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 _____	02/19/2025

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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

AHCA Form 3020-0001

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

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on the Background Screening (BGS) website, personnel record review and interview, the facility failed to maintain an accurate BGS Employee Roster for 6 of 15 sampled staff (A, C, F, H, J and Prior Administrator) as required within 5 business days of employment and within 5 business days of termination as required. Findings: 1. Caregiver A's personnel record review revealed a hire date of . He was terminated on . A review of the Background Screening (BGS) Employee Roster on at 12:53 AM listed caregiver A as still employed at the facility. 2. A third party agency Caregiver C's personnel record review revealed a hire date of . A review of the BGS Employee Roster on at 12:53 AM showed that she was	CZ814		

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CZ814	Continued From page 2 not updated at all. Furthermore, the Health Wellness Director (HWD) stated on at 8 AM that Caregiver C was from a third party agency. The third party agency had already provided the Level 2 BGS eligibility results dated for Caregiver C. 3. Caregiver C only works at the facility on a as needed basis, when the regular employees call in and/or more staff needed to meet the residents' care & needs. The HWD stated that Caregiver C does have access to the residents when working at the facility and Caregiver C was not working on the incident. On at *:00 AM an interview with the Health Wellness Director (HWDD) stated Caregiver C only works at the facility on as needed basis. The HWD stated that Caregiver C does have access to the residents when working at the facility and Caregiver C was not working on the 4. Unlicensed caregiver F's personnel record review revealed a hire date of . She was terminated on . A review of the BGS Employee Roster on at 12:53 AM listed caregiver F as still employed at the facility. 5. Unlicensed caregiver H's personnel record review revealed a hire date of . She was terminated on . A review of the BGS Employee Roster on at 12:53 AM listed caregiver (H) as still being employed at the facility. 5. Caregiver J's personnel record review revealed a hire date of . A review of the BGS Employee Roster on at 12:53 AM revealed Caregiver J was not added on the roster	CZ814		

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CZ814	Continued From page 3 within 5 business days at all. 6. The prior Administrator's, no personnel record onsite to review and no access to the personnel record because the Corporate Office has possession of the file pending a litigation stated by the Regional Director of Operations on at 1:45 PM on the telephone. A review of the BGS Employee Roster revealed the prior Administrator was hired on as a Certified Nursing Assistant (CNA). There was no documentation on the BGS Employee Roster that she was promoted as Administrator with the start date. The prior Administrator was terminated on and as of at 12:53 AM, the roster listed her as still being employed at the facility. (Photographic Evidence Obtained) On at 8:30 AM, an interview with the Health Wellness Director (HWD) confirmed all the findings after she reviewed the facility's BGS Employee Roster. Unclassified	CZ814		
CZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of , (b) Within 30 days after beginning employment,	CZ875		

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CZ875	Continued From page 4	CZ875		

each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department.
1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion.
2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies.
3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider.
(c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers.
(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an

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CZ875	Continued From page 5 adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training: 1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an	CZ875		

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CZ875	Continued From page 6 employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning , chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that	CZ875		

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CZ875	Continued From page 7 practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , , must complete the training required in this section before , , . Proof of completion of equivalent training completed before , , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed ensure staff who worked & interacted with residents with 's or related forms of received the required 1-hour training provided by the department within 30 days after beginning employment for 4 of 15 sampled staff (A, F. Nurse L and prior administrator). Findings: 1. Caregiver A's personnel record review revealed a hire date of . He was terminated on after being . There was no documented evidence that 1 hour of and training was completed within 30 days of hire. 2. Unlicensed caregiver F's personnel record review revealed a hire date of . She was terminated on . There was no documented evidence that 1 hour of and training was completed found in the file within 30 days of hire. Further review	CZ875		

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CZ875	Continued From page 8 revealed there was no 3-hour and training completed within 3 months after employment providing personal care on a regular basis with the residents. 3. Nurse L's personnel record review revealed a hire date of . There was no documented evidence that 1 hour of and training was completed within 30 days of hire. Further review revealed there was no 3-hour and training completed found in the file within 3 months of employment providing personal care on a regular basis with the residents. 4. The prior Administrator's, no personnel record onsite to review and no access to the personnel record because the Corporate Office has possession of the file pending a litigation stated by the Regional Director of Operations on at 1:45 PM on the telephone. Her date of hire , and termination date . On at 3:17 PM, an interview with the Administrator confirmed the findings. Class III	CZ875		
A 000	Initial Comments A Complaint Investigation #2024016632 and a generator monitoring was conducted at The Addison of Oviedo Assisted Living Facility & Memory Care with Limited Nursing Services (LNS) (formerly Benton House of Oviedo) on , , & . The facility had deficiencies at the time of the	A 000		

