

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/19/2024
---	--	--	--

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 survey was conducted at Sterling Aventura on Deficiencies were identified at the time of survey.	{A 000}		
{A 182} SS=F	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure all staff were trained in their duties and able to implement the emergency management plan. The staff were unaware of which residents required assistance to exit the building and did they know how many residents were in the building. Also facility staff did not know what to do during an emergency where they had to evacuate the building. Findings: In an interview with the Activities Director on , at approximately 6:45AM, he stated that the census was 145 residents; then, at approximately 6:47AM, he stated that there were 146 residents in the building. In an interview with Staff AH (agency staff	{A 182}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/19/2024
---	--	--	---

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 182}	Continued From page 1 /licensed nurse practitioner) on at 7:05AM, she stated that she did not know the census for the building, nor did she know exactly how many residents were on her floor. When asked how she would know if she had evacuated all the residents on the floor, she stated, "I would go . . . to each room to make sure no one stays behind." A review of the census showed 146 residents resided in the facility at the time of the survey. Uncorrected Class III	{A 182}		