STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967569	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF TITUSVILLE	**497 N WASHINGTON AVE TITUSVILLE, FL 32796**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced revisit to complaint investigation (CCR 2016000370) was conducted at Benton House of Titusville Assisted Living Facility in Titusville, Florida from / / to / /. At the time of the visit, the facility had deficiencies.

0025 Resident Care - Supervision

DEFICIENCY REMAINED UNCORRECTED.

Based on record review and interviews the facility failed to maintain a safe environment by placing 4 of 5 residents (Residents #2, #3, #31 and #32) at risk by failing to document contact with the resident ' s primary health care provider or family member and taking the necessary actions to protect the resident. Findings include:
1-On / /, in a record review of facility incident reports, it documents Resident #2 had on / / /, / / /, / / /, / / (2 different times), and /.
In a record review on / of Resident #2 ' s 1823 health assessment, which was updated on / / /, Resident #2 is listed as a risk.
In a record review on / of Resident #2 ' s progress notes, the progress notes document the following incidents regarding Resident #2 ' s ; / the primary health care provider was contacted with no follow up, / / /, the primary health care provider was not contacted, / / /, Resident #2 had a on his thigh as the result of a , no documentation of contact with Resident #2 ' s primary health care provider and , the primary health care provider was not contacted.
In record review on / of Resident #2 ' s progress notes, the progress notes do not document a on the following dates; / / /, / / /, / /, and / (2 different).
In a record review on / / of Resident #2 ' s file, it does not document developed a safety plan or other interventions to prevent Resident #2 from future .
On / / at 2:58 PM, in an interview with the administrator, the administrator stated she would review the files and have the nursing staff update them.
2-On /, in a record review of facility incident reports, it documents Resident #4 had the following incidents; , on his arm, /, /, / /, and /, .
In a record review on / / of Resident #4 ' s progress notes, the progress notes do not include documentation of / or / on the resident ' s arm.
In a continued record review on / / of Resident #4 ' s progress notes, the progress notes document Resident #4 threw himself on the ground when staff attempted to help him stand on / and / .
In a record review on / / of Resident #4 ' s 1823 Health Assessment, it was signed on and has not been updated to reflect the behavioral changes of Resident #4.
In an interview on at 2:58 PM with the administrator, the administrator stated she would have the

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nursing staff update the progress notes and review for a new 1823 health assessment for Resident 4.
In an interview on / / at 4:45 PM with a family member of resident #4, the family member stated Resident #4 has a hard time adjusting because the facility continues to move new staff in and out of the memory care unit.
3- On / /, in a record review of facility incident reports, it documents Resident #31 had the following incidents; / elopement, / , / attempted to run through a window in the memory care unit, / and /.
On / / , in a record review of the Florida Agency for Health Care Administration Versa System, it documents an adverse incident report filed on / for Resident #31. The adverse incident report on Resident #31 documents Resident #31 was found wandering on U.S. 1 by a local resident who returned Resident #31 to the facility.
In an interview on / at 11:50 AM with the administrator, the administrator stated Resident #31 eloped from the facility after a special event on / /. The administrator stated Resident #31 was living in the assisted living portion of the facility at the time of the elopement. The administrator stated Resident #31 was moved to the Memory Care unit after talking with her family and primary health care provider. The administrator stated everything has been documented in Resident #31 ' s resident file.
In an interview on / at 4:28 PM with the resident care supervisor, the supervisor stated the facility is working with Resident #31 ' s health care provider to adjust her medication. The supervisor stated she is aware of the incident of Resident #31 running into the window. The supervisor stated she is also aware of an incident of Resident #31 throwing rocks at the windows and staff.
In a record review on / of Resident #31 ' s progress notes, the progress notes for Resident #31 do not document the following incidents; / elopement, / , running into the glass in the Memory Care Unit, / , no documentation of the resident being moved into the Memory Care Unit and no documentation of Resident #31 throwing rocks at the window and staff.
In an interview on at 2:58 PM with the administrator, the administrator stated she would have the nursing staff update the progress notes and documentation for Resident #31.
4-In a record review on / of local law enforcement calls to service, the calls to service report documents local law enforcement was called to investigate an elopement of Resident #32 on / .
In an interview on / at 10:08 AM with the administrator, the administrator stated she was unaware of the elopement of Resident #32 and law enforcement being called. The administrator stated she would have to address Resident #32 ' s elopement with the staff.
In a record review on / of Resident #32 ' s progress notes, the progress notes do not provide documentation of Resident #32 ' s elopement. The progress notes also document the following incidents; / - Resident #32 had an outburst, the doctor was notified with no documentation of follow up, / - Resident #32 had an aggressive outburst, Resident #32 family was called with no follow up action, - Resident #32 found wandering in and out of other residents , no documented action taken and / - Resident #32 stole a cell telephone from another resident ' s , no documented action taken.