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A 000	Continued From page 9 survey visit.	A 000		
A 025 SS=J	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. (b) Daily observation by designated staff of the activities of the resident while on the premises,	A 025		

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A 025	Continued From page 10	A 025		

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 record review, facility's documentation and interviews, the facility failed to provide appropriate supervision of care and services to 1 of 4 sampled residents (#1) and 2) On at 5:59 AM, Resident #1 did not receive appropriate monitoring and supervision during the overnight shift hours of 11 PM-7 AM resulting in resident #1 being found unresponsive and not receiving as timely and subsequently was pronounced by Emergency Medical Services ( ).

Findings:

Review of incident report dated revealed on at approximately 6 AM the resident was discovered unresponsive during evening rounds. The care staff immediately notified the

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A 025	Continued From page 11 person in charge (PIC) who came to the room, took vitals and obtained no , or , 911 was called, , ( ) was started, and the Automated External Defibrillator ( ) machine was also utilized by Emergency Medical Services ( ). Emergency Medical Services ( ) arrived and took over. The resident was pronounced shortly after arrived. The resident resides in the Assisted Living community and is currently diagnosed with , Atherosclerotic (AHD), and . Review of resident #1's record revealed an admission date of . The last 1823 Health Assessment dated listing diagnoses to include 's , Atherosclerotic and D deficiency. Resident had with unclear speech but was alert and oriented to self/place. He needed assistance with activities of daily living (ADLs) in ambulation, bathing, , grooming, toileting and transferring and supervision with eating. Resident #1 also needed assistance with self-administered medications and was a Full Code that required , ( ). Review of Caregiver A's work schedule revealed he was scheduled to work 11:00 PM to 7:00 AM on . Review of Caregiver A's timesheet revealed he was late for his shift and arrived at the facility at approximately 11:19 PM observed by co-workers and he did not sign in. Caregiver A was scheduled to work from 11:00 AM to 7:00 AM. Caregiver A, who was responsible for the 100 wing of the Assisted Living Facility (ALF) on , where resident #1 resided, did not answer resident's call pendant when pushed	A 025		

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A 025	Continued From page 12	A 025		

multiple times beginning at 4:34 AM and was not responded to by Caregiver A until 5:59 AM.

Per review of Facility's undated Call Bell Requirement-Call Light Data Policy, facility's system in place was to ensure residents' call bells are answered in a timely manner , during the overnight hours with need to respond promptly to resident needs, including answering call bells. Policy defined "promptly" to mean a reasonable period of time, typically within minutes depending on specific circumstances and needs of residents and referenced ALF regulations through Chapter 58-5 of the Florida Administrative Code.

Per investigation conducted by the Agency, Caregiver A was supposed to check on his assigned residents on the 100-wing including resident #1 at 1:00 AM, 3:00 AM and 5:00 AM. However, investigation revealed Caregiver A never checked on Resident #1 during those times. Continued review of police and facility investigation it was revealed that Caregiver A went outside to his vehicle at 4:20 AM on to take an unofficial break and asleep during his shift (11 PM to 7 AM).

Resident #1 was last seen alive on at 11:20 PM by Caregiver F working on the 200 hallway, who went to resident's room to adjust his air conditioning because he stated he was hot.

Review of the call pendant report noted Caregiver A received 4 alerts on his pager at 5:40 AM, that Resident #1's pendant was going off. Caregiver A returned inside the building and went into Resident #1's room at 5:59 AM, where he found the resident on the floor with shallow breathing. 911 was called and Caregiver A was given

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A 025	Continued From page 13	A 025		

instructions by the 911 dispatch operator on how to perform which he initiated at that time. There was no documentation of what Caregiver A was doing between 5:40 AM, the time he received the alerts from resident #1, and when he arrived at the resident's room at 5:59 AM, a 19-minute gap in time.

Review of a police report dated at 0600 hours, documented two local police department Detectives responded to 1915 W CR 419 Oviedo FL 32766 (The ALF) in reference to a investigation. They were met by two other Detectives from the county upon arrival and spoke with the officers on the scene regarding the circumstances. The officers stated the decedent, Resident #1, was found by Caregiver A at approximately 0600 hours on , partially off his bed with his and resting on the lift assist that was attached to the bed.

