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 05/12/2025

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 survey was conducted at Sterling at Aventura from through . Deficiencies were found at the time of the survey. The facility was also cited under Event ID ECZE11. Class 1 deficienccy was found at tag A 0025 and A0030. A Class 1 deficiency is a deficiency that the Agency determines presents a situation in which immediate corrective action is necessary because the facility's non-compliance has caused, or is likely to cause, serious injury, harm, , or to a resident receiving care in a facility. The Class 1 non-compliance began on . The facility Administrator was notified of the Class 1 non-compliance on /3035. The census at the start of the survey was 137 residents. The facility failed to provide adequate supervision and ensure the safety and physical wellbeing of 6 out of 53 sampled residents who had multiple and sustained serious injuries	{A 000}		
{A 025} SS=L	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	{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 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 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	{A 025}		

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{A 025}	Continued From page 2 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 and ensure the safety and physical wellbeing of 6 out of 53 sampled residents who had multiple and sustained serious injuries (Residents 1, 2, 3, 4, 6 and 7). Resident 1 had 5 , sustained a , underwent , replacement surgery and spent 23 days in the hospital. Resident 2 had 3 and sustained a , , a hematoma to the and was hospitalized for 4 days. Resident 3 had 6 , sustained a , and was hospitalized for 17 days. Resident 4 had 2 , had a , and was 2 days in the hospital. Resident 6 had 2 , sustained hematoma and was hospitalized for 3 days. Resident #7 had 3 , needed stitches for to the and was 3 days in the hospital. Findings included: Review of the facility's Resident Incident Log showed that from , , through , , there were 87 resident reported with 19 residents having 2 or more .	{A 025}		

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{A 025}	Continued From page 3 Resident 1) A review of Resident 1's record revealed he had 5 unwitnessed at the facility from through . A review of Resident 1's progress notes dated revealed that he was found on the floor of his apartment after trying to transfer from a recliner to his wheelchair. Further review showed that a of the was ordered and no documentation that (Emergency Medical Services) were called or that the Resident was evaluated by a physician after he . Hospital records review showed that Resident 1 was brought to the hospital on for follow-up care for an unrelated medical concern but the Resident's was not reported to the medics or the hospital. A review of Resident 1's progress notes dated at 10:30 AM showed that he was taken to the hospital by (Emergency Medical Services) when he was screaming in , to the right , . A review of Resident 1's run report dated at 10:29 AM showed a chief complaint of right-side , , for the past two days, an impression of injury of the , , and the cause of injury was . Further review of the report narrative showed that the Resident's nurse reported that the Resident had a two days before. A review of Resident 1's hospital record dated showed the Resident was admitted to ( ) for a right Garden sub-capital secondary to a	{A 025}		

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{A 025}	Continued From page 4 ground level on . Further review of the hospital's , report showed the patient did not seek medical attention at the time of the , his , , progressively worsened, and he underwent right , hemi- , , , surgery. Further review revealed the Resident was referred to acute inpatient rehabilitation while undergoing close medical supervision. According to the National Institute of Health, a Garden sub-capital is a complete, unstable and fully displaced of the that requires , , surgery with partial or complete , replacement with a , device. In an interview on at 2:30 PM, asked why was not called after Resident 1 on the Director of Health Services stated that the Resident had no apparent injuries, had refused to go to the hospital and precautionary , of the were done. Asked to explain the Resident's injury the Director of Health Services stated that she could not explain why Resident 1 was screaming in , with a , 3 days later. In an interview on at 11:30 AM asked about Resident 1's the Nursing Supervisor stated, "All I know is that he was next to the wheelchair, the brakes did not lock. He did not want to go to the hospital. I didn't see any injuries. An , was ordered, just for precaution. Not of the , , only the . A , , was not ordered" In an interview on at 12:00 PM when asked to describe the facility's procedure when a	{A 025}		

