8 Review of the employee roster provided by the facility revealed a total of 50 direct care employees. Of the 46 employed at the time of the incident with Resident #1, only 16 had received additional training in the facility's and First Aid courses as of the time of the survey. Not included in the retraining were Employee B, who did not know how to respond when Resident #1 was found unresponsive, and Employee H, who discovered Resident #2 unresponsive and did not initiate . Photographic evidence obtained. Review of the attendees of the inservice included Employees C, D, E, F, and G. None reported in their interviews on they would instigate a code status check and do if they found an unresponsive resident without a . In a phone interview on at 4:00 pm, the stated that on around 8:45 am, she was contacted by the Sales Director asking what to do as Resident #1 had expired. She stated that when she asked how they knew that resident had expired, the Sales Director stated that she was informed that resident was stiff. She added that the Sales Director and the nurse on duty were on the call and were asking who would pronounce the resident . She confirmed, she did not instruct them to perform . She mentioned that she arrived at the facility thereafter and contacted 911 to pronounce the resident . When asked the facility protocol during emergencies, she stated that she was still learning as she was new to the facility (hired in) as well as State requirements since she came from out of state. She added that during the investigation, she realize most of the staff were not familiar with the emergency response protocol. She added that she has initiated the training and had not gotten to all staff	A 076		

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A 076	Continued From page 9 at the time of survey. Review of the Job Description for the revealed the requirement to be fully in state regulations and company policies relative to resident care. They were to be prepared to manage emergency situations. Photographic evidence obtained. In a follow up interview with the Administrator on at 6:15 pm, she stated she relied on the to conduct the survey and was not aware that training was not conducted. She added that the previous resigned without notice and the new one just started, and she had not managed to train all the staff. She also confirmed that the PIC folder did not have the protocol/procedure for or responding to emergencies. Review of the facility's training materials for , Page 1, revealed that for an unwitnessed collapse, "start first, and after 2 minutes leave victim in recovery position to activate ." Photographic evidence obtained. Class I	A 076		

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A 076	Continued From page 3 (instead of initiating herself.) When asked if the nurse is available in the facility at night, she said no. In an interview on at 9:50 am, Employee D, Resident Assistant ( ), stated that in case of an emergency, she would contact the med tech or the nurse and follow the direction. When asked if she had an active certification, she stated yes, she mentioned that all staff received training online at the facility during a group session. She denied receiving recent inservice training on emergency response or the policy. She mentioned that there were some trainings she received online through Relias upon hire. Facility records showed she was hired . When asked where the information was found, she said "at the resident's door next to their name, there is a red dot beside resident's name." In an interview on at 9:55 am, Employee E, Care Coordinator, stated that she was hired in and her work duties included coordinating activities for memory care residents and working as an as needed. She mentioned that she had an active certification received through the facility's online course. When asked what she would do if she found a resident unresponsive, she stated, "I had not thought about that," and she would summon the nurse or the Administrator. When asked how to identify a resident's code status, she said she didn't know. She said she would ask the front office. When asked if she has had any recent inservice training about responding to emergencies, she stated no. Employee F, , was interviewed on at 10:05 am. She stated that she received an in service approximately weeks ago regarding	A 076		

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	AL11969198	A. BUILDING: _____ B. WING _____	02/11/2022

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A 076	Continued From page 4	A 076		

response to emergencies. She was familiar with the facility practice of placing a red dot by the name on the door of residents with an executed and confirmed she was certified. When asked what do when a resident is found unresponsive, she stated she would call the med tech or the nurse and wait for directions.

In an interview on at 10:30 am, Employee G, LPN, stated that during an emergency the nurse's responsibility was to assess the resident and contact the responsible parties (the Resident Service Director, Administrator, family, and physician) and document the event. When asked her responsibility when a resident is unresponsive, she stated she would call the , and 911. She added, "You know this is an assisted living and we don't do much." She continued to state that she would obtain the information while with the resident and page for assistance. She confirmed having active certification provided online through the facility. She denied receiving any recent inservice on the facility's policy and procedure on 's. Facility records show she was hired on .

The Job Description of the LPN stated they were to serve as the "responsible person" in the absence of the Executive Director or Assistant Executive Director. They were expected to follow all policies and procedures of the community. Photographic evidence obtained.

In a phone interview on at 3:30 pm, Employee B stated she was summoned to Resident #1's room as the resident was no responsive. Upon assessment, the resident had no , and was . She contacted that regarding the facility's protocol in pronouncing

