STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967569	12/02/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= J
St - A - 0076 - 58a-5.0186 Fac - S-S= D
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= J
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments
A complaint inspection CCR#2013011900 was conducted on and

Benton House of Titusville had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and interview the facility failed to ensure the AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010 was completed for 1 of 13 sampled residents (#6).

Findings:

Resident record review for resident #6 revealed an AHCA Form 1823 dated There was no documentation to review to indicate an 1823 had been completed on the AHCA Form 1823, 2010.

Interview with the administrator and the resident services director on at approximately 3:50 PM who stated they were not aware the 1823 had not been updated.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview the facility failed to provide access to adequate and appropriate health care consistent with established and recognized standards in the community and did not:
1. Have a system in place to immediately identify residents who had

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Orders and failed to honor resident rights to withhold when a hospice resident had a the resident survived and suffered pain post and a decline in health for 1 of 13 sampled residents (#1). They failed to documented the family/healthcare provider was notified of the and that they responded to the family's concerns regarding medications for 1 of 13 sampled residents (#1)
2. Have a licensed nurse, as required, to administer a medication with parameters that resulted in a medication error for 1 of 13 sampled residents (#13).
3. Have a licensed nurse administer medications per physician order to 3 of 13 sampled residents (#1, 3 and 5).

Findings:

1. Review of record for resident #1 revealed an Assisted Living Facility Health Assessment Form (1823) dated that stated diagnoses of insufficiency, carotid and retention. The resident was independent with ambulation, dressing, eating, toileting and transferring and needed supervision with bathing.

Review of record for resident #1 revealed an 1823) updated on updated on that stated diagnoses of and

Review of the revealed on the attending physician and resident #1 signed the form.

Record review revealed the resident was admitted to hospice on .

Review of facility notes revealed:
"Resident had c/o (complained of) chest pain and took (for chest pain) pill -while conversing with resident - resident stopped talking and eyes started rolling and was having a - resident assistant called 911 - and we initiated - with (Automated External Defibrillator) - until paramedics arrived - was done for a minute and a half - resident was sent to hospital via fire rescue."

"resident returned from hospital, no new orders. Diagnoses were and Hospice will be in tomorrow to readmit the resident."

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2000 (8 PM) "Hospice nurse admit note - patient readmitted to hospice services after return to facility today from hospitalization. Patient alert and oriented times 3, pleasant and Family present. Signed admission paperwork."

"Resident started Crisis Care today at 7 PM for right pain unrelieved with ordered pain management post 5 milligrams (mg) at 6:30 PM with decreased pain; repeated dose at 8 (unable to read) PM."

11 "Resident transferred to hospice house for pain management."

"Resident discharged from facility."

Review of the facility's Policy and Procedure stated:
"The following procedure will be followed: Resident has executed a If a resident experiences a staff trained in
or a licensed health care provider present in the community may withhold In the event a resident is receiving hospice services and experiences community staff must immediately contact the hospice. The hospice procedures take precedence over those of the ALF."

Review of the hospital Emergency Provider Record dated stated the resident was seen at 1740 (5:40 PM). Patient stated he had (chest) pain, asked staff for (for chest pain). He had a witnessed versus and was shocked by the staff even though he was a The patient had no other complaints other than he was uncomfortable and mildly short of breath. The patient was alert and in mild distress.

Review of the Emergency Department Patient Chart dated stated, the staff from the Assisted Living Facility stated the patient clutched his chest, went back to took The nurse saw his eyes roll back and began to and stated, he had no pulse and began He was placed on the which advised to and he was shocked. He was alert and oriented times 3 when he arrived at the emergency (ER), and was complaining of

Progress:
Suspect (fainting) versus (low episode secondary to His condition was improved and stable and he was admitted to the hospital.

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Review of hospital Discharge Summary stated the resident was admitted on [redacted] and discharged on [redacted] stated the patient had a syncopal episode at the facility and was apparently coded. Emergency Medical Service was called, and he was brought to the Emergency [redacted] The resident was a hospice patient and hospice had to be rescinded to bring him into the hospital.