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{A 025}	Continued From page 5 resident had a or needed medical care the Administrator stated, "We call the family, the nurse calls the physician, and the physician makes the decision. If 911 is called first. The policy is to call 911 when somebody " In an interview on at 2:00 PM the Director of Health Services stated that Resident 1's PCP was contacted and a precautionary of the was ordered after he . When she was asked to explain how the Resident was found to have a , 3 days later the Director of Health Services stated that she could not explain the Resident's injury. A review of the facility's Sheet Profile for Resident 1 showed an admission date of with a medical history and diagnoses of wasting and atrophy, generalized , subsequent encounters for falling from bed, of left , presence of left , , unspecified abnormalities of gait and mobility and . A review of Resident 1's health assessment dated showed a medical history of left , , and diagnoses of , , , , , . The Resident's physical limitations showed he needed assistance times 1. The nursing requirements showed the Resident needed assistance with ADL (Activities of Daily Living) and medication administration. The ADL evaluation showed the Resident needed supervision with ambulation, transferring, toileting, and self-care and was independent with eating. The status showed he was alert and oriented to person and place, at times.	{A 025}		

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{A 025}	Continued From page 6 In an interview on at 3:00 PM Staff Nurse AB stated that Resident 1 needed assistance with activities of daily living. In an interview on at 11:50 AM the Primary Care Provider stated that the Resident was not able to walk without assistance, and she had not been contacted in , regarding the Resident's , report. The PCP stated that the facility had referenced the on when they contacted her after the Resident had another . Asked if the Resident was able to walk independently, the PCP stated, "Not when he was at Sterling, not without assistance" In an interview on at 1:00 PM when asked if she was aware that Resident 1 had a history of left , and if a , had been ordered after he on the Director of Health Services stated, "No, only the on that day. A , was done after his on " Further review of Resident 1's record revealed that he , on . Resident 2) A review of Resident 2's record revealed that she had 3 unwitnessed at the facility on , and . A review of Resident 2's progress notes dated showed the Resident was found lying on the floor entangled in blankets and unable to explain how she . Further review revealed the Resident had skin a tear to the left and arm, to the left , on her hair and a hematoma to the lower left side of the . Further review revealed the Resident	{A 025}		

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{A 025}	Continued From page 7 complained of , in the left , , she was transported to the hospital by , and the doctor was notified via text message. A review of Resident 1's hospital record dated showed she was evaluated at the Emergency Department for a ground level at the assisted living facility and complaints of and , . Further review showed the Resident was treated for a injury and and she was discharged to the facility with orders for care and follow up with the PCP. A review of Resident 2's progress notes dated showed she was found on the floor, and she could not explain how she . Further reviews showed the Resident received care for a reopened from a previous and a hospice order was obtained from the PCP. Further review showed the Nurse advised the family to obtain a personal aide due to the Resident's multiple . A review of Resident 2's progress notes dated at 1:08 PM revealed that she was found on the floor stating that she had while trying to go to the bathroom and complained of , in the right , and , area. Further review showed the Nurse requested , studies to the right , and , and an order was sent to a portable imaging provider. Further review showed no documentation that was called to evaluate the Resident after she or when the , studies were completed. A review of Resident 2's progress notes dated at 11:00 AM showed the results from the , were received indicating an acute	{A 025}		

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{A 025}	Continued From page 8 , right , the PCP was notified, and the Resident was sent to the hospital emergency room A review of Resident 2's hospital record dated showed the Resident presented at the Emergency Department status post a ground level at her ALF the day before and was diagnosed with a non-displaced right . A review of Resident 2's notes showed she returned from the hospital and on she was sent to the hospital via non-emergency ambulance regarding extreme , . In an interview on at 12:40 PM the Director of Health Services stated that Resident 2 was hospitalized and transferred to a skilled nursing facility. In an interview on at 12:00 PM when she was asked why the Resident was not sent to the hospital until the following day after she on the Director of Health Services stated that she did not know, and she had to review the record. In an interview on 05//02/2025 at 12:44 PM the Administrator stated "[Resident 2]'s was not a witnessed . She on . The agency nurse did not report she had a " A review of Resident 2's health assessment dated showed diagnoses and history of displaced [Left] (history), hypertensive , and , . The Resident's physical limitations showed she was at risk for . The	{A 025}		

