

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 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 complaint investigation for Complaint #2025001170 and #2025001601 was conducted at Sterling at Aventura from through . Deficiencies were identified at the time of the survey. Class I deficiencies were found at Tag A0025, A0032, A0079. 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. Two residents were out of the facility without staff knowing their whereabouts and were at risk of harm: One Resident eloped twice, on one occasion the Resident was brought to the facility after police found him, and he was unable to tell his address to the police; on another incident the same Resident was brought to the facility by strangers a day after he was missing from the facility. Another Resident was brought to the facility after 9:30 PM by first responders after she was pulled from a lake. The Resident was wet and shoeless and expressing feelings of despair.	A 000		

AHCA Form 3020-0001

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

TITLE

(X8) 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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 1 The facility was observed with only seven employees including a trainee and a temporary staffing agency employee without any training caring for a census of 137 residents including 14 residents under hospice care and 28 residents that were on the memory care floor with diagnoses of _____'s or _____. Deficiencies were identified at the time of the visit: The facility was also cited under event ID 1W8T12.	A 000			
A 007 SS=D	59A-36.006(1) FAC Admissions - Criteria (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least _____ 2. Be free from signs and symptoms of any communicable _____ that is likely to be transmitted to other residents or staff. An individual who has _____ () _____ may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication.	A 007			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 007	Continued From page 2 a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility employs a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a health care practitioner, or a mental health practitioner licensed under Chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 10. Not have any _____ or 4 _____. A resident requiring care of a _____, _____, _____ may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care practitioner;	A 007			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 007	Continued From page 3 b. The condition is documented in the resident's record and admission and discharge logs; and, c. If the resident's condition fails to improve within 30 days as documented by a health care practitioner, the resident must be discharged from the facility. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with ; c. Monitoring of gases; d. Management of post-surgical drainage tubes and vacuum devices; e. The administration of products in the facility; or f. Treatment of surgical or , unless the surgical or and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. , and , performed in the facility; b. , performed in the facility. 13. Not require 24-hour nursing supervision, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 14. Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as	A 007			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 007	Continued From page 4 determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and preferences of the individual; b. The medical examination report required by Section 429.26, F.S.; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule Chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable _____ or assistance with routine _____ care of _____ site _____ placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in Section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from _____ with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) Notwithstanding any other provisions of this	A 007			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 007	Continued From page 5 rule, an individual enrolled in and receiving licensed hospice services may be admitted to an assisted living facility pursuant to Section 429.26(1)(d), F.S. (e) Resident admission criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to meet the required requirements for admission for one out of 53 sampled residents (Resident #1). Additionally, the facility admitted Resident #1 with a stage three, without the resident being under hospice care on admission. Findings Included: A review of Resident 1's sheet showed the resident was admitted to the facility on . A review of Resident 1's progress notes showed the resident was readmitted from [] Hospital on with a 'quarter size' area. noted to area.' A review of Resident 1's health assessment dated showed no , 3, or 4 , In an interview on at 11:55 am, the Nurse Practitioner stated Resident 1 was admitted into the facility with a that developed while the resident was in the rehabilitation center. She stated that a care order was placed at the end of . The Nurse Practitioner stated regarding Resident	A 007			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 6 #1's and "it was kind of just there, it didn't get better, and he had on his / lower the skin was so fragile, and he wasn't able to stand up." The Nurse Practitioner further stated the was a staged 3 in the middle of the, "he had zero cushioning we even tried to give him ensure to build, but it didn't work." In an interview on at 11:21 am, the Hospice Team Manager stated the resident was admitted under hospice care on with no prior hospice admission. In an interview on at 11:25 am Hospice Patient Care Administrator stated the resident's preadmission evaluation showed that the resident was, alert and oriented x2 (knew his name and the place), referred to hospice due to functional decline." The Patient Care Administrator further stated that Resident #1 was admitted under hospice care on with a, to the on admissions. Class III	A 007			
