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 _____	07/18/2022

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 investigation #2022009593 and generator monitoring was conducted on at Benton House of Oviedo. A deficiency was found 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 or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . 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 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	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 59A-36.012, F.A.C. (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 of 3 sampled residents (#3). Findings: Resident#3's health assessment dated (before the incident) revealed a medical history of 2001, , without behaviors ( ), , , , History of ( ), and , , wears glasses, uses walker for mobility, memory loss,	A 025		

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A 025	Continued From page 2 Hospice, assistance with medication, bathing, and not an elopement risk. Review of the agency's internal report dated revealed around 2:45pm resident#3 was brought to the facility by firemen from the nearest firehouse across the street. It was reported the resident was walking down a 4-lane sidewalk and a motorist saw her and went to the firehouse to report the concern. Fireman brought her to the facility and evaluated her medical condition. The resident was given 8 ounces of water. The resident did respond to why she left the premises. Resident was last seen around 2:30 PM ambulating towards her apartment. Resident normally walks outside with a staff member. Resident was moved to memory care unit for safety. Family and physician were notified and agree with current plan to remain in memory care unit. In observation of the property and location where resident#3 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#3 was found was approximately 1000 off the property line and the same side of the street as the facility. A monitor at the reception desk that monitors the outside of the building was observed. In an interview on with staff D at 11:00am, stated that she was on duty at the time of the incident and staff were busy with other	A 025		

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A 025	Continued From page 3 residents and did not notice resident#3 leave the facility. In an interview on at 11:17am the Executive Director stated the resident never displayed any exit seeking behaviors and would often go outside and walk around the building or sit on the front porch, but she never left the premises. She stated the resident recently had Covid19 and was in isolation for 10 days and that might have caused her to leave. She stated the resident was aware that not following the rules of signing in and out and leaving the premises is considered an elopement. She stated the resident was immediately assessed when she was returned to the facility and there were no injuries incurred. She stated she was found walking to the church next door. She stated since then the physician and the family agreed to admit her to the memory care for his safety. In an interview on at 11:00am with resident#3 in memory care, she stated she did not remember the incident. Resident was verbal but limited in . . . . . ability to understand questions and was not alert to time, place, or date. The resident did not have identification on her person. In an interview with the administrator on . . . . . at 12:45pm, confirmed the statements above. Class III	A 025		