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{A 025}	Continued From page 9 nursing requirements showed and (, , , , , ,). The resident needed special precautions. The resident needed assistance with bathing and , and supervision with ambulation, toileting and transferring, The Resident needed assistance with medication self-administration. A review of the facility's Health and Service Evaluation dated for Resident 2 showed a high score potential for and needing extensive -on assistance for ambulation and mobility. Resident 3) A review of Resident 3's record revealed she had 5 unwitnessed at the facility from through . On , , , at 2:33 AM, 10:15 PM, . A review of Resident 3's progress notes dated showed that she was found on the floor lying on her and stated that she with her walker, hit the rear of her , and her hurt. Further review revealed that Resident 2 was transferred to the hospital Emergency Department via . Review of Resident 3's progress notes dated showed that she returned from the rehabilitation center with a diagnosis of acute C5 . A review of Resident 3's progress notes dated at 12 AM revealed the Resident was found lying on the floor and was unable to explain how she . Further review showed the Resident denied hitting her , refused to go to the hospital and the PCP was notified via text message. Further review showed the Resident	{A 025}		

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{A 025}	Continued From page 10	{A 025}		

exhibited , attempted to remove her and the family were advised that she may require an overnight sitter.

A review of Resident 3's progress notes dated at 2:33 AM showed she was found sitting on the floor unable to explain how she got there. Further review showed the Resident denied , or injuries but a to the left was noted. Further review showed the PCP was notified via text message.

A review of Resident 3's progress notes dated at 10:15 PM showed she was found sitting on the floor against the wall wearing only her socks. Further review showed that no injuries were noted, and the Resident was assisted in her wheelchair because she was unable to assist in the transfer. Further review showed that the PCP was notified, and a response was pending.

A review of Resident 3's progress notes dated showed an , revealed latent effect to right discoloration but there were no or .

A review of Resident 3's progress notes dated at 9:55 AM showed she was found sitting on the floor and against the wall near her bed. Further review showed Resident 3 told the nurse that she was trying to transfer from her bed to the wheelchair and off her bed. Further reviews showed that the Resident denied having , no injuries were noted, and the PCP was notified via text message.

A review of Resident 3's health assessment dated showed diagnoses of acute C5 , high , and history of

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{A 025}	Continued From page 11	{A 025}		

. Special precautions for were indicated and the physical limitations showed , mobility. The nursing requirements showed mobility assistance and medication assistance. The ADL (Activities of Daily Living) showed she needed supervision with ambulation, transferring, toileting, and bathing, was independent with eating and grooming. She needed assistance with self-administration of medication.

Resident 4)
A review of Resident 4 record revealed he had 2 unwitnessed at the facility, on and on .

A review of Resident 4's progress notes dated at 6:05 AM showed he was found lying on the floor in front of his bed, complaining of severe , in his left , area and . Further review showed Resident 4 stated that he had and did not recall how it happened. Further review showed he was transported to the hospital via , and the on-call telephone operator was told to notify the Resident's PCP.

A review of Resident 4's progress notes dated at 2:00 PM showed the Resident was shouting from behind the door of his apartment and was found lying flat on the floor just inside the door, with a dining chair toppled at his and the room in disarray. Further review showed the Resident was transported to the hospital Emergency Department via complaining of severe , in the and .

A review of the incident # 50331222 dated showed the Resident was found unable to move, the ALF nurse had stated that the chief complaint was , after a and

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{A 025}	Continued From page 12 the Resident was transported to the hospital as alert. A review of Resident 4's hospital Emergency Department record dated showed he presented with low after an unwitnessed . Per daughter she received a call from the ALF reporting he rolled out of bed, not taking medications in the past 2 months secondary to worsening and was admitted for further evaluation. A review of Resident 4's health assessment dated showed diagnoses of , acute low , without , closed of , , high , , , NSTEMI (non-ST- segment elevation). The physical limitations showed the Resident needed assistance. Nursing requirements showed , , , and , , . The special precautions were left blank. The activities of daily living (ADL) showed the Resident needed total care with transferring, needed assistance with toileting, , bathing and eating. The ambulation and self-care needs were left blank. In an interview on , the Nursing Supervisor stated that Resident 4 was discharged on and she was unable to access his records in the facility's EHR (Electronic Health Record) system. Interviewed at 12:48 PM the Director of Health Services stated that the Resident was non-compliant, and he was transferred to a skilled nursing facility.	{A 025}		