Impression:
1. [redacted]
2. [redacted]
3. [redacted]
4. Chest pain
5. [redacted]

In an interview with the Resident Services Director [redacted] on [redacted] at 1:15 PM who stated she was back in her office when [redacted] was started on resident #1. The staff who responded was Staff G and Staff E responded. Staff D, the nurse, initiated [redacted] and Staff E defibrillated the resident. The nurse did not know that the resident had a [redacted] The event happened in the foyer, there were no cameras in the building that worked at that time. She stated the family member was called and it was not written down

"We talked to the staff about what happened and talked to the corporate office. We talked to Staff D about it. We are talking to the corporate office, so that it does not happen again. The staff has not been retrained in our [redacted] policy."

There was no plan in place at that time to identify residents who had [redacted] to prevent further errors in administering or withholding [redacted]

There was no documentation to indicate the healthcare provider/family was notified of the significant change.

In an interview with the administrator, a nurse, on [redacted] at approximately 3:30 PM who stated, resident #1 ' s family had complained to her about his [redacted] medications being unlocked in his [redacted] and the facility locked the medications in the medication cart. She also stated that whenever the family member had a concern that she would address it right away. There was no written documentation that the facility responded to the family member's concerns.

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Interview with Staff D, the nurse, on [redacted] at approximately 3:30 PM; she stated at about 5 PM on [redacted] resident #1 got up from the dining [redacted] was holding his chest. She followed him back to his [redacted] asked him if he was having chest pain. I asked him if he was going to take some [redacted] he had an order to keep them at bedside. He told me he took one and then he came out of his [redacted] He was sitting in the front lobby in a chair at 5:14 PM. The staff paged me; he was talking to me and stated the [redacted] did not work as well as it used to. Then he stated the pain went away. When we were talking his head hit the wall and his eyes started rolling. I yelled to someone to call 911. His [redacted] started falling out of his mouth. Staff E, direct care, took his pulse and he did not have one. Staff G, direct care went to get the RCD. She started compressions and Staff E, direct care, was setting up the [redacted] pads. He was shocked. The [redacted] told them not to [redacted] him again. 911 came in and wanted to know why we stopped [redacted] and we told them he was breathing. The [redacted] was in the back of the facility in the nursing office, and we were in the front foyer. He returned the next day from the hospital and was put on Crisis Care for pain management. She stated she was not aware of the residents who had [redacted]

Interview with Staff E on [redacted] at approximately 3:40 PM who stated, resident #1 was not feeling good, he left the dining [redacted] went to sit in the foyer. I heard the nurse scream to call 911. She took his pulse in the chair and did not feel one. When she got there, his [redacted] were falling out, and she took them out. Staff G went to tell the RCD that we were going to do [redacted] She checked his pulse again, it was [redacted] and he was not breathing, when he was on the floor. The nurse and I slid him to the floor and Staff D and Staff G started [redacted] The secretary got the [redacted] and the nurse told me to put it on and turned it on. The [redacted] stated to [redacted] him and she shocked him. They continued to do [redacted] until he started breathing and waking up, and then 911 arrived.

In a phone interview with the hospice nurse on [redacted] at approximately 2:30 PM who stated when she saw resident #1 he had right chest pain, when he returned from the hospital, after the [redacted] They did not do a chest x-ray on him. His chest pain was different than the [redacted] pain. She was concerned about him, and got Crisis Care started to manage his pain in the ALF, after he returned from the hospital. There was no [redacted] the Hospice House. On [redacted], he was admitted to the hospice house for pain management, when a bed became available. She went to see him at the hospice house; he had started to decline at the hospice house. He was [redacted] and was alert and oriented times 2. He was discharged to a skilled nursing facility."

