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 _____	03/28/2024

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 #2024004907 was conducted on . . . . . at Benton House of Narcoossee. There were deficiencies identified at the time of the survey.	A 000		
A 030 SS=J	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 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.	A 030		

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 _____	03/28/2024

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 030	Continued From page 1 (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 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.	A 030		

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 _____	03/28/2024

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 030	Continued From page 2 429.28 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 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.	A 030		

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 ______	03/28/2024

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 030	Continued From page 3 (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, 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	A 030		

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 _____	03/28/2024

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 030	Continued From page 4 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 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	A 030		

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 _____	03/28/2024

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 030	Continued From page 5 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], 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 [illegible] or [illegible] 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 resident. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to honor resident rights by withholding [illegible] ([illegible]) for 1 of 1 sampled resident (#1) who was a full code and found unresponsive and did not have a [illegible] ([illegible]). Findings: Review of a facility incident report revealed on [illegible] at 7:58 AM, resident #1 was found in the	A 030		

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 _____	03/28/2024

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 030	Continued From page 6 bathroom of his apartment sitting slumped over on the toilet by Caregivers A and B. He was unresponsive and did not have a , . . . Further review noted the Caregivers did not initiate according to the facility policy. A facility note dated at 7:58 AM noted Caregiver A and Caregiver B went to resident #1's apartment to assist him to breakfast. They discovered him in the bathroom, unresponsive on the toilet with his on the toilet paper holder. He did not have a , , was blue in color and was stiff. There was on his and on the floor. There was also feces on the floor. They notified Nurse C via walkie talkie, and they responded to the room along with Caregiver D and Nurse E. Nurse C left the apartment to gather emergency documents and called 911. was not initiated by any of the staff and none of the responding staff brought the Automated External Defibrillator ( ) to the room for possible use. A facility note dated at 11:34 AM by Nurse C read, "staff was called to the resident's room and found resident in the bathroom ." On a review of resident #1's record revealed he was admitted to the facility on . The resident's record did not contain a . Resident #1's record contained a Resident Health Assessment form (1823) dated . The diagnoses listed on the health assessment included , , , and , . The resident was assessed to be independent with eating. The resident needed supervision with ambulation and assistance with all other activities of daily living.	A 030		

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 _____	03/28/2024

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 030	Continued From page 7 On . . . . . at 10:55am The Administrator confirmed the resident was a full code and the 5 responding staff did not initiate . . She said they thought the resident was . The Administrator said the system was to have a red dot on the door sign for residents with 's. Resident #1 did not have a red dot on his door. She said the night shift caregiver, Caregiver G, was terminated for not conducting rounds every hours. The administrator stated she thought resident #1 would not have been in the condition he was found in if Caregiver G had performed rounds. The Administrator confirmed she was in the facility at the time staff found resident. On an audit of 75 resident files found thirty-three (33) residents were documented as having a and forty-two (42) residents did not have . 's. On . . . . . at 12:40pm a tour was conducted that focused on red dots on door signs which according to the administrator was the system they used to identify residents with 's. The Administrator provided the census with room numbers and names of residents which documented each resident's code status. Review of the census and room notifications for found they did not all correspond/match as noted with the following differences: * resident #2 (a hospice resident who recently had , ... , on . . . . .) still had a red dot on the door sign indicating they had a . while census indicated they would need . This room was vacant. * . . . . Resident #3 had no red dot on the door (indicating need for) sign while census indicated they had a . and with a valid was on file.	A 030		

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 _____	03/28/2024

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 030	Continued From page 8 * . . . . Resident #4 had a red dot on the door sign (indicating they had a) while the census indicated they would need . , however, there was a valid on file. * . . . . Resident #5 had no red dot on door sign (indicating need for) while the census indicated they had a . . However, a record review was conducted and there was no evidence of a . . on file. The findings of the audit were shared with and confirmed by the administrator at 1:20pm. On at 1:20pm an interview was conducted with Nurse C. She said resident #1 was found by caregivers A and B. They notified Nurse C using the radio. The resident was found unresponsive sitting on the commode leaning forward. There was . . . observed on the floor in the bathroom and she thought the resident maybe hit his . . . on the toilet paper holder. She confirmed she did not initiate or bring the to the room. She said he was bluish and was observed in a very hard position. She explained that she would have had to throw him on the floor to perform . She further stated the resident was too heavy to put on the floor. There was and feces on him and the floor. She said she could not have done . . . Once she saw the resident's condition, she left the room and went to the office to call 911 and get emergency paperwork. Nurse C called 911 from her office. She notified Nurse E, and he went to the resident's apartment. The sheriff's department and the Emergency Medical Technicians' (EMT) arrived about 5 minutes later. On at 1:40pm an interview with Caregiver A was conducted. She said she and caregiver B found resident #1 in the restroom of his	A 030		