A 010 SS=D	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the	A 010			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 7 resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total	A 010			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 8 physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule	A 010			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 9 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner; 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an	A 010			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 10 interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the appropriateness of continued residency for one out of 53 sampled residents (Resident #16) who had under twenty-four-hour care of a private duty aide. Findings Included: Observation at 3:35 am Resident #16 lying in bed sleeping. In an interview on at 7:20 am Resident #16 Private Duty Aide #1 stated during her shift from 8 pm to 8 am the staff only would come into the resident room to complete their	A 010			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 11 rounds at 11 pm and 6 am. When asked what do the staff assist the resident with? The Private Duty Aide stated 'Nothing, they just come in to check if everything is ok.' The Private Duty further stated, "the staff knows I'm here with the resident, so they don't see the need to do anything." The Private Duty Aide also stated she'd been hired by the resident family in / after the resident had a 'the family wanted her to be safe since the staff can't be here all the time.' The Private Duty Aide further stated, "when the staff comes in, she can get pretty aggressive and (Resident #16) can't walk on her own." A review of the facility's hospice census showed Resident #16 was not under hospice care. A review of Resident #16 health assessment dated . showed the resident had a diagnosis of . Special precaution showed precaution. Activities of daily living showed the resident needed assistance with ambulation, bathing, . self-care, toileting, transferring and needed supervision with eating. A review of the facility progress notes dated showed Resident #16 was 'fighting' her private duty aide while she was assisting the resident during toileting. In an interview on at 9:20 am regarded Resident #16 having a private duty aide on site for 24 hours Staff B (Charge Nurse) stated, "her daughter pays for that, that's what her daughter wants." Staff B further stated the resident had and she'd been fine during the day and at sundown her behavior changes and she'd get in her mode. In an interview on at 11:25 Private	A 010			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 12 Duty Aide #2 first shift 8am-8pm stated, "I help the resident get in and out of bed, shower, change her, the resident is able to eat, but not able to transfer without physical assistance." The Private Duty Aide also stated if she needed help the staff would come and assist her with the resident; 'if they're not busy.' The Private Duty Aide further stated the resident gets aggressive sometimes "I mainly have to be the one to care for the resident the staff would assist since she's calmer with people she knows." Class III	A 010			
A 027 SS=I	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making . . . and remind residents about scheduled . . . for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a . . . health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to arrange medical services for two out of 53 sampled residents (Resident 22, Resident 8). Resident 22 was brought to the facility wet, shoeless and in an emotional distress state after	A 027			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 027	Continued From page 13 she was pulled out of a lake but a medical or a evaluation was not obtained. Resident 8 exhibited symptoms of shaking and an elevated temperature but she was put to bed without a medical evaluation and was later diagnosed with , acute , acute , injury and other life-threatening conditions. Findings included: Resident 22) A review of Resident #22's progress notes dated at 10:35 PM showed, "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 in 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 (Director of Nursing), and her primary care physician" Further review showed no documentation that the Resident was physically or , evaluated by a physician, a mental health provider or that a screening tool was used to determine the Resident's physical and mental state after she was rescued from the lake.	A 027			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