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{A 025}	Continued From page 13 Resident 6) A review of Resident 6's record revealed he had 2 unwitnessed at the facility on and . A review of Resident 6's progress notes dated at 12:30 PM showed he was found on the floor, lying on his and attempting to sit. Further reviews showed Resident 1 had a to the left side of the and was transported to the hospital Emergency Department via . A review of Resident 6's hospital record dated showed he presented to the Emergency Department via from [ALF] with , and left parietal , hematoma and after an unwitnessed . Further review showed the Resident was found in the bathroom and reported he was suspected to have been down in his bathroom for some time given the dried that covered his as well as . Further review showed that the Resident was amnesiac of the or the events preceding, a , was repaired with 1 staple, and he was admitted to the for further evaluation and monitoring. In an interview on at 10:00 AM via telephone when told that Resident 6 had dried on his and after he and she was asked how long was the Resident on the floor before was called the Director of Health Services did not answer. Further review of Resident 6's hospital record dated showed he was diagnosed with right , hematoma with acute	{A 025}		

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{A 025}	Continued From page 14 products along the tentorium and , intervention was not recommended given the risks of surgical treatment. A review of Resident 6's progress notes dated showed the Resident was discharged from the hospital and returned to the facility with acute right , hematoma and acute layering along the tentorium and left parietal , soft tissue hematoma with 1 staple. According to The Cleveland Clinic a hematoma is a type of , near the that can happen after a injury. Symptoms of and slurred speech can develop right after the injury or months later. hematomas can be life threatening. Acute hematoma is the most dangerous type of hematoma and has high mortality rates. A review of Resident 6's progress notes dated at 2:38 PM showed the Resident was found sitting upright on the bathroom floor and reported that he felt weak and slid down to the floor while holding his walker. Further review showed Resident 6 denied , no apparent injuries were noted, and a message was left for the PCP. A review of Resident 6's health assessment dated showed medical history and diagnoses of , high , and . The Resident's physical limitations showed none. The status showed . Nursing requirements showed none. The Resident needed supervision with ambulation, transferring, toileting, , bathing and grooming and was independent for	{A 025}		

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{A 025}	Continued From page 15 eating. The Resident needed assistance with self-administration of medication. In an interview on at 12:40 PM when asked about Resident 6's care plan the Director of Health Services stated, "He was reminded to use the pendant. Made sure there was adequate lighting in the room" In an interview on at 12:00 PM when she was asked how long Resident 6 was lying on the floor after he on , the Director of Health Services did not answer. Resident 7) A review of Resident 7's record revealed she had 3 unwitnessed at the facility: on , and . A review of Resident 7's progress notes dated at 8:45 PM showed the Resident returned from the hospital after she was admitted on for condition, loss of balance and difficulty walking. Further review of Resident 7's progress notes dated at 10:40 PM showed the Resident was found on the floor of her room from the . Further review showed that was notified and upon arrival paramedics bandaged the Resident's and transported her to the hospital Emergency Department. A review of Resident 7's hospital record dated showed she presented to the Emergency Department via and as per Resident 7 had just returned to the ALF about an hour before from the hospital and staff assumed that she tried to ambulate on her own and .	{A 025}		

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{A 025}	Continued From page 16 Further review showed Resident 7 had a 3 cm left lateral , after a and was admitted for further evaluation. Further review of Resident 7's hospital record showed the Resident was discharged on with instructions to be monitored 24/7 to avoid . Further review showed she was discharged to the ALF under 24-hour surveillance and the Resident's son was advised strongly to speak to facility staff to avoid and prevent . A review of Resident 7's progress notes dated showed she returned to the hospital with stitches to the left , , the PCP was notified pending response. A review of Resident 7's progress notes dated at 7:30 PM showed the Resident was found lying on the left side on the floor in the lobby next to her wheelchair and , from the stitches on her left , from a previous . Further review showed first aid was administered to the stitched area and it was covered. Further review showed that when he was notified the Resident's POA stated that arrangements would be made for a home health nurse to be present from 9 PM until 7 AM. Further review showed the PCP was notified via text message. A review of Resident 7's progress notes dated at 2:51 PM showed she was found sitting on the floor against the wall and the Caregiver stated that the Resident got up and when she was distracted doing something. Further review showed that no injuries were observed, and the Caregiver was given instructions to keep , and accompany the Resident "as much as can for safety" Further	{A 025}		

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{A 025}	Continued From page 17	{A 025}		

review showed the POA had not responded, and a message was left for the PCP.