Caregiver A provided a sworn written statement to the detectives stating he last checked on Resident #1 at 0100 hours, 0300 hours & 0500 hours and found Resident #1 to be asleep in his bed during all three checks. Caregiver A stated he was picking up trash and found Resident #1 halfway on the bed with his wrapped around the lift assist and resting on the lift assist attached to the bed, and that resident could not breathe. Caregiver A stated he then notified his supervisor, and his supervisor, called for emergency services.

Continued documentation in the police report noted caregiver A was briefly spoken to, to confirm the details of his written statement. The detective spoke to the medical examiner who declined the case and relayed that information to the staff at the facility. As the Detective was

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BENTON HOUSE OF OVIEDO	1915 W COUNTY RD 419 CHULUOTA, FL 32766

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preparing to leave the scene, Caregiver A approached him and said, "I need to confess something". Caregiver A went on to say he had taken an unofficial break at approximately 0420 hours and set a 30-minute timer on his phone to take a nap and asleep in his vehicle. Caregiver A received the alerts for Resident #1 on at 5:40 AM and did not find Resident #1 until 5:59 AM.

Police investigation noted Caregiver A stated at approximately 0540 hours he woke up and realized he had been asleep for longer than 30 minutes (1 hour 20 minutes). Caregiver A stated he had notifications on his work device saying that Resident #1 had requested emergency help, which he believed to be around 0500 hours. Caregiver A stated he then went inside at approximately 0540 hours and found Resident #1 in the position he initially described.

The detective retrieved documentation from the other staff at the facility in reference to Resident #1 activating his emergency assistance button and staff provided the detective with a printout which noted Resident #1 had requested emergency assistance at 0434 hours and activated that request 4 times until 0507 hours. Previously there was an activation for emergency assistance at 2322 hours on , with no other activity in between. Staff documents their checks with residents in a program and it noted there were no other activities listed for Resident #1. Staff stated they had recently switched to this system, and they were unsure of how to see the rest of the activities.

The detective went to speak with Caregiver A with the documentation from other staff to see if he had documentation of when he last checked

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A 025	Continued From page 15 on Resident #1, Caregiver A then admitted he did not check on Resident #1 for the entirety of his shift. Caregiver A stated he arrived at work late at approximately 2304 hours on and he knew Resident #1 had requested assistance, so another staff member completed that request and set up Resident #1 for bed, which was at 2322 hours. Caregiver A then stated he did not check on Resident #1 until he woke up from falling asleep in his vehicle and found Resident #1 at approximately 0545 hours struggling to breathe. Police investigation continued noting police officer located Caregiver A's vehicle in the parking lot of the facility, and in plain view, the police officer was able to see marijuana paraphernalia and burnt marijuana cigarettes. Caregiver A was asked by police if he smoked and Caregiver A was then asked if that's what he was doing last night, to which Caregiver A nodded his yes. On at 6:26 AM, the Emergency Medical Services ( ) & Fire Department terminated and called Resident #1's time of on at 6:26 AM. Resident #1 had no return of spontaneous circulation (ROSC) with no vitals. A facility note dated at 1:19 PM by Health Wellness Director (HWD) documented they received a call from the 11pm-7am (overnight) caregiver H at 6:10 AM and she stated that Resident #1 was found unresponsive on the floor and had no . Caregiver H also mentioned that Emergency Medical Services (-911) was called to the facility. The HWD informed Caregiver H that Resident #1 was a Full Code, and that	A 025		

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A 025	Continued From page 16 ( ) should be initiated. While the HWD was in route to the facility, she got another call from 11pm-7am (overnight) Caregiver H at 6:28 AM stating that the emergency medical services team had arrived at the facility & stated that Resident #1 was . When the HWD arrived at the facility at approximately 6:55 AM, the medical examiner was inside Resident #1's room, and two police officers were sitting outside Resident #1's door. The HWD called the Resident's son and informed him of his father's passing. On at 9:32 AM, an interview with the Administrator confirmed the investigation findings for Resident #1. Multiple interview attempts to get more information related to the incident were unsuccessful, to include attempted telephone interview on at 2:40 PM with Caregiver A, with no answer and unable to leave voicemail message and attempted a telephone interview on at 2:45 PM with Caregiver F, no answer, left voicemail message to return call, but received no call from either staff. Also attempted an interview on at 2:55 PM onsite with Caregiver G (waited for her to report to work on 2nd shift 3pm-11pm) but this staff ended up calling out. Another interview was attempted by telephone on at 12:53 PM with caregiver G but no answer. A voicemail message was left to return my call at her earliest convenience, but no call received. And attempted interview on at 3 PM with Lead Caregiver H (person in charge on) but again no answer and unable to leave a voicemail message and have not received a call .	A 025		

