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 _____	12/06/2022

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 Complaint Investigation #2022017608 was conducted from . Benton House of Oviedo had deficiencies at the time of the survey.	A 000		
A 025 SS=G	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 59A-36.012, F.A.C.	A 025		

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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 resident record review, facility documentation, and interview, the facility failed to provide appropriate supervision related to for 5 of 8 sampled residents (#1, #4, #5, #7 & #8) by not following the facility's policy and procedure by implementing interventions precautions, and failed to maintain accurate written documentation that the healthcare provider and family were notified as required. Findings: 1. Resident #1's record revealed an admission date of . The last 1823 Health Assessment, dated , included a medical history of risk, , , ,	A 025		

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A 025	Continued From page 2 , and history of of lower extremities. She needed assistance with activities of daily living (ADLs) for bathing, , toileting and transferring, and supervision with ambulation and grooming. She needed assistance with self-administration of medications. Facility notes included documentation that resident #1 four times prior to as follows: at 7:49 AM - Nurse I documented that he was called to resident #1s room by Caregiver K. Nurse I indicated he observed resident #1 lying on the floor between the recliner and the TV stand with her resting on the recliner. Resident #1's were red and with pitting . Resident #1 was not able to explain what happened. 911 was called, the resdient was sent to the emergency room, and the family and physician were notified. at 9:42 PM - Nurse J documented that she was alerted by another resident's family who heard resident #1 yelling for help from her room. Nurse J went to resident #1's room, and found her sitting on the floor next to the bathroom door. Resident #1 told nurse J that she was trying to put her slippers on and backwards against the wall. Nurse J assessed resident #1. There was no injury and no complaint of . Vital signs were checked. The family and physician were notified. at 9:30 PM - Nurse H documented that she found resident #1 sitting on the floor near the bathroom. Resident #1 said that she did not hit her . Nurse H assessed resident #1. There were no injuries and no complaints of discomfort. Vital signs were checked. There was no documentation that the physician and family were	A 025		

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A 025	Continued From page 3 notified of this on . at 8 PM - Nurse I documented that resident #1 earlier and continued to complain about . Resident #1 was not able to ambulate with her walker and refused assistance for temporary use of the wheelchair. The resident complained of urgency. The family and physician were notified. There was no documentation and no incident report about the on and no documentation of a lab ordered for the urgency. at 5:05 PM - Nurse B documented that she was following up and spoke with resident #1's son regarding a on which caused to her right arm, left , and left side of her . The healthcare provider completed an assessment at the facility but did not write any new orders. The son told Nurse B that resident #1 had an upcoming with the to complete a next month. at 10:30 PM, Medication Technician (Med Tech) C found resident #1 lying on the floor next to her bed per an incident report, dated at 1 PM. Med Tech C assessed resident #1. There was no clutter in the room, and resident #1 denied hitting her . Med Tech C and Caregivers F and G all lifted resident #1 from the floor and put her into the bed. at 12 AM - the Director of Nursing (DON) was conducting rounds and observed resident #1 sitting on the side of her bed attempting to go to the bathroom unassisted. Resident #1 was wearing her pendant but did not activate it to call for help. The DON assisted resident #1 to the bathroom and resident #1	A 025		

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A 025	Continued From page 4	A 025		

asked to sit in her recliner. Resident #1 sat in her recliner for the remainder of the night. At 6 AM, the DON went to assist resident #1 with morning ADLs and then assisted her into her recliner to watch TV.

at 6:30 AM - Med Tech C went to assist resident #1 with scheduled morning medications. Med Tech C documented that there was nothing out of the ordinary. Resident #1 was doing okay. Resident #1 ate breakfast in her room.

at 10:01 AM - Nurse A went into resident #1's room to assist with scheduled medications, and resident #1 was doing okay, nothing out of the ordinary.

at 12:45 PM - resident #1 was transported in a wheelchair to the dining room for lunch. Nurse A noticed that when resident #1 was being transported into the dining room she was lively and interactive, but then within 5 minutes later, resident #1 became with clear coming from her . Nurse A checked her vitals and called 911. The family was also notified. Resident #1 was transported to the local hospital, but then discharged at 2:13 PM and taken to a larger hospital per the family's request.

at 4:10 PM - Nurse A documented that a incident happened on at 10:30 PM. During lunch time on at 12:45 PM, Nurse A noticed that resident #1's health declined rapidly with extreme , her body was stiff more than usual. She called 911 and notified physician and family.