During a phone interview with the Advanced Registered Nurse Practitioner (ARNP) on [redacted] at approximately 2:05 PM she stated; her physician group became resident #1's

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primary physician a year ago. She saw him until he went into the Hospice House. It started with the hormone) error. He was he was very fragile. The ALF called me over the weekend and stated the Med Tech gave him an extra dose of hormone). They were to take his and we adjusted his medications. He was not very pleasant to the Med Techs after that. On the morning he was his cell phone was dropped under his bed by staff, and he was very upset and had worked himself up. "And then went out." The facility initiated He came back very quickly. He had no when she saw him the next day in the hospital. He did not have a bracelet on that indicated he was a She saw him when he got out of the hospital and returned to the facility. He was on crisis care.

She spoke to the administrator, a nurse, who stated it was previously up to the residents to decide if they wanted to wear a bracelet. The facility was now making bracelets for the residents who had He was admitted to the hospice house for and chest pain, when he returned from the hospital. It was almost like a that he experienced. After he was it became real to him that he was really close to Crisis Care was with him, at the facility after the hospital discharge. They stated he was upset, he knew where he was, but he did not remember the hospital. When she walked in and saw him, she decided to send him to the hospice house. When she saw the resident the next morning, he did not have any marks on his chest from the paddles. He stated he did not have pain from the paddles. He got for pain, until he refused to take the She was not aware of the origin of the pain, if it was chest pain or pain.

2. Record review for resident #13 revealed an 1823 dated that stated diagnoses of and and stated the resident needed assistance with self-administration of medications.

Review of physician order dated stated (for ER 50 mg (milligrams) at bedtime. Hold for pulse <55 of

Review of the 2013 MOR revealed the was charted as given; initials were in the box and signed by the unlicensed staff on through The pulse was 53 on and the was not held per physician's order. There no documentation on the back of the MOR that stated the was held.

The licensed nurse did not administer the with parameters as required that resulted in a medication error.

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Interview with the administrator, a nurse and the Resident Services Director on [redacted] at approximately 3:30 PM who stated they were not aware a nurse was required to check [redacted] before giving medications with parameters and were not aware of the error.

3. Observation of the Medication Pass for resident #3 and #5 on [redacted] at approximately 8:40 AM revealed the unlicensed staff assisted the residents with self-administration of medications.

Review of the Assisted Living Facility Health Assessment Form (1823) dated [redacted] stated the resident #3 needed medications administered.

Review of the Assisted Living Facility Health Assessment Form (1823) dated [redacted] stated the resident #5 needed medications administered.

Record review revealed an 1823 updated on [redacted] revealed resident #1 needed administration of medications.

Review of the [redacted] 2013 Medication Observation Record revealed the resident was assisted with self-administration of medications, by the unlicensed staff.

In an interview with the administrator, a nurse, and the Resident Care Director on [redacted] at approximately 3:40 PM who were not aware the 1823's stated the residents needed medications administered for residents #1, #3 and #5.

Class I

007([redacted] 58A-5.0186 FAC
Based on record review and interview the facility failed to contact hospice before resuscitating a resident had a properly executed [redacted] for 1 of 13 sampled residents (#1).

Findings:

Review of record for resident #1 revealed an Assisted Living Facility Health Assessment Form (1823) updated on updated on [redacted] that stated diagnoses of [redacted] and [redacted]

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Review of the revealed on the attending physician and resident #1 signed the form.

Record review revealed the resident was admitted to hospice on

Review of the facility's Policy and Procedure stated:
"The following procedure will be followed: Resident has executed a If a resident experiences a staff trained in or a licensed health care provider present in the community may withhold In the event a resident is receiving hospice services and experiences community staff must immediately contact the hospice. The hospice procedures take precedence over those of the ALF" (Assisted Living Facility).

Review of facility notes revealed:
Resident had c/o (complained of) chest pain and took a (for chest pain) pill -while conversing with resident - resident stopped talking and eyes started rolling and was having a - Resident Assistant called 911 - and we initiated with (Automated External Defibrillator) - until paramedics arrived - was done for a minute and a half - resident was sent to hospital via fire rescue.

There was no documentation to indicate hospice was notified and their procedures took precedence over those of the ALF.

