

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969905	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/17/2024
NAME OF PROVIDER OR SUPPLIER BENTON HOUSE OF OVIEDO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 (#2023014773) was conducted on 1/17/24 at Benton House of Oviedo. A deficiency was found at the time of the survey.	A 000			
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known allergies the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical restraints, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.	A 054			

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: AL11969905	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/17/2024
NAME OF PROVIDER OR SUPPLIER BENTON HOUSE OF OVIEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 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 054	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the medication observation record (MORs) was immediately updated each time a medication is offered or administered for 1 of 5 sampled reviews (#4). Findings: In a review of resident#4's health assessment it revealed a medical history of _____, arthralgias in multiple sites and _____. A review of resident#4's MORs dated _____ revealed the resident was prescribed the medication _____ 50 mg, one tablet by _____ at bedtime. The medication was marked off as taken on _____ and _____. During a medication count by staff A, she stated the medication was off by one tab on _____ by staff B, who was the med tech on the same med cart before her. In a review of the facility's personnel record for staff B, it confirmed she was hired as a med tech and she was terminated on _____, for giving an extra dose of _____ to resident#4 and never marked it on the MORs. In an interview on _____ at 11am with resident#4, she stated she did not recall the incident. In an interview on _____ at 12pm with the administrator, she confirmed the above findings. Class III	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969905	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/17/2024
NAME OF PROVIDER OR SUPPLIER BENTON HOUSE OF OVIEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 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