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 _____	R 06/26/2024

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

(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 000}	Initial Comments A revisit to a complaint investigation (complaint numbers 2023014257) was conducted at Sterling Aventura on through . A deficiency was identified at the time of the survey.	{A 000}		
{A 165} SS=E	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or	{A 165}		

AHCA Form 3020-0001

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

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{A 165}	Continued From page 1	{A 165}		

its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.
(6) [redacted], neglect, or [redacted] must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of

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{A 165}	Continued From page 2 s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a preliminary report to the agency within 1 business day after the occurrence of an adverse incident, and a full report within 15 days that include the results of the facility's investigation into the adverse incident. Also, the facility failed to report , neglect, or , to the Department of Children and Families. Findings included: 1) Review of the Agency Incident Reporting System (AIRS) showed the facility filed a preliminary report regarding Resident #40. According to the report, "Resident #40 alleged Staff AD (medication technician) came in the room to give him medications. He was laying on his and when she gave him water, it dripped down his	{A 165}		

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{A 165}	Continued From page 3 . . . . He got angry and stated, "I had one of my possessed moments" and he bolted upright. He alleged that Staff AD then threw water on him. After accusation was made to Administration on . . . . . , administration put Staff AD on administrative leave pending investigation." Further review of AIRS showed the agency closed the report after the facility failed to provide the additional requested information. On at 7:10 AM, observation showed Resident #40 lying in bed. Then a caregiver assisted him to get up from bed and stand up. The caregiver assisted the resident to walk while holding his until sitting him on his recliner. Further observation showed Resident #40 walked with difficulty. He walked in tippy and leaning . . . . On . . . . . at approximately 7:15 AM, when asked about what happened on the day of the incident, Resident #40 stated that Staff AD threw water at him. Resident #40 further stated that when Staff AD would come in his room to give him his medication, she would always come in aggressive and impatient. He stated, "She was the one to give me my medicine in the afternoon, and she was the only one I had problems with when she gave me water. Every time she came in to give me my medication and give me the water, water would run down my . . ." Resident #40 explained that during medication pass, Staff AD would pour the medication in his and then gave him the water, which would always run down his . Then on that day, he got angry about the recurrent situation so as he was laying down, he got up and scream to the staff, why she kept pouring water down his . . . After he screamed, Staff AD threw the water at him and ran out the	{A 165}		

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{A 165}	Continued From page 4 door. Resident #40 further stated that afterwards, he walked to the door, and I saw Staff AE (certified nursing assistant) and told her what happened. On at approximately 10:04 AM, the Assistant Director of Nursing (ADON) stated that on the day of the incident, she and the Director of Nursing (DON) interviewed Resident #40 and Staff AD. The resident stated that he asked Staff AD for a service to be done and she came with a bad attitude, washed her and then flicked water on him. The ADON stated that allegedly according to Staff AD, Resident #40 ran after her. Then, Staff AD alleged that the resident had hurt her, and she had a scratch on her arm. The ADON further stated that she and the DON did not see a scratch on Staff AD's arm, only a birthmark, so they sent the staff to urgent care. The ADON further stated that after interviewing some residents, they reported that Staff AD had a bad attitude. On at 8:31 AM, during a telephone interview, Staff AE, stated that on the day of the incident she was in the lobby, and I heard Staff AD stating the man her because water spilled on him as she was running out from Resident #40's room. Staff AD said to Staff AE that the resident grabbed her and scratched her. But she did not see her scratch as Staff AD never showed it to her. When asked if Resident #40 was running, Staff AE stated that she saw the resident on the doorway, but he could not run. Also, Staff AE stated that Resident #40 was normally calm. A review of the facility's resident policy showed, the facility would "DHSS (Health and Social Services) to self-report the incident by	{A 165}		

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{A 165}	Continued From page 5 calling: Adult [redacted] and Neglect Hotline." On [redacted] at 8:21 AM, when asked if the facility reported the incident to the Department of Children and Families, the Administrator stated, "No, I didn't report it." 2) A review of the Agency for Health Care Administrator records revealed that during two complaint investigations conducted from [redacted] through [redacted] and from [redacted] through [redacted], the facility was cited for failure to report on AIRS incidents involving four residents (Residents #1,2,3,15). Review of AIRS showed no documentation the facility filed any incident report for Residents #1,2,3,15. [redacted] at 8:11 AM, when asked if the facility reported the incidents on AIRS that they were cited for in the previous survey, the Administrator stated, "We have a new nurse, so I don't know if they reported it, but I'll check and let you know." Uncorrected Class III	{A 165}		