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 _____	03/28/2024

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 030	Continued From page 9	A 030		

apartment. His . . . was on the toilet paper holder. There was and feces on the floor and on the resident. The light was off in the bathroom, but the light was on over his bed. Also, the television was on at the time they found the resident unresponsive. She said Caregiver B called Nurse C on the radio. She explained that she called Caregiver D to come with her and they went quickly to the apartment. Soon after they entered the residents room Nurse E arrived. There was a total of 5 staff in the apartment at one point. Caregiver A confirmed was not initiated for the resident. According to Caregiver A they thought the resident was already . . . . . Caregiver A said a lot of . . . was observed on the floor in the resident's bathroom floor. Caregiver A said she was certified in . and had training on the facility policy. When the EMT's and police arrived at the facility all the staff left the residents' room. Caregiver A said she usually worked in memory care but there was a call out in the ALF.

On at 1:55pm an interview with Caregiver D was conducted. She said she went to resident #1's room after caregiver A notified her via walkie talkie. Nurse C and Nurse E were already in resident #1's room. She did not do anything with the resident because the nurses were already there in the bathroom with him. Caregiver D said if she ever finds someone unresponsive, she said she would call the nurse. She was certified and said she had . . training.

On . . . . . at 4pm an interview with Nurse E said he responded after Nurse C informed him of the incident with resident #1. The resident was in the bathroom slumped over sitting on the toilet. The resident was unresponsive with no , . . He confirmed he did not initiate or bring the

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 _____	03/28/2024

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 030	Continued From page 10 to the resident's room. He said the police and fire rescue arrived within about 5 minutes. He said he was aware of the facility policy. On at 4:20pm a facility tour found 1 available in the hall outside of the memory care unit. It was in a white cabinet clearly marked . One set of pads was attached. The pads Expired on The did not turn on and the battery light was not illuminated. The administrator removed the battery and found it had also expired on . At 4:50pm on , the Administrator was able to produce another that was kept in her office. The second found located in the administrator's office was functional when tested. Observation of the battery and pads revealed they were not expired. The administrator replaced the nonfunctioning in the cabinet marked next to the memory care unit. A review of the facility's Policy dated revealed the following documentation: "Resident does not have a : If a resident experiences a , staff trained in ( ), or a licensed health care provider present in the community, will administer , ." Class I	A 030		
A 075 SS=G	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under	A 075		

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 _____	03/28/2024

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 075	Continued From page 11 this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility. (4) Facility staff may withhold or withdraw [redacted] or the use of an automated external defibrillator if presented with an order not to [redacted] executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing [redacted] or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to [redacted] executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing [redacted] or use of an automated external defibrillator as otherwise permitted by law. (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews the facility failed to ensure the Automated external defibrillator ( ) unit was functional and the pads were not expired in case of a medical emergency as required in Florida	A 075		

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 _____	03/28/2024

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 075	Continued From page 12 Statute 429.255(3a). Findings: On . . . . . at 4:20pm a facility tour found 1 available in the hall outside of the memory care unit. It was in a white cabinet clearly marked . One set of pads was attached. Observation of the pads revealed they expired on . Upon an attempt to turn it on, the . . did not turn on and the battery light was not illuminated. The administrator removed the battery and found it had also expired on . . . . . . At 4:50pm on . . . . . , the Administrator was able to produce another that was kept in her office. The second found was not located in the resident care area but rather located in the administrator's office. Upon inspection of this unit, it was found to be functional when tested. Observation of the battery and pads revealed they were not expired. The administrator replaced the nonfunctioning . . . in the cabinet marked next to the memory care unit at this time. (. . . pads have adhesive gel so the gel will stick to the patient's skin and act as a conductor of electricity. If . . . pads are expired, there might be insufficient adherence to the skin, leading to the electric pulses not penetrating the skin properly. The machine will end up being less effective, and the patient will not receive a sufficient amount of electric pulses to stabilize their . . . rhythm. https://www.mindray.com/en/media-center/blogs/how-often-do- . . .-replacement-pads-need-to-be-replaced#:~:text=The%20reason%20why%20AED%20pads,not%20penetrating%20the%20skin%20properly.)	A 075		

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 _____	03/28/2024

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 075	Continued From page 13 Class II	A 075		