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A 025	Continued From page 17 On at 5:59 AM, Resident #1 did not receive appropriate monitoring and supervision during the overnight shift hours of 11 PM-7 AM. (Photographic Evidence Obtained) Class I	A 025		
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	A 030		

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A 030	Continued From page 18 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 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	A 030		

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A 030	Continued From page 19 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 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	A 030		

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A 030	Continued From page 20 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, 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	A 030		

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A 030	Continued From page 21 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 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	A 030		

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A 030	Continued From page 22 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 resident. This Statute or Rule is not met as evidenced by: Based on the resident record review, facility's documentation and interview, the facility failed to honor resident rights by not following the facility's policies on Advance Directives specifically , , ( ) being initiated in a timely manner that resulted in a for 1 of 4 sampled residents (#1). Findings:	A 030		

Agency for Health Care Administration

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A 030	Continued From page 23 Review of incident report dated revealed on at approximately 6 AM the resident was discovered unresponsive during evening rounds. The care staff immediately notified the Person in Charge who came to the room, took vitals and obtained no , or , . 911 was called. ( ) was started, and the Automated External Defibrillator ( ) machine was also utilized by . Emergency Medical Services ( ) arrived and took over. The resident was pronounced shortly after arrived. The resident resides in the Assisted Living community and is currently diagnosed with , Atherosclerotic (AHD), and . Review of resident #1's record revealed an admission date of . The last 1823 Health Assessment dated listing diagnoses to include 's , Atherosclerotic and D deficiency. Resident had with unclear speech but was alert & oriented to self/place. He needed assistance with activities of daily living (ADLs) in ambulation, bathing, , grooming, toileting and transferring and supervision with eating. Resident #1 also needed assistance with self-administered medications and was a Full Code that required ( ). On at 5:59 AM, Resident #1 did not receive appropriate monitoring and supervision during the overnight shift hours of 11 PM-7 AM. Review of Caregiver A's timesheet revealed he was late for his shift and arrived at the facility at approximately 11:19 PM observed by co-workers	A 030		

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A 030	Continued From page 24 and did not sign in. Caregiver A, who was responsible for the 100 wing of the Assisted Living Facility (ALF) on , where resident resided, did not answer resident's call pendant when pushed multiple times beginning at 4:34 AM and was not responded to by Caregiver A until 5:59 AM. Per review of Facility's Call Bell Requirement-Call Light Data Policy, facility's system in place was to ensure residents' call bells are answered in a timely manner , , during the overnight hours with need to respond promptly to resident needs, including answering call bells. Policy defined "promptly" to mean a reasonable period of time, typically within minutes depending on specific circumstances and needs of residents and referenced ALF regulations through Chapter 58-5 of the Florida Administrative Code. Per the facility investigation, Caregiver A was supposed to check on his assigned residents at 1:00 AM, 3:00 AM and 5:00 AM. However, investigation revealed Caregiver never checked on Resident #1 during those times. Continued review of police and facility investigation it was revealed that Caregiver A went outside to his vehicle at 4:20 AM on to take an unofficial break and asleep during his shift (11 PM to 7 AM). Resident #1 was last seen alive on at 11:20 PM by Caregiver F working on the 200 hallway, who went to resident's room to adjust his air conditioning because he stated he was hot. Review of the call pendant report noted Caregiver A received 4 alerts on his pager at 5:40 AM, that Resident #1's pendant was going off. Caregiver A returned inside the building and went into	A 030		