There was no documentation for resident #1's

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A 025	Continued From page 5 hospitalization and injury. There was no follow-up documentation by the facility when resident #1 was discharged from the hospital and admitted to the skilled nursing rehabilitation center. Review of the hospital record, dated at 2:12 PM, reflected that resident #1 sustained a to her , / post . There was no to the . No surgery intervention was required, there were orders for ( ) and ( ) at a rehabilitation center. On at 3:45 PM, Nurse A said that she did not witness the the night before, on , but she observed that when resident #1 came into the dining room via wheelchair, she started drooling from her within minutes and the resident could not her words. On at 12:30 PM, the DON said that she did not know that resident #1 . The DON confirmed that Med Tech C did not report the to her when she reported to work on the 11 PM-7 AM shift on . The DON said that she already knew resident #1's history of , so she happened to just assist her with going to the bathroom at midnight and assisted her with early morning with ADLs at 6:30 AM. The DON agreed that a intervention should have been put in place for resident #1 prior to this incident. Photographic Evidence Obtained 2. Resident #5's record revealed an admission date . The latest 1823 Health Assessment, dated , included a medical history of , and 's , , and	A 025		

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A 025	Continued From page 6 . He needed assistance with all ADLs. He ambulated with a walker with one person supervision and assistance. He needed assistance with self-administration of medications. The facility documented twenty with resident #5 without any precaution intervention in place, and did not follow the facility's policy between to as follows: 1 - at 9:08 PM - Nurse B documented an unwitnessed . Resident #5 was getting up off his in front of his recliner chair. He stated that he was walking in his apartment, turned right and his left gave out on him. He went down to the floor on the side of his . He sustained has a to the right and a to his lower left side of his . Resident #5 did not remember what he hit his on to a have . The were cleaned with cleanser/patted dry and covered with . Vital signs were good. The physician and family were notified. 2 - at 7:40 AM - Med Tech L documented an unwitnessed . Caregiver G found resident #5 on the floor by the dresser in his room. Resident #5's was under the dresser. He stated he was fine and didn't bump his . There was no documentation that the healthcare provider and family were notified for this on . 3 - at 12:51 PM - Nurse B documented an unwitnessed in his room. Resident #5 pushed his pendant. He was found sitting on his in the living room floor. He had a small to his right that has been cleaned with cleanser/patted dry and	A 025		

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A 025	Continued From page 7 covered with a . . . aid. Vital signs were normal. He did not complain of , and denied . Resident #5 was up and walking with his walker. His gait was slow and unsteady at times. Resident #5 signed refusal for emergency transport. The physician and family were notified. 4 - at 7:35 PM - Nurse B documented an unwitnessed . Resident #5 pushed his emergency pendant. Staff observed the resident in his living room sitting on his in front of his desk with his walker behind him. Resident #5 stated that he took a step backwards and lost his balance. He said he did not hit his . . . . Resident #5 did not complain of , and . Resident #5 signed refusal for emergency transport. Vital signs were good. His family and physician were notified. 5 - at 11:37 AM - Nurse B documented an unwitnessed . Resident #5 pushed his emergency pendant. Staff found him sitting on his . . . . . on the floor with his . . out in front of him in the living room. He denied hitting his . . . . Resident #5 stated he was turning around with his walker, did not put his brakes on, and lost his balance. He denied , and . Resident #5 did not have any new . . . . . Vital signs were good. Resident #5 signed refusal of emergency transport. His physician and family were notified. . 6 - . . . . . at 6:31 PM - Nurse B documented an unwitnessed . She was radioed to resident's room and observed resident #5 lying on his on the floor beside his bed. Resident #5 stated that he rolled out of bed onto the floor. Resident #5 has a small to his forehead. Denies , and denies . . . Resident #5's gait is slow and unsteady at times.	A 025		