Interview with the on at 1:15 PM who stated she was back in her office when was started on resident #1 on The nurse who responded was Staff C, direct care, Staff G, direct care and Staff E, direct care. Staff D, the nurse, initiated and Staff E defibrillated the resident. The hospice agency was not called at that time. Hospice called us after it all happened, they called here. The nurse did not know that the resident had a

Class III

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on record review and interview the administrator failed to:
1. Ensure there was a system in place for staff to immediately identify residents who had in order to facilitate initiating and to prevent initiating on hospice residents with RO's for 1 of

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13 sampled residents (#1). The facility failed to document the family/healthcare provider was notified of the and that the facility responded to the family's concerns regarding medications for 1 of 13 sampled residents (#1)
2. Ensure the AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010 was completed for 1 of 13 sampled residents (#6),
3. Ensure physician orders were followed for a medication with parameters, and failed to ensure a licensed nurse was available to administer the medication with parameters to prevent the medication error for 1 of 13 sampled residents (#13),
4. Contact hospice before resuscitating a resident who had a properly executed for 1 of 13 sampled residents (#1).
5. Ensure an adverse incident report was submitted within one business day when they failed to honor advance directives for 1 of 13 sampled residents (#1).

Findings:

1. The facility did not have system in place for staff to immediately identify residents who had

Review of record for resident #1 revealed an Assisted Living Facility Health Assessment Form (1823) dated that stated diagnoses of insufficiency, carotid and retention. The resident was independent with ambulation, dressing, eating, toileting and transferring and needed supervision with bathing.

Review of record for resident #1 revealed an 1823 updated on revealed diagnoses of and

Review of the revealed on the attending physician and resident #1 signed the form.

Record review revealed the resident was admitted to hospice on

Review of facility notes revealed:
Resident had c/o (complained of) chest pain and took (for chest pain) pill -while conversing with resident - resident stopped talking and eyes started rolling and was having a - resident assistant called 911 - and we initiated - with (Automated External Defibrillator) - until paramedics arrived -

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was done for a minute and a half - resident was sent to hospital via fire rescue.

On "Resident returned from hospital, no new orders. Diagnoses were and Hospice will be in tomorrow to readmit the resident."

On 2000 (8 PM) "Hospice nurse admit note - patient readmitted to hospice services after return to facility today from hospitalization. Patient alert and oriented times 3, pleasant and Family present. Signed admission paperwork."

On "Resident started Crisis Care today at 7 PM for right pain unrelieved with ordered pain management post 5 milligrams (mg) at 6:30 PM with decreased pain; repeated dose at 8 (unable to read) PM."

11 "Resident transferred to hospice house for pain management."

Resident discharged from facility."

Review of the facility's Policy and Procedure stated:
"The following procedure will be followed: Resident has executed a If a resident experiences a staff trained in or a licensed health care provider present in the community may withhold In the event a resident is receiving hospice services and experiences , community staff must immediately contact the hospice. The hospice procedures take precedence over those of the ALF."

Review of the hospital Emergency Provider Record dated noted the resident was seen at 1740 (5:40 PM). Patient stated he had (chest) pain, asked staff for (for chest pain). He had a witnessed versus and was shocked by the staff even though he was a The patient had no other complaints other than he was uncomfortable and mildly short of breath. The patient was alert and in mild distress.

Review of the Emergency Department Patient Chart dated revealed, the staff from the Assisted Living Facility stated the patient clutched his chest, went back to took The nurse saw his eyes roll back and began to and stated, he had no pulse and began He was placed on the which advised to and he was shocked. He was alert and oriented times 3 when he arrived at the emergency (ER), and was complaining of

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Progress:
Suspect (fainting) versus (low episode secondary to . His condition was improved and stable and he was admitted to the hospital.

Review of hospital Discharge Summary stated the resident was admitted on and discharged on stated the patient had a syncopal episode at the facility and was apparently coded. Emergency Medical Service was called, and he was brought to the Emergency The resident was a hospice patient and hospice had to be rescinded to bring him into the hospital.

Impression:
1.
2.
3.
4. Chest pain
5.