A review of Resident 7's progress notes dated 11:05 PM showed she was admitted to hospice care.

In an interview on at 12:30 PM asked about Resident 7's care plan the Director of Health Services stated that the hospice agency provided a hospital bed and floor mats were placed.

In an interview on at 12:54 PM when asked what the facility did to avoid for residents at risk the Nursing Supervisor stated, "We obtain orders for (Physical, , ,) We try to keep them in line of sight of the staff"

In an interview on at 1:00 PM when asked about the facility's resident care plan for , the Director of Health Services stated, "We have a post- plan. No, we don't have individualized care plans to prevent . We are now in the process of developing care plans based on the resident's needs"

In an interview on at 10:00 AM via telephone when she was asked what the procedure was when residents needed urgent medical care or had a the Director of Care Services stated, "We call the family, the nurse calls the physician, and he makes the decision. If the Resident is , 911 is called first".

In an interview on at 12:30 PM via telephone when asked why there were so many unwitnessed resident and what had been done to prevent them the Administrator stated, "It

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{A 025}	Continued From page 18 depends on the person, we are creating a prevention committee, and we have a report." When she was asked if resident were investigated, root causes were identified or if the lack of staffing was a factor the Administrator stated, "No. But we are not short-staffed, we have enough staff. A 1 to 30 ratio overnight. We try to respond to calls within 10 minutes, that's the goal" Uncorrected Class 1	{A 025}		
{A 030} SS=L	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program,	{A 030}		

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{A 030}	Continued From page 19	{A 030}		

1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private

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{A 030}	Continued From page 20 communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue	{A 030}		

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{A 030}	Continued From page 21 the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , , the guardian shall be	{A 030}		

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{A 030}	Continued From page 22 given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local	{A 030}		

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{A 030}	Continued From page 23 long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure five of 53 (#1, #2, #5, #6, #8) out 53 sampled residents live in a safe environment,	{A 030}		

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{A 030}	Continued From page 24 free from and neglect, and treated with consideration and respect and with due recognition of personal dignity. The facility failed to ensure Residents #1, #2, #3, #6 were assessed to prevent future after multiple , which resulted in hospitalizations with and hematomas. The facility failed to provide in person medical care for Residents #1, #2, #6, and #8 for more than three days after a or illnesses. The facility failed to respect the rights of Resident #5 who was placed on a secure memory care floor after an elopement without the approval of a primary care physician or a psychiatrist. Resident #22 eloped and was found in a lake by a stranger and was never assessed by physician or psychiatrist for Findings: 1) A review of Resident #1's hospital records dated documented: "Patient is a male with PMH significant on 2L NC at home, , , , , L , s/p , , , with preserved Ejection Fraction (HFpEF), Mycobacterium Avium , (MAC), (PNA), , not on home meds, , recurrent , who was admitted to HCA[hospital] on with right , , . Patient reported he may have 2 days prior to admission. X rays showed acute sub capital with impaction, varus angulation, and approximately 1.3 cm of , displacement. Orthopedic surgeon was consulted. Patient underwent a right , , on for right Garden 4 subcapital ."	{A 030}		

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{A 030}	Continued From page 25 A review of Resident #1's progress notes documented that he had a on in his room and was observed laying on the floor on his right side next to his wheelchair and that an order for only the was requested. However, the Resident was not transported to the hospital until two days later ( ) after complaining of , . A review of Resident #1's health assessment with a completion date of showed a diagnoses of , , , Left , , . The physical status showed needed assistance times 1. The status showed alert, awake and oriented times three and at times. The resident had , and precautions. The activities of daily living showed supervision with ambulation, , self-care, transferring, and assistance needed with bathing and independent with eating. A review of the facility incident log showed Resident #1 had five , and there was no care plan in place to prevent future . A review of the Admissions and Discharge log showed Resident #1 was admitted on and discharged on after he . In an interview on at 12:48 PM, when asked about the number of , the Administrator stated, "I think it depends upon the person, we do a report, and on the memory care, we will be doing a new safety committee." When asked about Resident #1's injury, the Administrator stated, "We are unable to explain the , ." A review of the facility's prevention policy	{A 030}		

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{A 030}	Continued From page 26	{A 030}		

showed: "Residents identified at a high risk for will have individualized interventions included in the service plan."