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A 030	Continued From page 25 Resident #1's room at 5:59 AM, where he found the resident on the floor with shallow breathing. 911 was called and Caregiver A was given instructions by the 911 dispatch operator on how to perform which he initiated at that time. There was no documentation of what Caregiver A was doing between 5:40 AM, the time he received the alerts from resident #1, and when he arrived at the resident's room at 5:59 AM, a 19-minute gap in time. Review of a police report dated at 0600 hours, documented two local police department Detectives responded to 1915 W CR 419 Oviedo FL 32766 (The ALF) in reference to a investigation. They were met by two other Detectives from the county upon arrival and spoke with the officers on the scene regarding the circumstances. The officers stated the decedent, Resident #1, was found by Caregiver A at approximately 0600 hours on , partially off his bed with his and resting on the lift assist that was attached to the bed. Caregiver A provided a sworn written statement to the detectives stating he last checked on Resident #1 at 0100 hours, 0300 hours and 0500 hours and found Resident #1 to be asleep in his bed during all three checks. Caregiver A stated he was picking up trash and found Resident #1 halfway on the bed with his wrapped around the lift assist and resting on the lift assist attached to the bed, and that resident could not breathe. Caregiver A stated he then notified his supervisor, and his supervisor called for emergency services. Continued documentation in the police report noted caregiver A was briefly spoken to, to confirm the details of his written statement. The	A 030		

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A 030	Continued From page 26	A 030		

detective spoke to the medical examiner who declined the case and relayed that information to the staff at the facility. As the Detective was preparing to leave the scene, Caregiver A approached him and said, "I need to confess something". Caregiver A went on to say he had taken an unofficial break at approximately 0420 hours and set a 30-minute timer on his phone to take a nap and asleep in his vehicle. Caregiver A received the alerts for Resident #1 on at 5:40 AM and did not find Resident #1 until 5:59 AM.

Police investigation noted Caregiver A stated at approximately 0540 hours he woke up and realized he had been asleep for longer than 30 minutes (1 hour 20 minutes). Caregiver A stated he had notifications on his work device saying that Resident #1 had requested emergency help, which he believed to be around 0500 hours. Caregiver A stated he then went inside at approximately 0540 hours and found Resident #1 in the position he initially described.

The detective retrieved documentation from the other staff at the facility in reference to Resident #1 activating his emergency assistance button and staff provided the detective with a printout which noted Resident #1 had requested emergency assistance at 0434 hours and activated that request 4 times until 0507 hours. Previously there was an activation for emergency assistance at 2322 hours on , with no other activity in between. Staff documents their checks with residents in a program and it noted there were no other activities listed for Resident #1. Staff stated they had recently switched to this system, and they were unsure of how to see the rest of the activities.

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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 030	Continued From page 27	A 030		

The detective went to speak with Caregiver A with the documentation from other staff to see if he had documentation of when he last checked on Resident #1, Caregiver A then admitted he did not check on Resident #1 for the entirety of his shift. Caregiver A stated he arrived at work late at approximately 2304 hours on and he knew Resident #1 had requested assistance, so another staff member completed that request and set up Resident #1 for bed, which was at 2322 hours. Caregiver A then stated he did not check on Resident #1 until he woke up from falling asleep in his vehicle and found Resident #1 at approximately 0545 hours struggling to breathe.

Police investigation continued noting police officer Sargeant located Caregiver A's vehicle in the parking lot of the facility, and in plain view, the police Sargeant was able to see marijuana paraphernalia and burnt marijuana cigarettes.

Caregiver A was asked by police if he smoked and Caregiver A was then asked if that's what he was doing last night, to which Caregiver A nodded his yes.

On at 6:26 AM, the Emergency Medical Services ( ) & Fire Department terminated and called Resident #1's time of on at 6:26 AM. Resident #1 had no return of spontaneous circulation (ROSC) with no vitals.

A facility note dated at 1:19 PM by Health Wellness Director (HWD) documented they received a call from the 11pm-7am (overnight) caregiver H at 6:10 AM and she stated that Resident #1 was found unresponsive on the floor and had no , . Caregiver H also mentioned that Emergency Medical Services

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	AL11969905	A. BUILDING: _____ B. WING _____	02/19/2025