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In an interview on / at 2:58 PM with the administrator, the administrator stated she would address with nursing staff to have the notes updated.

Class III

0054 Medication - Records

DEFICIENCY REMAINED UNCORRECTED.

Based on record review and interviews the facility failed to properly maintain Medication Observation Records (MORs) for 4 of 5 residents (Resident #2, #4, #31 and #32) by not including the name and contact number of the health care provider on the MOR.
Findings include:
1. In a record review on / of Resident #2's resident file, revealed the MOR for Resident #2 for the month of 2016 did not list the name of the primary healthcare provider and the primary healthcare provider's contact number.
2. In a record review on / of Resident #4's resident file, revealed the MOR for Resident #4 for the month of 2016 did not list the name of the primary healthcare provider and the primary healthcare provider's contact number.
3. In a record review on / of Resident #31's resident file, revealed the MOR for Resident #31 for the month of 2016 did not list the name of the primary healthcare provider and the primary healthcare provider's contact number.
4. In a record review on / of Resident #32's resident file, revealed the MOR for Resident #32 for the month of 2016 did not list the name of the primary healthcare provider and the primary healthcare provider's contact number.
In an interview on at 2:58 PM with the administrator and resident care supervisor, the supervisor stated it would be corrected and the information would be hand written on the MOR for all of the facility residents. The supervisor stated she would contact the pharmacy and find out why they are not including the required information.
Class III

0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on record review and interviews the facility failed to ensure 1 of 5 staff (med tech DD) had completed the required 2 hours of continued education training for staff who provide assistance with the self-administration of medication.
Findings include:
In a record review on / of med tech DD employee file, the employee file documented med tech DD

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had completed training for Assistance with the Self-Administration of Medication in 2013. The file did not provide documentation of med tech DD having completed the 2 hours of continued education, for years 2014 and 2015, as required for staff who provide assistance with the self-administration of medication.
In an interview on at 2:48 PM with med tech DD, who stated she does currently provide residents with assistance of self-administration of medication to facility residents. Med Tech DD stated she did not complete the required 2 hours of continuing education training related to assistance with the self-administration in the years 2014 and 2015.
In an interview on / at 2:58 PM with the administrator, the administrator stated she did not have any additional documentation that med tech DD completed the required two hours of continued education relating to assistance with the self-administration of medication for the years 2014 and 2015.
Class III

0165 Risk Mgmt & QA: Adverse Incident Report

DEFICIENCY REMAINED UNCORRECTED.

Based on record review and interviews the facility failed to file an adverse incident report for 1 of 5 residents (Resident #32) who was at risk while on elopement from the facility.
Findings include:
In a record review on I/ of local law enforcement calls to service, the calls to service report document local law enforcement was called to investigate an elopement of Resident #32 on .
In a record review on / / of the Florida Agency for Health Care Administration Versa system, the Versa system did not have any information documenting the facility had filed an adverse incident regarding the / elopement of Resident #32.
In an interview on / at 10:08 AM with the administrator, who stated she was unaware of the elopement of Resident #32 and law enforcement being called. The administrator stated she would have to address Resident #32's elopement with the staff.
In an interview on / at 11:50 AM with the administrator, who stated she found the details of Resident #32's elopement. The administrator stated Resident #32 had left the facility without signing out. The administrator stated when Resident #32 could not be located by staff, they followed protocol and contacted local law enforcement. The administrator stated Resident #32 was located by law enforcement at a church attending Sunday service. The administrator stated she was unaware of the need to file an adverse incident report. The administrator stated staff were concerned about the risk to Resident #32 since they did not know when she left the facility.
Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967569 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF TITUSVILLE	497 N WASHINGTON AVE TITUSVILLE, FL 32796

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0052	Correction	ID Prefix A0078	Correction	ID Prefix A0081	Correction
Reg. # 58A-5.0185 (3)	Completed	Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.0191(2) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0082	Correction	ID Prefix A0090	Correction	ID Prefix AZ815	Correction
Reg. # 58A-5.0191(3) FAC	Completed	Reg. # 58A-5.0191(11) FAC	Completed	Reg. # 408.809, 435.02(2), 435.06	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE 4/21/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
1/28/2016	

STATE FORM: REVISIT REPORT (...) EVENT ID: 0PMH12

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

RE: Revisit to #2016000370

Dear Administrator:

This letter reports the findings of a complaint revisit survey conducted on 8, 2016by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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. Should you have any questions please call this office at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

BBT

Orlando Field Office
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