A review of the facility's post policy states: "Every resident with an unwitnessed must be assessed as soon as the staff becomes aware of the occurrence. Care plan must be reviewed and updated as necessary with appropriate intervention to the reoccurrence of the incident/ ."

2)

A review of Resident #2's progress notes dated showed the resident was found on the floor in her room and complaining of , and that an order for an , was placed for right , and , and but was not immediately transported to the hospital. However, resident #2 was not transported to the hospital until one day later ( ) after the , showed an acute , right according to her progress notes dated .

A review of Resident #2's health assessment with a completion date of showed a diagnoses of displaced history of , hypertensive , , , , , . The nursing service requirements showed and . The resident had special precautions. The activities of daily living showed assistance needed with bathing, , and supervision needed with ambulation, toileting, transferring, and independent with eating and self-care.

A review of the facility's incident log showed Resident #2 had three (,

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{A 030}	Continued From page 27 ,). A review of Resident #2's records showed no care plan in place after the first . 3) A review of the facility's incident log showed Resident #3 (, , twice, ,) six times. A review of Resident #3's progress notes showed the resident had a on that sent her to hospital for 17 days and discharged with a diagnosed of C5 INF Endplate also has a brace no stop date when brace should come off. A review of Resident #3's records found no care plan even after the first . A review of Resident #3's health assessment with a completion dated showed diagnoses of an acute C5 , , , and . The physical or sensory limitations , mobility with precautions. The activities of daily showed the resident needed supervision with all activities of daily living except eating and self-care. 4) A review of the police report showed a missing person report was filed for Resident #5 on . The police report stated further that Resident #5 also eloped on . However, Resident #5 was not listed as an elopement risk.	{A 030}		

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{A 030}	Continued From page 28 A review of the progress notes dated showed after the resident returned ( ) from his elopement, he was placed on the memory care floor, which was a secure floor for more than four hours against his will without approval from a physician or psychiatrist. A review of the facility census showed that Resident #5 was assigned and resided on the sixth floor in # . A review of the progress notes dated stated: "At approximately 8:50 AM nurse was called to memory care, upon arrival resident observed in front of elevator yelling at staff members and trying to get on elevator to leave, nurse explained to resident. In an interview on at 2:01 PM when asked if Resident #5 was seen by a physician before he was placed on the memory care floor, the Director of Health Services stated, "It was her and the Administrator that placed him on the memory care floor." In an interview on at 12:48 PM when asked who placed Resident #5 on memory care, the Administrator stated, "I did put him on. We did that until we contacted the son. He needed to be in a locked area." When asked about the policy to be placed on a memory care, the Administrator stated, "Generally speaking, yes, we do an assessment. It was not to be permanent. He was there for four hours. I know he returned from elopement at 10:35 AM." The Administrator stated that they placed him on the memory care at 8:00 AM until he was transported to the hospital at 12:00 PM. The Administrator stated that refused to take him out because he was alert. The Administrator stated, "Ultimately, his physician came at 12:00 PM."	{A 030}		

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{A 030}	Continued From page 29 When asked why Resident #5 was not assessed when he eloped on , the Administrator stated that he did not elope. In an interview on at 12:00 PM Resident #5's primary care physician stated that he placed him under on and that he was an elopement risk. A review of Resident #5's health assessment with a completion date of showed a diagnoses CLD-36, , Hypercalcemia. The physical limitations showed precautions. The status showed not applicable. The nursing requirements showed not applicable. The resident had precautions. The resident was not listed as an elopement risk. The activities of daily living showed supervision needed with ambulation, eating, and assistance needed with bathing, , self-care, toileting, and transferring. 5) A review of Resident #6's hospital records dated documented the following: "84M PMH , , , and presenting to ED on with after an unwitnessed . Patient was found down in his bathroom and was suspected to have been down for some time as he had dried on his and . CT of the is personally reviewed and reveals a modest right , tip hematoma with acute products along the tentorium." A review of Resident #6 progress notes dated documented the resident was found lying on the bathroom floor with a towel under his . However, the progress notes did not	{A 030}		