There was no plan at that time to identify residents who had to prevent further errors in administering or withholding

There was no documentation to indicate the healthcare provider/family was notified of the

In an interview with the administrator on at approximately 3:30 PM who stated, resident #1's family had complained to her about his medications being unlocked in his the facility locked the medications in the medication cart. She also stated that whenever the family member had a concern that she would address it right away. There was no written documentation that the facility responded to the family member's concerns.

2. The facility did not ensure the AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010.

Record review for resident #6 revealed an AHCA Form 1823 dated There was no documentation to review to indicate an 1823 had been completed on the AHCA Form 1823, 2010.

3. Physician orders were followed for medications with parameters, and a nurse was available to administer the medications to prevent the error for 1 of 13 sampled

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residents #13.

Record review for resident #13 revealed an 1823 dated that stated diagnoses of and and stated the resident needed assistance with self-administration of medications.

Review of physician order dated stated (for ER 50 mg (milligrams) at bedtime. Hold for pulse <55 of

Review of the 2013 MOR revealed the was charted as given; initials were in the box and signed by the unlicensed staff on through The pulse was 53 on and the was not held per physician's order. There was no documentation on the back of the MOR that stated the was held.

The licensed nurse was required to administer medications with parameters.

4. Facility followed policy and procedures
Review of the revealed on the attending physician and resident #1 signed the form.

Record review revealed the resident was admitted to hospice on

Review of the facility's Policy and Procedure stated:
"The following procedure will be followed: Resident has executed a If a resident experiences a staff trained in or a licensed health care provider present in the community may withhold In the event a resident is receiving hospice services and experiences community staff must immediately contact the hospice. The hospice procedures take precedence over those of the ALF" (Assisted Living Facility).

Review of facility notes revealed:
Resident had c/o (complained of) chest pain and took a (for chest pain) pill -while conversing with resident - resident stopped talking and eyes started rolling and was having a - Resident Assistant called 911 - and we initiated with (Automated External Defibrillator) - until paramedics arrived - was done for a minute and a half - resident was sent to hospital via fire rescue.

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There was no documentation to indicate hospice was notified and their procedures took precedence over those of the ALF.

5. The facility did not complete an adverse incident report.
Review of the for resident #1 revealed the attending physician signed and dated it on

Review of facility notes revealed:
resident had complained of chest pain and took (for chest pain) pill - while conversing with resident - resident stopped talking and eyes started rolling and was having a - resident assistant called 911 - and we initiated with Automated External Defibrillator until paramedics arrived - was done for a minute and a half - resident was sent to hospital via fire rescue.

Review of the adverse incident reports revealed no report was completed for the resident on when was performed and the resident had a

Class I

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview the facility failed to ensure an adverse incident report was submitted within one business day when they failed to honor advance directives for 1 of 13 sampled residents (#1).

Findings:

Review of record for resident #1 revealed an Assisted Living Facility Health Assessment Form (1823) updated on that stated diagnoses of and The resident needed assistance with ambulation, bathing, dressing, and toileting and needed supervision with eating and transferring.

Review of the for resident #1 revealed the attending physician signed and dated it on

Review of Hospice record revealed the resident was admitted to hospice on

Review of facility notes revealed:

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resident had complained of chest pain and took (for chest pain) pill - while conversing with resident - resident stopped talking and eyes started rolling and was having a - resident assistant called 911 - and we initiated with Automated External Defibrillator until paramedics arrived - was done for a minute and a half - resident was sent to hospital via fire rescue.

Review of the adverse incident reports revealed no report was completed for the resident on , when was performed when the resident had a

Interview with the administrator, a nurse, and the Resident Services Director on at approximately 3:50 PM who were not aware the incident was an adverse incident.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Benton House Of Titusville
497 N Washington Ave
Titusville, FL 32796

Dear Administrator:

Re: CCR #2013011900

This letter reports the findings of a state licensure survey that was conducted on 2013 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. The agency has approvied another timeframe. Staff from this office will conduct a review after 2014, to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone (407) 420-2502; Fax (407) 245-0998