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A 025	Continued From page 8 Vitals normal. Physician and family notified. 7 - at 6:58 PM - Nurse B documented an unwitnessed . Nurse B was radioed to resident #5's room and observed resident #5 in his apartment lying on the floor on his with his out in front of him. He stated that he in his kitchen fixing breakfast, took a step backward, and lost his balance. He scooted to his bedroom to try to get up himself. Resident #5 was able to move his upper and lower extremities without , . Resident #5 had a small hematoma with an to the of his . There was some reddish drainage on floor. The resident did not remember hitting his . Resident #5 signed refusal for emergency transport. Vital signs were normal. His physician and family were notified. On at 4:57 PM, Nurse B documented that resident #5 returned to the assisted living facility by medical transport from the hospital for a , placed on Thursday . Resident #5 was to avoid tight clothing, keep the site clean and dry. He was not to lift objects heavier than , for 5 weeks. He was not to raise his left arm higher than level. Resident #5 was to use a wheelchair, not a walker. Resident #5 was explained that if he , he will have to go to the Emergency Room for evaluation due to the new , device. Resident #5 requested a private caregiver to assist him with care. 8 - at 2:09 AM - Med Tech C documented an unwitnessed at 1:47 AM. Med Tech C was called to resident #5's room and found him on the floor. Resident #5 stated he was trying to get up and slipped out of bed. Resident #5's walker was sitting upright next to him. There	A 025		

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A 025	Continued From page 9 was no clutter around him. Resident #5 had a on his left . Staff took vital signs and cleaned the and placed a aid on it. Emergency Medical Services ( ) arrived at 1:38 AM and took the resident to the hospital for further observation. His family was notified. There was no documentation that the healthcare provider was notified about this . On at 4:32 PM, the DON wrote a care plan for resident #5. It included: safety instruction regarding to 4-wheel walker for ambulation inside/outside apartment; use a reacher to pick up items; keep emergency pendant within reach at all times; lock walker before standing. 9 - at 9:46 PM - Nurse J documented an unwitnessed . Resident #5 called for help. Staff observed him sitting on the bedroom floor. His walker was upright next to him. There was no clutter in the way. His clothes and basket were all over the floor in the hallway. Resident #5 stated that he tried to open the door in the room, he stepped , the basket was falling, and he backward on his . No injuries were noted. Vital signs were normal. was notified but resident #5 refused to sign the form with . His family and physician were notified. 10 - at 2:11 AM - Med Tech C documented an unwitnessed . Resident #5 called for help. Staff observed resident #5 sitting on bedroom floor, with his walker next to him upright. There was no clutter in the way. Resident #5 stated that he slipped out of bed when trying to get up. He did not have any bumps and . The resident denied , . He asked a caregiver to help him get into bed. There was no documentation that the healthcare provider and	A 025		

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A 025	Continued From page 10 family were notified for this . . Fall 11 - . . . . . at 7:26 PM - Nurse B documented an unwitnessed . Resident #5 pushed hie emergency pendant. Staff observed resident #5 sitting on the floor on his by the entry way to his apartment. Resident #5's . . were bent toward his . . Resident #5 had shoes on his . . . Resident said he was closing his freezer door and moved toward his left side and lost his balance. Resident #5 vital signs were normal. He denied , and . . . His physician and family were notified. . . 12 - . . . . . at 1:42 AM - Med Tech C documented an unwitnessed . She found resident #5 in his apartment on the floor next to his bed. He was sitting on his . Resident #5 stated he slipped down as he was trying to get up, , and landed on his . His walker was beside him. Resident #5 had his pendant around his but did not press it to call for help. He said he did not think about it. He denied , . No bumps were seen. Staff put him to bed. There was no documentation that the healthcare provider and family were notified about the . . Fall 13 - . . . . . at 1:14 PM - Nurse B documented an unwitnessed . She found resident #5 sitting on his . . . . . with his . . straight out in front of him on the floor near his refrigerator. Resident #5 stated that he stepped when he was taking his morning medication standing bent over the table and slid down to the floor. Resident #5 said he did not hit his . He had no , . and . . . . . Vital signs were normal. There were no new open areas, no bumps, and no discoloration on his skin. His physician and family were notified. There was no	A 025		