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A 030	Continued From page 28 (-911) was called to the facility. The HWD informed Caregiver H that Resident #1 was a Full Code, and that ( ) should be initiated. While the HWD was in route to the facility, she got another call from 11pm-7am (overnight) Caregiver H at 6:28 AM stating that the emergency medical services team had arrived at the facility & stated that Resident #1 was . When the HWD arrived at the facility at approximately 6:55 AM, the medical examiner was inside Resident #1's room, and two police officers were sitting outside Resident #1's door. The HWD called the Resident's son and informed him of his father's passing. On at 9:32 AM, an interview with the Administrator confirmed the investigation findings for Resident #1. Multiple interview attempts to get more information related to the incident were unsuccessful, to include attempted telephone interview on at 2:40 PM with Caregiver A, with no answer and unable to leave voicemail message and attempted a telephone interview on at 2:45 PM with Caregiver F, no answer, left voicemail message to return call, but received no call from either staff. Also attempted an interview on at 2:55 PM onsite with Caregiver G (waited for her to report to work on 2nd shift 3pm-11pm) but this staff ended up calling out. Another interview attempt by telephone on at 12:53 PM with caregiver G but no answer. A voicemail message was left to return the call at her earliest convenience, but no call was received. And attempted interview on at 3 PM with Lead Caregiver H (person in charge on) but again no answer and unable	A 030		

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A 030	Continued From page 29 to leave a voicemail message and have not received a call . A review of the facility's Advance Directives policy for , , ( ) and ( ) as follows: 8. All community team members should be certified, if required by state licensing regulations. A state-required copy of the current certification must be maintained in the personnel file of each community team member, as required. Caregiver's G, F, and H (Lead) did not know where the machine was located and not able to locate the machine until after the First Responders and Fire Department already arrived at the facility at 6:12 AM (on the scene) with eventually terminating no code and no vitals, calling time of of Resident #1 at 6:26 AM. (Photographic Evidence Obtained) Class I	A 030		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who	A 077		

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A 077	Continued From page 30 has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ˛ ˘ ; 2. If employed on or after . , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator.	A 077		

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A 077	Continued From page 31 Administrators who attended core training prior to , , , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must	A 077		

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A 077	Continued From page 32 satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , . . , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on facility's documentation, resident & personnel record reviews and interviews, the facility failed to ensure the administrator {1}be responsible for the operation of the facility to include the management of all staff in the provision of appropriate care to 1 of 4 sampled residents (#1) resulting in a when the staff in attendance did not initiate , , ( ) in a timely manner and{2} the facility failed to obtain qualified employees working overnights who were properly trained and had the facility's in-service trainings and tools to conduct their job as required for 4 of 4 sampled staff (A, F, G, H-lead) during of the emergency	A 077		

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A 077	Continued From page 33 response to an event resulting in the of 1 of 4 residents (#1). Findings: Review of resident #1's record revealed an admission date of . The last 1823 Health Assessment dated listing diagnoses to include 's , Atherosclerotic and D deficiency. Resident had with unclear speech but was alert & oriented to self/place. He needed assistance with activities of daily living (ADLs) in ambulation, bathing, , grooming, toileting and transferring and supervision with eating. Resident #1 also needed assistance with self-administered medications and was a Full Code that required ( ). Resident #1 was last seen alive on at 11:20 PM by Caregiver F working on the 200 hallway, who went to resident's room to adjust his air conditioning because he stated he was hot. In addition, investigation found that all four staff identified working the overnight shift on (11 PM-7 AM) did not initiate timely on Resident #1 and could not locate where the machine was located in the facility. Review of the police investigation found Caregiver A was responsible for Resident #1 and the rest of residents on the assisted living facility (ALF) hallway 100. Caregiver A did not check on Resident #1 his entire shift (11pm to 7am) until at 5:59 AM. Caregiver A was later and was terminated immediately for smoking marijuana in his vehicle on an unofficial break at 4:20 AM, falling asleep	A 077		

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A 077	Continued From page 34 and neglecting to care and supervise a elderly man (Resident #1) by not returning inside the ALF until 5:40 AM. Further investigation found Caregiver G was responsible for Memory Care residents on and assisted Caregiver A with the 911 call at 6:07 AM on , Caregiver F was responsible for residents on the ALF hallway 200 on and called 911 from the Media room at 6:08 AM and Caregiver H was the lead person in charge on and worked in Memory Care but could not be found in the facility during the incident. A review of documentation provided by the First Responders & Fire Department's Computer Aided Dispatch ( ) report, which are public records #2024-12-03572 listed below the events in order of staff's response for Resident #1 on at the ALF: 1. Emergency Medical Services ( ) was dispatched to the facility on at 6:07 AM. 2. was enroute to the facility on at 6:10 AM and arrived at the facility at 6:12 AM and took over performing on Resident #1 from Caregiver A. 3. terminated on Resident #1 for no return of spontaneous circulation and no vitals, and they called time of on at 6:26 AM. A facility note dated at 1:19 PM by the Health Wellness Director (HWD) documented they received a call from 11pm-7am Caregiver H at 6:10 AM and she stated that Resident #1 was	A 077		

