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
	AL11970098	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF NARCOOSSEE	2910 N NARCOOSSEE RD SAINT CLOUD, FL 34771

(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 #2023006029 was conducted on [redacted] at Benton House Narcoossee Assisted Living Facility. There were deficiencies identified 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 [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]. 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	A 025		

AHCA Form 3020-0001

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

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
	AL11970098	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF NARCOOSSEE	2910 N NARCOOSSEE RD SAINT CLOUD, FL 34771

(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 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 observation, interview, and record review the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision for 3 of 4 sampled residents. Resident (#2 and #3) who sustained a with injury and resident (#1) who eloped from the facility. Findings: 1. On a review of resident #2's record revealed she was admitted on . Her record contained a Resident Health Assessment Form (1823) dated . She lived in the	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970098	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF NARCOOSSEE	2910 N NARCOOSSEE RD SAINT CLOUD, FL 34771

(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 2 secured memory care unit. Her diagnoses included Severe 's and may . She required supervision with and grooming and assistance with bathing and toileting. Review of a facility incident report revealed Staff E documented on at 7am, upon arrival to her shift, she found resident #2 in a lot of . The resident was not able to move her right . She complained of whenever her right was touched. Resident #2 was transferred to the hospital via 911. She was found to have a . Review of a facility note dated at 11:30am documented by the DON said she received a call on at 12:20am advising resident #2 had . Review of an incident report dated on , documented the date of the incident was at 8:46pm. Resident #2 had an unwitnessed in the hallway. The resident went to bed but woke up about 3am complaining of in her right . She awakened again about 6:45am with continued complaints of . She was transferred to the hospital where she was found to have a right . The incident report documented the resulting in a occurred at 8:46pm on . The facility incident report documented resident #2 was transferred to the hospital after an evaluation by staff E that was performed at 7am on 10 hours and 14 minutes after the . On at 2:10pm an interview was conducted with the Director of Nursing (DON). She confirmed resident #2 at 8:46pm on	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970098	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF NARCOOSSEE	2910 N NARCOOSSEE RD SAINT CLOUD, FL 34771

(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 3 . She was not transferred to the hospital until more than 10 hours later when staff E evaluated her at 7am on . 2. On a review of resident #3 record revealed she was admitted on . She lived in the secured memory care unit. Her record contained a (1823) dated . Her diagnoses included , and . She was at risk for . She required assistance with all activities of daily living. Review of the facility notes revealed: On 2:50pm documented by the DON. Spoke with the resident's daughter. Resident was admitted to the hospital with a of C2. She required a brace for 6 weeks. There was no facility note regarding the circumstances and timeline leading to resident #3's injury. Review of a facility incident report dated revealed resident #3 at 12:20am found on the floor next to her bed. Transferred to the hospital Via 911. Review of a document titled "Provider Communication Form" dated (no time indicated) revealed resident #3 and split her forehead open and had on her right and left arms. On at 2:12pm in an interview with the Director of Nursing (DON), she confirmed the above findings. Resident #3 was a known risk. She and sustained a C2 resulting in a transfer to a higher level of care. A review of the facility policy dated	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970098	A. BUILDING: ______ B. WING ______	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF NARCOOSSEE	2910 N NARCOOSSEE RD SAINT CLOUD, FL 34771

(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 4	A 025		

revealed the facility would assist residents in reducing risks by evaluating and identifying potential risk factors, and work with the resident, responsible party, and third-party providers to implement agreed upon interventions.

3. On a review of resident #1 record revealed he was admitted on . He lived in the secured memory care unit. His record contained an 1823 dated . His diagnoses included 's, advanced , , , , High Elopement risk.

Review of a facility Incident Report dated at 1:42pm revealed resident #1 was found in the community parking lot. He was escorted into the community with the assistance of the DON. The report was documented and signed by staff E on . The administrator signed it on . The DON signed it on .

Review of facility notes:
On at 11:05am Staff B documented she notified MD of , aggressive behaviors, and exit seeking behaviors.
On at 2:42pm Staff E documented resident was very agitated and exit seeking. Left the premises and was found on the road. He had some scratches on his . He was transported to the hospital for evaluation.
On at 3:16pm Staff E documented resident returned via ambulance and was not happy to be . One on one supervision until further notice.
On at 10:43am Staff E documented resident tried to elope out of another resident's window.
On at 7:17pm Staff B documented found

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
	AL11970098	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF NARCOOSSEE	2910 N NARCOOSSEE RD SAINT CLOUD, FL 34771

(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 5 resident trying to go out a window in another resident's room. Window was open and resident was putting his [illegible] out the window. On [illegible] at 3:30pm Staff documented resident was transferred to a higher level of care. Review of the incident report revealed resident #1 eloped from the secured memory care unit on [illegible] at 11:50am. He was found on the sidewalk on Narcoossee Road in front of the facility. He had scratches on his [illegible]. It was determined he exited the secured memory care unit through a window in another resident's room. On [illegible] at 12:25pm an interview was conducted with Staff E. She said resident #1 eloped two or three times. Review of the facility elopement policy dated [illegible] revealed the definition of resident elopement was a [illegible] resident who leaves the community without staff knowledge or supervision. A resident who lacks safety awareness On [illegible] at 2:15pm an interview with the DON was conducted. She confirmed resident #1 got out of the facility secured memory care unit on [illegible] at 1:42pm. He was found in the front parking lot. No interventions were put in place to ensure he would remain in the secure unit without eloping. She confirmed he eloped again on [illegible]. He was able to manipulate a window lock in another resident's room, open the window, remove the screen, climb out the window and over a hedge. He then made his way, through the grass, from the [illegible] of the building past the parking lot in front of the building, and onto the sidewalk along Narcoossee Road.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970098	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF NARCOOSSEE	2910 N NARCOOSSEE RD SAINT CLOUD, FL 34771

(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 6 Class II	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 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	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970098	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF NARCOOSSEE	2910 N NARCOOSSEE RD SAINT CLOUD, FL 34771

(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 032	Continued From page 7 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, record review and interview the facility failed to make, at a minimum, a daily effort to determine that at risk residents have identification (ID) on their persons that includes their name and the facility's name, address, and telephone number for 5 of 5 residents reviewed. (4, 5, 6, 7, 8). Staff must be generally aware of the location of all residents assessed at high risk for elopement at all times. Findings:	A 032		

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
	AL11970098	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF NARCOOSSEE	2910 N NARCOOSSEE RD SAINT CLOUD, FL 34771

(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 032	Continued From page 8 On a record review of residents at risk for elopement revealed residents #4, 5, 6, 7, and 8 were at risk. 1. Resident #4 file contained a Resident Health Assessment form (1823) dated . Elopement risk marked yes. 2. Resident #5 file contained an 1823 dated . Elopement risk marked yes. 3. Resident #6 file contained an 1823 dated . Elopement risk marked yes. 4. Resident #7 file contained an 1823 dated . Elopement risk marked yes. 5. Resident #8 file contained an 1823 dated . Elopement risk marked yes. On at 2pm a tour of the memory care unit was conducted. Residents were not observed to have any ID on their person. On at 2:10pm the Director of Nursing confirmed residents at risk for elopement did not have ID on their person and the facility did not make any effort, at least daily, to ensure the residents at risk for elopement had ID. Class III	A 032		