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{A 030}	Continued From page 30 mention the dried on Resident #6's and . Observation on at 2:00 PM sound Resident #6 seated in a wheelchair. A review of Resident #6's progress notes dated documented that resident returned from the hospital with an acute layering along the tentorium, left , soft tissue hematoma and . A review of the facility's incident log showed Resident #6 had more than two (,). However, a care plan to prevent was never placed after the first . A review of Resident #6's health assessment with a completion date of showed the resident needed supervision with ambulation, bathing, , self-care, toileting and transferring and independent with eating. 6) A review of Resident 8's hospital admissions and discharged record dated and found: "The discharged assessment plan showed: " , , , severe , , , ." A review of Resident #8's progress notes dated showed the resident was shaking in the wheelchair, warm to touch, and and was placed in bed and not sent out to the hospital immediately due the daughter's objection until a day later. A review of Resident #8's progress notes dated at 8:10 AM documented: "At	{A 030}		

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approximately 8:10 AM nurse was called to resident unit was in memory care dining. The resident was observed to be . However, with response, resident vitals were taken t-97.9, b/p p-77 rr-22 911 was activated at 8:15 AM. 911 asked to bring resident to apartment and lay her flat on floor. Resident's was taken again at 8:23 AM p-77 resident was showing no signs of distress, and no grimacing expression of , . The nurse stayed with resident until EMT arrived with 2 men and 1 woman with stretcher. The resident was assessed by EMT and an line was placed into right . The resident was placed on a stretcher, and left with EMT at 8:45 AM. The resident was sent to [hospital].'

A review of John Hopkins Medical Centers's database showed that 911 calls are to be made right away for the following conditions: "fainting, sudden , or , changes in vision. Severe or , or or that doesn't stop."

A review of Resident #8's health assessment dated showed a diagnoses of 's . The resident's status showed . The resident had risk and skin precaution. The activities of daily living showed assistance needed with ambulation, bathing, , eating, self-care, toileting and transferring.

The Cleveland Clinic states the following about : " occurs when your system has a dangerous reaction to an . It causes extensive throughout your body that can lead to tissue damage, organ failure and even . Many kinds of

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can trigger , , which is a medical emergency. The quicker you receive treatment, the better your outcome. Symptoms of , : low , , or , , warm or clammy/sweaty skin, or disorientation, shaking or chills, extreme , or discomfort, , issues, and low energy/ ."

7)

A review of Resident #22's progress notes dated entered at 10:35 PM documented the following: "Nurse was informed by the front desk that paramedics had just returned [Resident #22] to the facility. Upon arrival, the nurse met with the paramedics in the resident's room and observed her sitting on the bed, soaked, without shoes, and appearing to be emotional distress. The paramedics reported that someone found the resident in the lake and called 911. [Resident #22] expressed feelings of , , stating she feels embarrassment and that no one likes her. At this time, she was unable to clearly what had happened. She mentioned she went out with her daughter and then went for a walk around the lake. No complaints of , , no injuries were observed. Refused to go to the hospital for further evaluation and treatment. A message was left for her power of attorney by the DON, and her primary care physician. However, there was no immediate assessment done by a psychiatrist to determine Resident #22's mental state after she was found in a lake.

In an interview on at 11:40 AM Resident #22 stated, "I was not treated by paramedics. I was not injured. I was not seen by the [primary care doctor] or psychiatrist.

In an interview on at 10:44 AM when

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asked if she was working when Resident #22 was found in the lake, Staff AA License Practicing Nurse (LPN) stated, "I got a call from the receptionist. Someone had call that she was in the lake. They did not know whether she or slid into the lake. I called the Director of Health Services. I thought she was . I asked her some questions about , she stated, No." When asked if the resident was drinking, the DOHS stated that she smelled like . The DOHS stated, "She slurred her speech." When asked about what time it was, Staff AA stated, "between 8PM-9PM. It was before the shift changed. It was late." When asked about her job title, Staff AA stated, "I am a LPN." When asked if she assessed the resident, Staff AA stated, "I made an assessment that she was not . I asked her while I was on the phone with the DOHS. We did not send her to the hospital."

