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 _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF OVIEDO	1915 W COUNTY RD 419 CHULUOTA, FL 32766

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation #2024000311 was conducted at Benton House of Oviedo on . The facility had a deficiency identified at the time of the visit.	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	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision to prevent elopement for 1 1 of 2 sampled residents, (#1). Findings: A review of resident#1's record revealed a facility admission date of . . . . . The resident's medical history included and , memory. The resident did not require any assistance with activities of daily living and was not an elopement risk at the time of the incident. A review of facility documentation in the resident's record revealed the following:	A 025		

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A 025	Continued From page 2 resident was upset asking for his wife and raising his voice stating, "who is the boss around here I need to see them now." Staff redirected him to his apartment. Resident is up walking around and does not have his on. The resident pointed to his and said this is not right and apologized to the staff. Family notified. Resident attempted to stand when got stuck to the carpet and resident went down to left . He was assisted to chair, vitals taken. No complaints from residents. After dinner resident was around inside. He asked where his wife was. A reminder that she was in heaven since 2017 was enough to calm him down. He then wanted to go out to make sure the garage door was down. While redirected to his room he stated his wife usually takes care of him. resident appears agitated and stated he was looking for his brother, wife, and sister. He was redirected to his room. The resident was upset and threw his phone towards the staff and then shouted to get out of his room. resident was up all-night . Resident was taken to memory care to keep him safe. In the morning the resident continued to talk about going out, calling a cab, and going down the street to his home. resident was up all night was taken to memory care for safety. resident had been redirected on all shifts. Resident came out his room stating "you know my wife in this jail and I need paperwork and I know the doctor. The resident was redirected several times. On at 8:05pm the daughter called the facility and requested assistance for the resident as he was locked out of his room. Upon entering	A 025		

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A 025	Continued From page 3	A 025		

the resident's room, the screen door in his room was open, and the resident was not in his room. A community search was conducted, and the resident was not located. Daughter called facility to say the resident was at the gas station down the street about a ½ a mile from the facility. The resident's daughter picked him up and he was brought to the facility and the resident was placed in the memory care unit. No injuries were incurred.

During an interview on at 10:30am Staff C stated resident#1 was aggressive and exit seeking on the assisted living side. She stated he always wanted to leave and go home. She stated he would throw lamps in his room and breaks windows. She stated he would say if you don't let me out of here, I will hurt someone. She stated he was only here at the facility a short time before he eloped. She stated after the elopement he was moved to memory care. She stated the resident was last seen about a half hour in his room prior to his elopement.

During an interview on 10:45am Staff F stated resident #1 was quiet and reserved and did not cause any problems. He likes to walk the halls and always needed reminders. She stated when he first came here, he was appropriate for the assisted living side. She stated he was and could understand commands and was able to express his needs. She stated she has participated in elopement drills often during the year.

During an interview on at 12pm with the family member of resident#1, she stated she was not aware that resident#1 was an elopement risk, and she does not fault the facility as they take very care of the resident and responded

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A 025	Continued From page 4 appropriately to the incident. In an interview on [redacted] at 12:30pm with the administrator she confirmed the above findings. She stated he did not appear to be aggressive or exit seeking when he was admitted. She stated he was residing on the assisted living side when the incident occurred and assisted living residents are allowed to leave the facility but are supposed to sign in and out before leaving. She stated he did not appear [redacted] or appear to have [redacted] decline at the time of the incident. She stated his behaviors became worse when he was placed in memory care after the incident. She stated he was not aware of aggressive or exiting seeking behaviors while he resided on the assisted living side. Class II	A 025		