A 027	Continued From page 14 In an interview on _____ at 11:40 AM Resident #22 stated, "I was not treated by the paramedics. I was not injured. I was not seen by the [primary care doctor] or the psychiatrist" In an interview on _____ at 10:44 AM when asked if she was on duty when Resident 22 was brought _____ from the lake, Staff AA, a Licensed Practicing Nurse (LPN) stated, "I got a call from the receptionist. Someone had called 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 (Director of Health Services) stated that she smelled like _____. The DOHS stated, "She slurred her speech." When asked at what time that was, Staff AA stated, "Between 8 PM or 9 PM. It was before the shift changed. It was late." When asked about her job title, Staff AA stated, "I am an LPN." When asked if she had 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." In an interview on _____ at 3:59 PM when asked if Resident #22 was medically evaluated after she was found in the lake, the Administrator stated, "It sounds like she was feeling _____. She was assessed by [Staff AA]" A review of Resident #22's health assessment dated _____ showed _____, (_____), _____ (Carotid _____ of the _____ _____). The physical limitations showed the Resident ambulated with assistance. The _____ status showed alert, awake,	A 027	

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 027	Continued From page 15 oriented to self, place and time. The nursing requirements showed precautions. The activities of daily living showed the Resident was independent with ambulation, bathing, eating, self-care, toileting, and transferring. According to the National Institute of Health, "_____ is a major public health concern. According to the Center for Disease Control and Prevention (CDC), more than 47,000 individuals killed themselves in 2019. Even more common than _____ by _____ are _____ attempts and _____ thoughts. Screening for _____ Risk: Early detection is a critical prevention strategy. The majority of people who die by _____ visit a health care provider within months before their _____. This represents a tremendous opportunity to identify those at risk and connect them with mental health resources. Yet, most healthcare settings do not screen for _____ risk. Using an evidence based clinical pathway can guide the process of identifying patients at risk and managing those who screen positive." Resident 8) A review of Resident 8's progress notes dated _____ at 8:51 PM showed the resident was observed shaking in her wheelchair, warm to touch and was put to bed and given _____. Further review showed that at 9:55 PM the Resident began _____, and a message was left with her PCP for _____ and _____ medication. Further review showed that when the Resident's daughter was notified, she stated that she did not want the Resident to go to the hospital. A review of Resident 8's progress notes dated _____ at 8:10 AM showed _____ (emergency	A 027		

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 027	Continued From page 16 medical services) were called after the resident was found in a state in the dining room, and she was transported to the hospital emergency room via A review of Resident 8's hospital record dated showed diagnoses of acute (a caused by), acute , severe physical deconditioning, possible on admission, (low) on admission, , and acute failure. Further review showed Resident 8 was admitted for further evaluation and treatment. A review of Resident #8's health assessment dated showed diagnoses of The resident's status showed The resident had special precautions for and skin precautions. The activities of daily living showed the Resident needed assistance with ambulation, bathing, , eating, self-care, toileting and transferring. According to The Cleveland Clinic, " 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 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/	A 027			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 027	Continued From page 17 Class II Based on record review and interview, the facility failed to arrange medical services for two out of 53 sampled residents (Resident 22, Resident 8). Resident 22 was brought to the facility wet, shoeless and in an emotional distress state after she was pulled out of a lake but a medical or a evaluation was not obtained. Resident 8 exhibited symptoms of shaking and an elevated temperature but she was put to bed without a medical evaluation and was later diagnosed with , acute , acute , injury and other life-threatening conditions. Findings included: Resident 22) A review of Resident #22's progress notes dated at 10:35 PM showed, "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 in 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 (Director of Nursing), and her primary care physician"	A 027			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 027	Continued From page 18 Further review showed no documentation that the Resident was physically or , , , evaluated by a physician, a mental health provider or that a screening tool was used to determine the Resident's physical and mental state after she was rescued from the lake. In an interview on at 11:40 AM Resident #22 stated, "I was not treated by the paramedics. I was not injured. I was not seen by the [primary care doctor] or the psychiatrist" In an interview on at 10:44 AM when asked if she was on duty when Resident 22 was brought from the lake, Staff AA, a Licensed Practicing Nurse (LPN) stated, "I got a call from the receptionist. Someone had called 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 (Director of Health Services) stated that she smelled like . The DOHS stated, "She slurred her speech." When asked at what time that was, Staff AA stated, "Between 8 PM or 9 PM. It was before the shift changed. It was late." When