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A 077	Continued From page 35	A 077		

found on the floor. He was unresponsive and had no , . Unlicensed caregiver H also mentioned that First responders (911) was called. The Health Wellness Director (HWD) informed Caregiver H that Resident #1 was a Full Code, and that , , ( ) should be initiated. While Health Wellness Director (HWD) was in route to the facility, they got another call from 11pm-7am Caregiver H at 6:28 AM stating that the emergency medical services team stated that Resident #1 was . When Health Wellness Director arrived at the facility at approximately 6:55 AM, the medical examiner was inside Resident #1's room, and two police officers were sitting outside his door. The Health Wellness Director (HWD) introduced herself to the police officers and let them know she was at the facility to assist in any way she could. The Health Wellness Director (HWD) called son and informed him of his father's passing.

The prior Administrator was the Manager on Duty when this incident occurred but did not arrive at the facility until after 9 AM, and was not , with the facility staff, and the law enforcement agency during their investigation. It was the prior Administrator's responsibility and part of her duties to obtain qualified staff when employed at the ALF to ensure that all residents' needs and the care and supervision could be met. Qualified staff must complete in-service training within the timeframe set by the Florida Statute regulations for ALF's and they are to have First Aid and , , , , ( ) certification in case such an emergency arises. Investigation findings noted it was the prior Administrator's responsibility to ensure staff hired were qualified and she failed in this task with the outcome to include the staff employed

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A 077	Continued From page 36 who did not have the qualifications as noted below: A. Caregiver A was hired on , 5 months before the incident on , had no training completed prior to interacting alone with any the residents and other staff and there was no documentation of First Aid and , ( ) certification found in the file. B. Caregiver G was hired on , 6 months before the incident on , still employed at the facility and now works on 2nd shift 3 PM-11 PM specifically only in Memory Care. Her personnel file was missing some relevant training and did not have evidence of First Aid/ certification found in the file. C. Unlicensed caregiver F was hired on , almost 2 years before the incident on , and was missing relevant training and her certification was noted to have expired on (9 months before the incident on). D. Lead Caregiver H was hired on , 6 months before the incident on . This employee had all her in-service training completed except that her First Aid/ certification was an online training only (Florida Statute language requires this training to be to with a live interactive qualified trainer). In addition, the Lead Caregiver H could not be found in the facility during the incident on with Resident #1 and she was the designated person in charge. Also note the prior Administrator had no personnel record onsite to review and no access to the personnel record because the Corporate	A 077		

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A 077	Continued From page 37 Office had possession of the file due to a pending litigation as stated by the Regional Director of Operations on at 1:45 PM on the telephone. This staff's date of hire was noted as and terminated . She was the Manager on Duty on and did not arrive at the facility until 9 AM. Interview on at 3:17 PM with the current Administrator confirmed the findings. (Photographic Evidence Obtained) Class I	A 077		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d).	A 081		

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A 081	Continued From page 38 (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility	A 081		

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A 081	Continued From page 39 administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training	A 081		

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A 081	Continued From page 40 within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure staff received the required training prior to interacting working with residents for 6 of 15 sampled residents sampled staff (A, C, G, Nurse L, Nurse M and prior Administrator) and in-service training completed within 30 days of employment for 1 of 15 sampled staff (A). Findings: 1. Caregiver A's personnel record review revealed	A 081		

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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 081	Continued From page 41 a hire date of . He was terminated on after being . There was no documented evidence for the training listed below: a. no two-hour pre-service orientation training with an overview of resident rights, facility type, and services offered to be completed prior to interacting & working on the floor with the residents. b. no one-hour facility specific training on recognizing , neglect and , . c. no three hours of training in Activities of Daily (ADLs) and behavioral needs. d. no one hour training in major incident reporting & adverse incident reporting. 2. A third party employee, Caregiver C's (as needed only) hire date , she has no personnel record on onsite at the facility and no documentation of in-service trainings listed below: a. no two-hour pre-service orientation training with an overview of resident rights, facility type, and services offered to be completed prior to interacting & working on the floor with the residents. b. no one-hour facility specific training on recognizing , neglect and , . c. no three hours of training in Activities of Daily (ADLs) and behavioral needs. d. no one hour training in major incident reporting	A 081		

