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
	AL11970392	A. BUILDING: _____ B. WING _____	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE NONA	10298 SAVANNAH PARK DR ORLANDO, FL 32832

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A 000	Initial Comments A complaint investigation (2024010091) and a generator monitoring were conducted at Hearthstone Nona on . The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide adequate supervision to prevent 1 of 1 sampled resident from eloping from a secured memory care unit (7.) Findings: A review of resident #7's record revealed a facility admission date of . The residents' medical history included . A facility elopement risk assessment score was 12 (10 or greater equaled elopement risk.)	A 025		

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A 025	Continued From page 2 On at 6:45 pm nurse B documented the resident left memory care through the unit's main entry door. It appeared she then exited the community by the courtyard doors closest to the memory care entrance. A person who was driving by the community came into the facility and informed the concierge that a person was at the end of the sidewalk, and they looked . The concierge immediately went to the sidewalk while radioing the care staff and identified who the resident was. The resident was escorted into the facility with ease. On at 10 am, resident #7 was seen sitting at a dining room table in memory care. A private aide was at the table with her. The private aide said she was hired by the family. She said a private aide was with the resident every Monday through Saturday from 8 or 9 am to 5 or 6 pm. The resident was alert and . On at 2:16 pm, nurse B said that at the time of the elopement she was staying in a room in the facility but was not officially on duty at the time. She said the staff called her and she went downstairs. She viewed the camera footage that same evening and saw the resident push on the main memory care door, which opened with no problem. The door was supposed to have a safety mechanism, which if held for 15 seconds, would open then sound an alarm. The nurse said although the camera did not have sound, she was able to see the door open immediately. She said the door tech who came out the next day informed them that if the door was held open it would deactivate and had to be re-activated with a key fob. The nurse said the facility did not know about that. She said the tech changed it to where it locked the door regardless of how long it was	A 025		

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A 025	Continued From page 3 held open. The nurse said she thought the door alarm sound was increased by one decibel following the elopement. She said that following the elopement one staff member manned the door until the door tech came the next day. She said group activities normally held in the foyer were moved to a different location since residents were able to see staff coming in and out of the doors. On at 2:55 pm, as a result of being asked for access to the camera footage, the wellness director said the cameras did not record. On at 3:36 pm, the administrator said that when the resident eloped, the memory care door was not working and was not secured. She said the resident left the facility by way of a door located just outside memory care. She did not know if a system was in place to test the doors prior to the elopement. She said she would check maintenance logs. On at 3:49 pm, the administrator said there was not a system in place to test the doors. On , , and the wellness director gave a 10-minute in-service to one person to remain in the common area at all times. On and the wellness director gave a 15-minute in-service on elopement. On at 2:16 pm, caregiver C said the resident was familiar with the door she eloped through because her private aides frequently took her outside. The caregiver said that on the evening of the elopement she had already put the resident to bed. She said she and the only other caregiver working were probably with other	A 025		

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A 025	Continued From page 4 residents. The caregiver said she did not hear a door alarm. She said when she checked the resident's room she wasn't there. She asked around if anyone saw her. She began searching and got a message from the front desk that the resident was outside. She ran out and saw her outside with the concierge. She brought her in. She said her supervisor said one caregiver should always be in the common area. The facility's undated elopement policy indicated, in part, the facility will promote the safety and well-being of all its residents and prevent elopement by identifying residents at risk and ensuring the effective operation of the facility's alarm system for ˻ residents. Elopement is defined when a resident leaves the facility property without the facility's knowledge. Residents who are known to or are beginning to exhibit signs of ˻ or who are new to the facility will be discussed at morning stand-up meetings. Assignments will be made for staff regarding frequent or periodic checks on these residents, at a minimum each day. Should an elopement occur, contributing factors as well as the interventions and measures which were implemented to prevent this occurrence will be documented. Class II	A 025		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in	A 056		

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A 056	Continued From page 5 accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine	A 056		

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A 056	Continued From page 6 the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.	A 056		

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A 056	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to make every reasonable effort to ensure that prescriptions for 1 of 3 sampled residents (2) who received assistance with self-administration of medications were refilled in a timely manner. Findings: A review of resident #2's record revealed a medical history of , , , and , , . The residents needed assistance with self-administration of medications. A review of the resident's , Medication Observation Record (MOR) revealed her was either "not available" or "waiting on pharmacy" on , 4, 6, 7, 9, 11, 13, 14, 15, 16, and 18 and her on 11, 15, 16, and 17. There was no documentation on either the MOR or in the resident's record to indicate the facility made efforts to obtain refills prior to the medications running out. On at 1:45 pm, the findings were discussed with the wellness director and an opportunity was given to provide additional documentation. On at 2:40 pm, the wellness director had no additional documentation and said she did not know why the medications ran out. The facility's medication reorders policy, revised , indicated all medications must be reordered from the pharmacy in a timely manner.	A 056		

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A 056	Continued From page 8 Class III	A 056		