asked about her job title, Staff AA stated, "I am an LPN." When asked if she had 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." In an interview on at 3:59 PM when asked if Resident #22 was medically evaluated after she was found in the lake, the Administrator stated, "It sounds like she was feeling . She was assessed by [Staff AA]"	A 027			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 027	Continued From page 19 A review of Resident #22's health assessment dated _____ showed _____ (Carotid _____ of the _____. The physical limitations showed the Resident ambulated with assistance. The _____ status showed alert, awake, oriented to self, place and time. The nursing requirements showed _____ precautions. The activities of daily living showed the Resident was independent with ambulation, bathing, eating, self-care, toileting, and transferring. According to the National Institute of Health, "_____ is a major public health concern. According to the Center for _____ Control and Prevention (CDC), more than 47,000 individuals killed themselves in 2019. Even more common than _____ by _____ are _____ attempts and _____ thoughts. Screening for _____ Risk: Early detection is a critical prevention strategy. The majority of people who die by _____ visit a health care provider within months before their _____. This represents a tremendous opportunity to identify those at risk and connect them with mental health resources. Yet, most healthcare settings do not screen for _____ risk. Using an evidence based clinical pathway can guide the process of identifying patients at risk and managing those who screen positive." Resident 8) A review of Resident 8's progress notes dated _____ at 8:51 PM showed the resident was observed shaking in her wheelchair, warm to touch and was put to bed and given _____. Further review showed that at 9:55 PM the Resident began _____ and a message was left with her PCP for _____ and _____.	A 027			

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 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 027	Continued From page 20 medication. Further review showed that when the Resident's daughter was notified, she stated that she did not want the Resident to go to the hospital. A review of Resident 8's progress notes dated _____ at 8:10 AM showed _____ (emergency medical services) were called after the resident was found in a _____ state in the dining room, and she was transported to the hospital emergency room via _____. A review of Resident 8's hospital record dated _____ showed diagnoses of acute _____ (a _____ caused by _____), acute _____, severe physical deconditioning, possible _____ on admission, _____ (low _____) on admission, _____, and acute _____ failure. Further review showed Resident 8 was admitted for further evaluation and treatment. A review of Resident #8's health assessment dated _____ showed diagnoses of _____. The resident's _____ status showed _____. The resident had special precautions for _____ and skin precautions. The activities of daily living showed the Resident needed assistance with ambulation, bathing, _____, eating, self-care, toileting and transferring. According to The Cleveland Clinic, " _____ 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 _____ can trigger _____, which is a medical emergency. The	A 027		

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 027	Continued From page 21 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/_____. Class II	A 027			
A 032 SS=J	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2) (a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement	A 032			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 032	Continued From page 22 at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to obtain an assessment for Resident #5 for risk of elopement after a previous elopement. Resident #5 eloped again and was missing for several hours before	A 032			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 032	Continued From page 23 being returned to the facility by strangers. The facility failed to make a daily effort to determine and ensure Resident # 5 had identification on his person of his name, the facility's name, address and telephone number. The facility failed to know the general whereabouts of Resident #22 who was found less than one mile away from the facility by a stranger in a lake. The facility Administrator and Director of Health Services (DOHS) failed to identify four out of 53 residents (37, 40, 50, 51) at risk for _____ and elopement in the facility. Findings: 1) A review of the police report dated _____ showed Resident #5 was reported as a missing person from the facility and had a prior elopement that occurred in _____. A review of Resident #5's progress notes dated _____ documented the following: "At 10:45 PM, certified nursing assistant (CNA) reported that the resident had not been observed during the final rounds of her shift. CNA indicated that the last sighting of the resident occurred between 4:00 PM and 5:00 PM., as the resident was seen going downstairs. Phone call was placed to front desk where receptionist stated that she has not seen the resident since the beginning of her shift." A review of Resident #5's progress notes dated _____ at 10:45 AM: "nurse was made aware resident returned to community with two women who did not leave their name or number." A review of the admissions and discharge log	A 032			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 