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A 081	Continued From page 42 & adverse incident reporting. 3. Unlicensed caregiver G's personnel record review revealed hire date . She's currently still employed at the facility working specifically 2nd shift hours 3 PM-11 PM only in Memory Care unit. There was no documentation for in-service training courses below: a. no one-hour facility specific training on recognizing , neglect and , . b. no one hour training in major incident reporting & adverse incident reporting. 4. Nurse L's personnel record review revealed hire date . She's still employed at the facility and missing in-service no documentation of training listed below: a. no one-hour facility specific training on recognizing , neglect and , . b. no one hour training in major incident reporting & adverse incident reporting. 5. Nurse M's personnel record review revealed hire date . She's still employed at the facility and there was no documentation for in-service training listed below: a. no one-hour facility specific training on recognizing , neglect and , . b. no one hour training in major incident reporting & adverse incident reporting.	A 081		

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A 081	Continued From page 43 6. The prior Administrator had no personnel record onsite to review and no access to the personnel record because the Corporate Office has possession of the file pending a litigation stated by the Regional Director of Operations on at 1:45 PM on the telephone. Hire date was , she was terminated on She was the Manager on Duty on the incident with Resident #1, arriving at the facility at 9 AM. On at 3:17 PM, an interview with the Administrator confirmed the findings. Class III	A 081		
A 083 SS=G	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the	A 083		

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A 083	Continued From page 44 training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure staff had a valid First Aid and , , ( ) certification and must be in the facility at all times staff for 3 of 4 sampled caregivers (A, F and G) and 2) the certification must be completed in person by an approved trainer that requires the students' to demonstrate for 1 of 4 sampled caregiver (H). Findings: 1. Caregiver A's personnel record review revealed hire date . He was terminated on after being . There was no documented evidence of a First Aid and , , ( ) certification card found in the file onsite. 2. Unlicensed caregiver F's personnel record review revealed hire date , terminated on . Her First Aid certification card expires but the certification card was separate and expired on (earlier in year). 3. Unlicensed caregiver G's personnel record review revealed hire date and still employed at the assisted living, specifically only working in the Memory Care unit and on 2nd shift (3 PM-11 PM). She had no First Aid & certification card onsite at the facility. The last time she worked on .	A 083		

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A 083	Continued From page 45 4. Lead Unlicensed caregiver H's personnel record review revealed hire date , terminated on . Her First Aid & certification card was online and expires . (Photographic Evidence Obtained) On at 3:33 PM, an interview with the Administrator confirmed the findings and further stated she will make sure all employees complete First Aid & certification, no matter what shifts, so there is always coverage in the facility at all times. Class II	A 083		
A 090 SS=D	59A-36.011(11) FAC Training - (11) . . . . . . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure staff completed one	A 090		

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A 090	Continued From page 46 hour ( ) training specifically to the facility's policies and procedures within 30 days after employment as required for 3 of 4 sampled caregivers. Findings: 1. Caregiver A's personnel record review revealed hire date . He was terminated on after being . There was no documented evidence that 1-hour training was completed on file. 3. Unlicensed caregiver F's personnel record review revealed hire date , terminated on . There was no documentation evidence that a 1-hour training was completed on file. 4. Unlicensed caregiver G's personnel record review revealed hire date and still employed at the assisted living, specifically only working in the Memory Care unit and on 2nd shift (3 PM-11 PM). She had no 1-hour training completed on file. On at 3:33 PM, an interview with the Administrator confirmed the findings and had an opportunity to go through the personnel records requested to make sure the above staff did not have their 1-hour training. Class III	A 090		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall	A 161		

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A 161	Continued From page 47 maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed	A 161		

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A 161	Continued From page 48 staffing agency or staff employed by an entity ␣ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain the prior Administrator's personnel record onsite at the facility available for the agency to review as required. Findings: An observation on at 5 AM, the prior Administrator's personnel chart was not onsite and was not available to review any training, credentials and any other relevant information. The prior Administrator had no personnel record onsite to review and no access to the personnel record because the Corporate Office has possession of the file due to pending a litigation stated by the Regional Director of Operations on at 1:45 PM on the telephone. Date of hire and terminated . She was the Manager on Duty on for Resident #1 and did not arrive at the facility until 9 AM. On at 3:33 PM, an interview with the	A 161		

Agency for Health Care Administration

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A 161	Continued From page 49 Administrator confirmed the finding. Class III	A 161		