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A 076	Continued From page 5 resident [redacted], and she was informed not to do anything. She stated that she had worked as needed (PRN) at the facility and she was not trained on the protocol. She confirmed she didn't receive any training or inservice on the protocol for emergency response following the incident with Resident #1. She confirmed that Resident #1 was a full code (she had not executed a [redacted]) and did not perform [redacted] as resident appeared [redacted]. Facility records showed Employee B was hired [redacted]. 2. Resident #2's clinical record indicated she was admitted to the facility on [redacted] and expired on [redacted]. Diagnoses included [redacted], and [redacted]. She was listed as full code. An incident report progress note authored by Employee H dated [redacted] at 12:30 am read, "I entered in residents' room for a 2-hour check, I found resident leaned over her walker in the bathroom. I called for other staff to assist me as I called EMT. EMT came and pronounced her [redacted]. I then called [the Administrator] to explain to her the situation, she followed all the steps that needed to take place. At 3:00 AM funeral home arrived. Her room was locked up to secure her belonging. Family also notified." Photographic evidence obtained. In a phone interview on [redacted] at 2:25 pm, Employee H, Medical Technician, stated that she had reported to work on [redacted] at 11:00 pm and while doing her rounds, she found Resident #2 on the bathroom floor. She described Resident #2 as unresponsive, with no [redacted], to touch, and stiff. She stated she panicked, and she summoned other staff for help and	A 076		

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A 076	Continued From page 6 proceeded to call 911. She stated that was not initiated as the resident seemed like she had transitioned. She added that paramedics arrived shortly after and pronounced the resident . When asked if she had received training on emergency response, she said "no" but she did have online training after the incident. Records showed Employee H was hired . The Administrator confirmed on at 11:45 am that she was in the facility and that was not done for Resident #1 since, "the event happened so quickly, and Emergency Medical Technician (EMT) arrived within minutes." When asked about Resident #2, she stated that was initiated by Employee H. After revealing the notes from the staff to indicate had not in fact been conducted, she stated she had not seen the note and she received information through staff interview. The Administrator was then asked to explain the corrective actions the facility has taken since Resident #1's code status was not honored when she was found unresponsive in , . She stated, "all staff members are trained on what to do in this situation, as to procedure to call family, medics and staff. We have an emergency book located in several places in the building. In our , inservice meeting we reviewed person in charge (PIC) duties and how to handle emergencies efficiently and effectively". She added that not all staff were trained on where to find the emergency book. Only handpicked staff were designated as the PIC, and those individuals were trained. When asked how the training was conducted, she stated that all staff were informed they would be enrolled to the training class through the facility. She stated that	A 076		

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A 076	Continued From page 7 the training was provided online by Emergency Educational Institute NF, LLC- aligned with American Association. Review of the facility's policy and procedure titled: "Policies regarding ( ) orders effective 11/15/2013, read " Resident does not have a : if a resident experiences a , staff trained in , ( ), or a licensed health care provider present in the community, will administer ." Photographic evidence obtained. The Job Description of the PIC was reviewed and explained they were to act as the "responsible person" or "in-charge" person in the absence of the Executive Director. The listed "major tasks, duties, and responsibilities" mandated this individual "be prepared for, and manage emergency situations including disasters, fire, and no-show employees" and qualifications included evidence of first aid and certification. The PIC also needed to be "fully in state regulations and company policies relative to resident care." Photographic evidence obtained. The Administrator continued to explain in the interview that they were in the process of auditing the resident's status. When asked what the facility protocol was during an emergency, she stated that staff should call the person in charge (PIC) and 911 depending on the situation. When asked how staff obtained the information, she said it was on the resident's door beside their resident name and in the resident chart. She added that she was in the process of reviewing the accuracy of the red dots.	A 076		

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A 076	Continued From page 8 Review of the employee roster provided by the facility revealed a total of 50 direct care employees. Of the 46 employed at the time of the incident with Resident #1, only 16 had received additional training in the facility's and First Aid courses as of the time of the survey. Not included in the retraining were Employee B, who did not know how to respond when Resident #1 was found unresponsive, and Employee H, who discovered Resident #2 unresponsive and did not initiate . Photographic evidence obtained. Review of the attendees of the inservice included Employees C, D, E, F, and G. None reported in their interviews on they would instigate a code status check and do if they found an unresponsive resident without a . In a phone interview on at 4:00 pm, the stated that on around 8:45 am, she was contacted by the Sales Director asking what to do as Resident #1 had expired. She stated that when she asked how they knew that resident had expired, the Sales Director stated that she was informed that resident was stiff. She added that the Sales Director and the nurse on duty were on the call and were asking who would pronounce the resident . She confirmed, she did not instruct them to perform . She mentioned that she arrived at the facility thereafter and contacted 911 to pronounce the resident . When asked the facility protocol during emergencies, she stated that she was still learning as she was new to the facility (hired in) as well as State requirements since she came from out of state. She added that during the investigation, she realize most of the staff were not familiar with the emergency response protocol. She added that she has initiated the training and had not gotten to all staff	A 076		

Agency for Health Care Administration

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A 076	Continued From page 9 at the time of survey. Review of the Job Description for the revealed the requirement to be fully in state regulations and company policies relative to resident care. They were to be prepared to manage emergency situations. Photographic evidence obtained. In a follow up interview with the Administrator on at 6:15 pm, she stated she relied on the to conduct the survey and was not aware that training was not conducted. She added that the previous resigned without notice and the new one just started, and she had not managed to train all the staff. She also confirmed that the PIC folder did not have the protocol/procedure for or responding to emergencies. Review of the facility's training materials for , Page 1, revealed that for an unwitnessed collapse, "start first, and after 2 minutes leave victim in recovery position to activate ." Photographic evidence obtained. Class I	A 076		