032	Continued From page 24 showed an admission date of _____. A review of Resident #5's records found no assessment for his elopement on _____ and on _____. A review of the facility's sign in and sign out resident's log showed no signature on _____ and _____ for Resident #5. Photographic evidence obtained. Observation on _____ at 11:03 AM found no identification on his person that included his name, and the facility's name, address and telephone number. A review of Resident #5's health assessment with a completion date of _____ showed diagnoses of _____ an 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. In an interview on 04/028/2025 at 10:42 AM when asked if Resident #5 was assessed for an elopement risk when he eloped on _____, the Director of Health Services stated that she could definitely check. In an interview on _____ at 12:48 PM when asked if Resident #5 eloped before, the Administrator stated, "[Resident #5] went to the [sporting goods store] and could not remember	A 032			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 032	Continued From page 25 how to get . He was oriented and alert to time and place. The police called and the nurse went to get him." When asked if he signed out, the Administrator stated, "Yes." We created a tag and there was information in his wallet and on the assisted device." When informed that there was no information of the facility address on the assisted device and on the resident, the Administrator stated, "Okay." The Administrator stated further that he was placed under after he returned from elopement on In an interview on at 12:00 PM Resident #5's primary care physician stated that he placed the resident under for combativeness on A review of the facility's elopement policy (date not found) showed: "The community will assure resident who are, physically, mentally, or emotionally and residents who require a secure living environment are assess for risk of elopement. The community will assure procedures are in place to reduce the risk of elopement. Definitions: Elopement: when a resident who is, physically, mentally, emotionally and/or chemically leaves a care giving environment unnoticed or unsupervised. Missing Resident: A resident whose whereabouts are unknown can be considered to be missing. Residents at-risk for elopement will be listed in the community's communication systems, as on the white board, the 24-hour report log, and discussed at rounds, stand-up and staff meetings. Missing resident search: If a resident is missing, initiate and follow the procedure below using the missing resident checklist: confirm the resident is missing by checking the sign in/out book, visitor sign in/out book."	A 032			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 032	Continued From page 26 2) A review of the police report dated documented a call received at 9:29 PM of a female (Resident #22) found in a lake, and it was unknown how person got into the lake. The report stated further that an individual was with person and fire rescue arrived at 9:34 PM. A review of Resident #22's progress notes dated showed resident was found in the lake by someone. In an interview on at 11:40 AM Resident #22 stated that she went for a walk in the lake. Resident #22 stated that it was around 8:00 PM. Resident #22 stated that she climbed down and got into the lake. Resident #22 stated, "I she took my shoes off. I tried to get up and could not. I saw some people walking by and I yelled to get help." Resident #22 stated that she thinks the police brought her. Resident #22 stated, "I did not tell anyone where I was going. I signed out but I did not get tell anyone where I was going." In an interview on at 11:04 AM Staff when asked to explain what happened when Resident #22 was found in a lake, Staff AA License Practicing Nurse stated, "I got a call from the receptionist. Someone had called that she (Resident #22) was in the lake. They did not know whether she or slid into the lake. When asked if the resident was a , Staff AA stated that she never In an interview on at 3:59 AM when asked if an investigation was conducted when	A 032			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 032	Continued From page 27 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. They called the daughter. I can only say the paramedics were involved. The lake was a quarter of a mile away." When asked if she eloped in the past, The Administrator stated she had not eloped in the past. When asked if Resident #22 signed out, the Administrator stated, "She did not sign out." The Administrator stated that according to the notes, Resident #22 returned around 11:35 PM (). When asked if the rounds were done, how come the facility did not know if the resident was missing, the Administrator was unable to provide an answer. 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. A review of Resident #22's progress notes dated at 11:35 PM documented: "Nurse was informed by the front desk that paramedics had just returned [Resident #5] to the facility. Upon arrival, the nurse met with the paramedic in the resident's room and observed her sitting on the bed, soaked, without shoes, and appearing emotional distress. The paramedics reported that	A 032			

