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
	AL11965733	A. BUILDING: _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING AVENTURA	2777 NE 183rd ST AVENTURA, FL 33160

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A 000	Initial Comments A complaint investigation (complaint #2022017096) was conducted at Sterling Aventura from through . A deficiency was identified at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision as appropriate for each resident and maintain a general awareness of the resident's whereabouts for one out of 31 (Resident #1) sampled residents. Resident #1 eloped from the 3rd floor of the facility Memory Care Unit and was found by law enforcement near the facility. Findings included: On . . . . . at 1:54 PM, the Administrator stated that Resident #1 eloped from the memory care unit (located on the third floor) on at about 5:00 AM. He stated,	A 025		

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A 025	Continued From page 2 Resident #1 left the facility by exiting through the emergency doors. The Administrator further stated the staff on duty at the time said to him that they heard the alarm sound and went to check it out and did not see anyone. The Administrator stated the police found the resident on a main street nearby the facility. A review of Resident #1's health assessment (AHCA Form 1823) completed revealed diagnoses of [illegible], High [illegible], and [illegible]. The resident needed supervision with ambulation, bathing, [illegible], toileting and transferring. Resident needed assistance with self-administration of medications. Resident was not identified as an elopement risk on the day she eloped. She has been reassessed by health care provider on [illegible] and currently identified as an elopement risk. A review of Resident #1 facility progress notes dated [illegible] revealed "Memory Care caregiver reported that at approximately 5:00 am Resident #1 was observed standing in the memory care lobby. Caregivers redirected Resident #1 [illegible] to her apartment. At about 5:20 AM while coming out of [another resident room] they [Staff] heard the 3rd floor east side door alarm near the dining room going off. Caregiver opened the door to see if anyone was going downstairs and no one was seen. Both caregivers started a room check and noticed resident wasn't in her apartment, which is nearby the exit door. At 6:20 AM a police officer came to the building reported that a [illegible] person was	A 025		

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A 025	Continued From page 3 seen across the street and transported to the hospital for evaluation." Review of hospital records revealed that on , rescue transferred Resident #1 to the hospital after they found the resident on the street around 5:00 AM. The records indicated Resident #1 was disoriented and was [AAOx0 (awake and alert but not oriented to person, place, or time)]. On at 2:14 PM the Director of Nursing stated, after Resident #1 returned from the hospital she noticed the resident had lab work done while at the hospital which showed the resident had a medical issue. She stated the medical issue may have caused her to have increased . She stated she retrained the staff on responding to door alarms and resident elopement. On at 10:42 AM, Resident #1's daughter stated, she was notified by the facility staff that her mother pushed the emergency door and walked out of the facility. She stated the police found her mother around 5:00 or 6 :00 AM on the street and transported her to the hospital and called the assisted living facility in the area. She stated the facility staff sent a picture to the hospital informing them the resident lived at the facility. The daughter stated her mother has never tried to leave the facility before. The daughter stated at the hospital her mother had some test done and had abnormal lab, received and discharged from the hospital. She stated she transported her mother from the hospital to the facility the same day. On at 10:53 AM, during a telephone interview with Staff E (night shift certified nursing	A 025		

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assistant (CNA), she stated that she was on duty with two other staff members when Resident #1 eloped. She stated that she had seen Resident #1 about 10 minutes earlier, then she went with a co-worker to assist another resident, and she heard the alarm sound. She stated when she went to see why the alarm sound, she realized the door was opened and informed other staff in the building. She stated she noticed the resident was missing, and staff began searching for the resident and could not find her. She stated after about one to two hours the police came to the facility.

On [redacted] at 3:16 PM Staff G stated, " I am a certified nursing assistant (CNA) and I work part time from 11 PM to 7 AM and 3 PM to 11 PM. I work on the second, third and fifth floors. Resident #1 does a lot of walking around and she has said to me before "I want to go home." So, I keep a close [redacted] on her and follow closely behind her during my shift when I'm work on the third floor. She stated additional training on elopement response for all staff was provided.

Review of the facility's elopement policies and procedures showed the following:
-Missing Resident Plan Policy #AL-019:
The facility will respond immediately with emergency procedures when a Resident has been identified as missing. The community will prepare all staff to respond quickly and effectively with appropriate steps to locate a missing Resident with or without [redacted].

If an alarm/monitored door goes off:
- Search area immediately adjacent to door (inside and outside).
- Initiate a [redacted] count. Each team member will account for the residents assigned and report to

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A 025	Continued From page 5 Wellness Director by name who has been accounted. - This practice will ensure that even if a Resident is found at the door or in the immediate vicinity, another Resident did not go out unnoticed. Class III	A 025		

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