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
	AL11969905	A. BUILDING: _____ B. WING _____	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF OVIEDO	1915 W COUNTY RD 419 CHULUOTA, FL 32766

(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 #2022003678 was conducted on [redacted] at Benton House, Oviedo. There were deficiencies at the time of the visit.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C.	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision for 1 out 2 sampled residents (#1). Findings: Resident#1's record revealed a facility admission date of . An 1823 health assessment form dated indicated the resident's diagnoses included and Balance . His mental ability was and disorientation. The 1823 form indicated he was not an elopement risk.	A 025		

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A 025	Continued From page 2 Review of the agency's internal report dated stated at approximately 4pm on staff A was driving down highway 419 going westbound after clocking out. She noted resident#1 was walking down the sidewalk along the side of the highway. She immediately called the facility and reported resident#1's whereabouts. Executive director answered the phone and staff A gave the location of the parking lot of Edward Jones/Walgreens Pharmacy. Staff A had pulled over and summoned the resident and waited with him until executive director arrived in minutes. Resident stated he was looking for his favorite steak restaurant. He was pleasant with no signs of distress. In observation of the property and location where resident#1 was found showed the facility is located on a 4-lane highway with a median in the center of the 4 lanes. The facility has fencing in the front of the property except for the entrance and exit of the driveway. There is a walkway around the facility and cameras located on the outside the facility. The distance between the facility and the location where resident#1 was found was approximately 1 mile and the resident would have had to cross the busy highway to get to the Walgreens parking lot where the resident was found. Surveyor observed a monitor at the reception desk that monitors the outside of the building. In an interview on at 11:17am the Executive Director stated she completed the admission assessment for resident#1 to the assisted living side and at that time he was oriented to time, date, and location. She stated the resident had a normal routine of walking 2 to 5 miles a day around his home before he came to the facility. When he came to the facility, he told	A 025		

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A 025	Continued From page 3 us of his behaviors of walking, and he was informed that might be a problem with walking 5 miles a day. She stated the resident knew who he was and where he was at the time of admission. She stated that the resident would walk the outside of the building everyday around the building on the path. She stated there are also cameras outside. She stated that day of the elopement he went out to dinner with his family, and they took him to the restaurant. She stated when the resident came . . . , he did his normal stroll and we saw him leave and thought he was just walking around the building. She stated they did not seem him leave the premises. She stated he was aware he was supposed to sign out when leaving the facility. She stated I don't think he had an intention of leaving but during the walk wanted to go to the restaurant. She stated the physician and family were notified immediately. She stated Resident #1 was assessed at the time of the incident and there were no injuries or distress. She stated since then the physician and the family agreed to admit him to the memory care for his safety. In an interview on at 12 PM with resident#1 in memory care, he stated he did not remember the incident. The resident was able to express himself verbally however, he was not aware of his address, time of day, day of week, month, or names of staff. He stated he wasn't sure why he was there and wants to go home. The resident did not have identification on his person. In an interview with the administrator on . . . . . at 10:30am, confirmed she was not at the facility at the time of the incident and was not sure why they did not see the resident leave the premises on the cameras as they are manned at	A 025		

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A 025	Continued From page 4 the front desk. She stated she was not aware that elopement risk residents are required to have identification on their persons at all times. Class III	A 025		
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	A 032		

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A 032	Continued From page 5 facility staff and law enforcement as necessary. 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 observation, interview and record review the facility failed to have 2 of 2 sampled residents (#1 and #2) who are at risk for elopement have identification on their persons that includes their name, address, and telephone number. Findings:	A 032		

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A 032	Continued From page 6 Review of the record for resident#1 revealed form1823 health assessment dated . . . . . confirmed resident #1 was an elopement risk. Review of the record for resident #2 revealed form 1823 health assessment dated . . . . . confirmed resident #2 was an elopement risk. In an observation on at 12pm of resident #1 and resident #2 in the memory care unit, confirmed neither resident#1 nor resident #2 had any identification on their person as required for residents at risk for elopement. In an interview on at 11:00am with the administrator, she confirmed the above statements and stated she was not aware that elopement risk residents needed to have identification on their person. Class III	A 032		