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 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 032	Continued From page 28 someone found the resident in the lake and called 911. [Resident #22] expressed feelings of stating she feels like an embarrassment and that no one likes her. At this time, she was unable to clearly what had happened." A review of the medication observation record (MOR) for Resident #22's prescribed medications scheduled between 8:00 PM-10:00 PM showed she received the medications at 10:52 PM on In an interview at 10:24 AM Staff AF (Medication Technician) stated that she worked at the facility for 17 years. Staff AF stated, "I am a medication/technician. Yes, I do work mostly floors on the 3:00 PM-11:00 PM shift. I work between floors." When asked about Resident #22, Staff AF stated that she was one of her residents on the fourth floor. "I have an order to give her medications between 5:00 PM-7:00 PM and 8:00 PM and 8:00 PM-10:00 PM." When asked when a medication is considered late, she stated that if that patient was out and the patient returns that was the time it was given. When asked if the medication was given late on, stated that she does not know. Staff AF stated, "She is independent she can sign out." Staff AF stated that she was not an elopement risk because she was independent. Staff AF stated that when they can't find a resident and when it is time to give them their medications, she would call downstairs to see if the resident signed out. When asked if she called downstairs to speak with the receptionist to verify if the resident (#22) signed out, Staff AF stated that she could not remember. Staff AF stated, "If she signed out at the front desk, we don't call that elopement. If I don't see her in her room, I go downstairs	A 032		

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 05/12/2025	
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 032	Continued From page 29 (receptionist). If a resident doesn't sign, that was exactly what we call missing. They (receptionist) take their pendant when the residents sign out so that the residents does not lose it. When the resident comes , we give it to them." When asked if there were residents at risk for elopement or , Staff AF stated that no one on her PM shift. When asked the name of the CNA who was working on the floor when Resident #22 eloped, Staff AF stated that she could not remember. Staff AF stated that the nurse was already with Resident #22 in the room. When asked if the police or rescue was present, Staff AF stated, "I saw rescue." Staff AF stated that Resident #22 was dressed and that she was going out with her daughter. When asked what time Resident #22 returned, Staff #22 stated that she did not know because the CNA paged her. In an interview on at 2:04 PM when asked who worked at the front desk in the evening when Resident #22 was found in the lake, the Staff AC (Receptionist) stated that she had been working at the facility for six years and her responsibility was to keep track of the residents, receive family, mail, transfer calls. Staff AC stated that she worked Mondays through Wednesdays. From 3:30 PM-11:00 PM. She stated that she knew 90% of the residents and that she knew who Resident #22 was. Staff AC stated that she does not remember when Resident #22 came from the lake. She stated that it was nighttime. She stated that she usually doesn't ask the residents where they are going. When asked who was the someone that brought the resident , she stated that she does not know. When asked if it was the fire department or police department that came to the facility, Staff AC stated that she does not know. When asked how far the lake from the facility was, Staff	A 032		

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 032	Continued From page 30 AC stated that she was not from the area. Staff AC stated that she was from another area. When asked if she saw Resident #22 leave, Staff AC stated, "No." When asked if there are residents that were elopement risk or , she stated, "We have a few." When asked to name them or if she had a list, Staff AC stated that there was not such list. In an interview on at approximately 2:30 pm, when asked about the incident when her mother was found in the lake, the daughter stated that her sister was in town, and she picked her mother up between PM outside of the facility. The daughter stated that she had dinner and took her mother to the facility and dropped her off. The daughter stated that she (daughter) did not go into the building. When asked what time, the daughter stated that it was around the time she was putting her kids to bed. The daughter stated, "I am 100% sure, I did pull up. I usually pull up in front to drop her off and pick her up." When asked what happened, the daughter stated, "So, I heard she was [wet part], but not that she was in the lake." When asked if she signed her mother out, the daughter stated, "No." When asked who dropped her mother off after dinner, the daughter stated that she thought she dropped her off. The daughter stated that the nurse told her that fire rescue picked her mother up. The daughter stated, "I knew she was going for a walk." When asked if she told anyone where she was going when she picked up her mother, the daughter stated, "No." The daughter stated that the facility called her and stated that her mother was okay and that they brought her . When asked if her mother had any elopement or issues, the daughter stated, "No."	