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A 025	Continued From page 11 documentation and no order that resident #5 was permitted to take his own medication without assistance when he on ..... Resident #5's 1823 Health Assessment, dated and signed by the healthcare provider, indicated that he needed assistance with self-administration of medications. Photographic evidence was obtained. 14 - ..... at 9:09 PM - Nurse B documented an unwitnessed . Nurse B was radioed to resident #5's room and observed him sitting on the floor on his . His were straight out in front of him, and his upper leaned against his recliner chair. Resident #5 stated he was standing up by the kitchen table, went to turn around, and lost his balance while walking backward to sit down. Resident #5's private caregiver was in his bedroom getting his clothes ready. Resident #5 stated that he did not hit his . No injuries were seen. Vital signs were normal. Resident #5 signed refusal for emergency transportation. His physician and family were notified. There was no documentation when the private caregiver was hired for resident #5 during the ..... Fall 15 - ..... at 4:38 PM - Nurse A documented an unwitnessed . She observed resident #5 sitting on the ground with his ... slightly flexed. The resident reported no , . There was no documentation that the healthcare provider and family were notified for this .. 16 - at 5:25 AM - Med Tech C documented an unwitnessed . She observed resident #5 sitting on the floor in his room. Resident #5 reported no , and ..... Resident #5 stated he did not hit his ... . There	A 025		

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A 025	Continued From page 12 were no open . . . . or marks. Resident #5 stated that he lost his balance on way to the bathroom. Resident #5's walker was upright next to him. She assisted resident #5 to bed. His family was contacted. There was no documentation that the healthcare provider was notified for this . . Fall 17 - . . . . . at 8:25 PM - Nurse B documented an unwitnessed . Resident #5 pushed his emergency pendant for help. Nurse B observed resident #5 sitting on the floor on his . . . . . beside the toilet and his . . . against a small trash can. Resident #5 stated that he had a . . . . movement and when he was done, he was bending forward to wipe himself and loss his balance. Resident #5 has a small . . . . . to his right and a on his right lower . . . area. The areas were cleaned. Resident #5 denied hitting his . He did not have and , . . . His physician and wife were called. Vital signs were normal. 18 - at 6:37 PM - Nurse B documented an unwitnessed . Nurse B was radioed to resident #5's room and observed him sitting on the floor on his . . . . . in front of his chair in his dining room. He said he lost his balance, the chair moved away from him, and he ended up on the floor. There were no open areas noted. He denied , . . Vital signs were normal. His family and physician were notified. 19 - at 9:59 PM - Nurse J documented an unwitnessed . . She was alerted to go to . Resident #5's wife was visiting. His wife asked Nurse J for assistance to help him get up off the floor because he was about to but he lowered himself down and now was unable to get up. The resident did not	A 025		

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(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 025	Continued From page 13	A 025		

have any , . He did not have any injury or . His physician was notified. Vital signs were normal.

20 - at 6:56 PM - Nurse B documented an unwitnessed . She responded to resident #5 pushing the emergency pendant. She observed the resident #5 lying on his on the floor beside his bed. His walker was in the living room. Resident #5 stated he was swinging a cushion in his and forth to throw it in the recliner, let go of the cushion, and lost his balance. He backward on my . Resident #5 did not have any open areas and no redden areas. Resident #5 stated he did not hit his . He did not have and , . Nurse B assisted resident #5 to bed. Vital signs were normal. His physician and family were notified.

On at 10:10 AM, the DON said she completed a care plan for for resident #5. The DON was asked to provide a copy of the care plan because the facility's notes just documented that a care plan was completed for a 4-wheel rolling walker, safety while in use, and a reminder to wear and push his pendant when he needed help. The DON could not provide a copy of the care plan for . She said it is just written in the facility notes. The DON said resident #5 was a retired physician and always took charge of his care, therefore a consultation concerning resident #5's multiple was not requested.

The facility did not follow their own policy, that after any resident who have had 2 within a 30-day period or had 3 or more within a three month period would be assessed for high risk, and conduct weekly meetings between the Administrator and DON to discuss a plan.

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	AL11969905	A. BUILDING: _____ B. WING _____	12/06/2022

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A 025	Continued From page 14 3. Resident #8's record revealed an admission date on . The last 1823 Health Assessment, dated , included a medical history of 's without behaviors, condition, , , , and a history of . She needed assistance with all ADLs and needed assistance with self-administration of medications. She was recently admitted to Hospice services on and on . On at 3:52 AM, Med Tech M documented that she heard a noise from resident #8's room. Resident #8 was found on the floor with the mattress on top of her. She called for backup for assistance. The resident had a on her left . Resident #8 complained of , on her left side near her and abdomen. Hospice was called and the family was notified. There was no documentation for a follow-up after resident #8 , and after Hospice was notified on . There was no documentation leading up to resident #8 declining in health to lead to her on , 8 days after her . On at 11:10 AM, the DON confirmed the finding and could not provide any other documentation. 4. Resident #4's health assessment revealed a medical history including mild , , , , declining functional status, and a history of . Assistance with ADLs included supervision with ambulation and grooming, assistance with bathing, , transferring and toileting. The resident required assistance with medication administration.	A 025		