A review of Resident #22's progress notes dated entered at 10:57 Nurse observed resident in [room #], stated she is feeling much better overall, voiced no at this time and no c/o of , . She struggles with feelings of , during the holidays and is upset about her children's behavior towards her. She clarified the incident stating that she did not go out with her daughter but rather took a walk around the lake by herself, where she slipped and ."

According to Resident #22's daughter on at 3:41 PM when asked if she picked up her mother from the facility, the daughter stated that she picked her mother up between PM. The daughter stated that her mother and sister all had dinner together and she dropped her mother off to around 9 PM-10:00 PM in the front of the building. When asked what

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happened to her mother, the daughter stated, "So, I heard she was wet part but not that she was in the lake."

A review of Resident #22's health assessment with a completion date of 2023 showed . The physical status showed ambulates with assistance. The status showed alert, awake, oriented times three. The nursing notes showed precautions. The resident had precautions. The resident was not listed as an elopement risk. The activities of daily living showed independent with ambulation, bathing, eating, self-care, toileting, and transferring.

In an interview on at 12:48 PM the Administrator stated that Resident #2's was not witnessed by anyone. The Administrator stated further that the agency nurse that did not report Resident #2 had a .

In an interview on at 3:59 PM when asked if an investigation was conducted when Resident #22 was found in the lake, the Administrator stated, "No." The Administrator stated, "It sounds like she was feeling . She was assessed by [Staff AA]."

A review of the facility's elopement policy showed: "Admitted residents, in the event they present with emotional or chemical , if acute will be referred to their medical provider and supervised according accordingly as well as assessed for elopement risk."

Uncorrected
Class I

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{A 152} SS=F	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be .	{A 152}		

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{A 152}	Continued From page 36 This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment free of hazards. Additionally, the facility to ensure architectural and structural appurtenances were maintained. Findings included: On at 3:07AM- An observation was viewed the facility entrance was locked, but it was locked from the inside. Staff M work from 11pm to 7am, could not open the door from the inside. On at 3:20AM - An Observation was viewed in resident # 24 room, uncovered a Bathroom toilet holder on the floor. Photographic evidence was obtained. On at 3:28AM - An Observation was viewed in resident # 23 room, uncovered a prescribed medication in the bathroom. Photographic evidence was obtained. On at 3:30AM - An Observation was viewed in resident # 22 room, uncovered a Glass Plus cleaner bottle in the bathroom. Photographic evidence was obtained. On at 3:53AM - An Observation was viewed that no soap in the restroom on the 8th floor. On at 3:54AM - Observation was viewed that unsecured storage closet on the 8th floor. Photographic evidence was obtained. On at 4:21AM - An Observation was viewed in resident # 28 room, uncovered	{A 152}		

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{A 152}	Continued From page 37 excessive boxes in the resident's room. Photographic evidence was obtained. On at 4:08AM - An observation uncovered paint stains and worn carpeting on the 4th. Floor. Photographic evidence was obtained. On at 4:09 AM - Interviewed Staff O, what is happening with the floors? They have a lot of stains. The Staff O stated, "They are working on the floors". On at 4:11AM - Observed in resident's room (resident # 34) uncovered under the bathroom sink, bottle. Photographic evidence was obtained. On at 4:26AM - Observed in resident's room (resident # 35) uncovered a voltaren medication in the living room area basket. Photographic evidence was obtained. at 6:07 AM - An observation in the Kitchen, uncovered slippery kitchen area floor. Area appeared to have food in several areas. Pecans left on the counter including dry raisins. Roach trap set in the kitchen. Dirty rags left on the counter. Ice creams in small freezer melted. It appeared that the freezer was not working. Photographic evidence was obtained. On at 7:06AM An observation in Resident's room (Resident # 33), uncovered the resident had a broken closet. Photographic evidence was obtained. On at 2:13PM Interviewed Staff A via phone, how often does pest control does their inspection? Staff A answered: every month.	{A 152}		

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