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A 025	Continued From page 15 Resident's #4's facility notes revealed the following unwitnessed : - Staff was called to resident #4's room and found the resident had on her out of chair. was called. The resident sustained a hematoma to her forehead with an , an to her , and a small on her left . - Staff observed the resident sitting on the floor by her bed with her out in front of her and her against the walker. The resident has a small to right . - Staff went to resident's apartment responding to her emergency pendant call. Staff observed the resident lying on the floor on her left side with her left bent towards her , and outward turning of her right . The resident was sent to the hospital and did not return to the facility. 5. Resident #7's closed record and health assessment, dated , revealed a medical history including , and , , . ADLs included supervision with ambulation and transfer, and assistance of medication administration. Review of the facility notes revealed the following unwitnessed : at 9 AM - Staff found the resident sitting on the floor with her right area . She said she on a box and her right . Staff applied pressure to the area. She did not have , . Family took the resident to the hospital for further evaluation. On , the resident arrived by family transport to the facility. The resident had a to her right with 6 , which would be removed on . The resident had a small to the	A 025		

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A 025	Continued From page 16 top of her right . . . that was covered with a . . . aid. - The resident had an unwitnessed . She was found sitting on her . . . . . on the floor by her bed. She did not have on shoes, and her emergency pendant was under the bed. Her walker was by the dresser, out of reach. The resident stated she was going to the bathroom, slipped, and then pushed the emergency pendant for help. The resident denied hitting her . . . , and did not have any open areas. On at 2:30 PM, the DON confirmed the above findings and did not know why interventions were not put into place for residents #4 and #7. Photographic evidence was obtained. Class II	A 025		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able	A 030		

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A 030	Continued From page 17 to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules	A 030		

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A 030	Continued From page 18 or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at	A 030		

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A 030	Continued From page 19 any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , ... for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless,	A 030		

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A 030	Continued From page 20 for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and	A 030		

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A 030	Continued From page 21	A 030		

the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the

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A 030	Continued From page 22 resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have documentation of grievances for all residents in order to investigate, recommend and report the results to the resident. Findings: A request was made on . . . . . to review the facility's grievance log. Review of the grievance log book did not list any grievances, just blank pages. On at 3 PM, the administrator stated the grievance log is blank because the residents don't remember the grievance log is behind the receptionist's desk. She stated most of the time the residents will inform her, or staff of an issue and we resolve it. She stated she does not document any of the complaints or grievances. She stated she did not know that was a policy that should be put in place. Class III	A 030		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168	A 079		

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A 079	Continued From page 23	A 079		

212
16-25 253
26-35 294
36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and [illegible]
( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.

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A 079	Continued From page 24 b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident	A 079		

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A 079	Continued From page 25 care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that	A 079		

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A 079	Continued From page 26 resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on facility documentation and interview, the facility failed to maintain an accurate written work schedule that reflected 24-hour staffing pattern for any given time period, to include any changes to the written work schedule as required. Findings: On [redacted], the written work schedule was reviewed to check for the staff who worked during a [redacted] that occurred with resident #1. Facility notes documented by the Director of Nursing (DON) reflected that the DON worked the overnight shift on [redacted] until 7 AM the next morning of [redacted], assisting resident #1 with activities of daily living. The written work schedule listed that the DON worked 9 AM- 5 PM on [redacted] and 9 AM-5 PM on [redacted]. The written work schedule did not reflect her	A 079		

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 _____	12/06/2022

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 079	Continued From page 27 working 11 PM- 7 AM. The written work schedule was not updated to reflect the correct work time. Photographic evidence was obtained. On [redacted] at 3:30 PM, the DON confirmed the finding, and said she makes the nurse and caregiver staff work schedules every week. Class III	A 079		
CZ813 SS=D	59A-35.090(3)(c), FAC Results of Screening & Notification In File 59A-35.090 Background Screening. (3) Results of Screening and Notification. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have the documentation for results of the background screening for 1 of 7 sampled staff (E). Findings: In a review of personnel records on [redacted] for staff E, it confirmed there was no documentation of the results for background screening. On [redacted] at 11 AM, the administrator confirmed the finding. Unclassified	CZ813		