A 032			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 032	Continued From page 31 A review of the facility's sign-in and sign-out residents' log showed no signature on by the Resident #22 or family member signing the resident out. 3) In an interview on _____ at 12:48 PM When asked if there were any other elopement risk, the Administrator stated, "No." When asked if there are any _____, the Administrator stated, "No." However, Residents #37, #40, #50 and #51 had elopement risks on their health assessments or were considered _____. A review of Resident #37's health assessment with a completion date of _____ showed a diagnosis of _____. The _____ status showed _____. The resident was listed as an elopement risk. The resident was independent in ambulation, bathing, _____, self-grooming, toileting and transferring. A review of Resident #40's health assessment with a completion date of _____ showed a diagnosis of _____. The activities of daily living showed assistance needed with ambulation, bathing, _____, toileting, transferring, and supervision needed with eating. The nursing status showed home health as needed. The resident was an elopement risk. Observation on _____ at 12:32 PM found Resident #50 on the Memory Care floor which was a secure floor. A review of the facility records found that Resident #50 was assigned to _____ # _____. In an interview on _____ at 12:32 PM Staff	A 032			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 032	Continued From page 32 AD (Certified Nursing Assistant) stated they bring (Resident #50) to the Memory Care floor to spend the day with them for breakfast lunch and dinner because she In an interview on _____ at 2:15 PM when asked about elopements, the Director of Health Services stated that Resident #51 was a _____ and that she was placed on the Memory. The DOHS stated further that her name and room number were placed on her assistive device. Class I	A 032			
A 052 SS=D	429.256() ; 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an _____ syringe that is prefilled with the proper dosage by a pharmacist and an _____ that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including	A 052			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 33 names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her (d) Applying medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific	A 052			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 34 parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self-administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must	A 052			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 35 not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility. 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record. 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.	A 052			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 36 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, facility failed to follow the procedure outlined by the State when assisting 3 of 53 residents with self-administration of medications (Residents #12, #33, #49). Findings included: In an interview on _____ at 7:45 AM, Resident # 49 stated that medications are a problem at the facility. She stated that the day before, her morning medications prescribed at 8:00 am, were given to her at 11:00 AM. In an interview on _____ at 7:55 AM- Staff U stated, "Yes, yesterday several residents did not get their morning medications until much later, after 11:00 AM. It was my day off and I was asked to come in because a nurse refused to pass medications". In an interview on _____ at 8:50 AM, Resident # 12, seated in the dining room, stated, "Yes, the medication nurse was late this morning. On weekends there is another nurse (Agency) that gives the medications". In an interview on _____ at 10:55 AM - Staff S when asked, are these the morning medication for residents? stated, "Yes, these are the medications for the 8AM to 10AM distribution." On _____ at 10:56 AM observation on the electronic Medication Observation Record revealed, for Resident # 49: 25 mg, 85 mg, 24 mg, 40, 25 mg, 100 mg.	A 052			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 37 40 mg at 7:00 am. In an interview on _____ at 12:18 AM Staff C, regarding why the medication were passed out late, stated " Yes, there was a delay with the medications on Sunday because the agency nurse threatened to walk out. She refused to pass medications". A review of Resident # 33's Health assessment dated _____, showed that the resident needed assistance with Self-Administration of medications. Class III	A 052			
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented	A 055			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 055	Continued From page 38 by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued	A 055			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 055	Continued From page 39 medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may be disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain centrally stored medications in a locked cabinet, or other locked storage receptacle, room, or area at all times. Findings included: On at 3:26AM - An Observation in Resident # 25 room, uncovered a prescribed medication prescribed , drops on the counter. Photographic evidence was obtained.	A 055			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 055	Continued From page 40 On at 3:28AM - An Observation in Resident # 23 room, uncovered a prescribed medication . Lotion unlocked on the bathroom open stand. Photographic evidence was obtained. On at 4:11AM - An Observation in Resident # 34 room uncovered under the bathroom sink, bottle. Photographic evidence was obtained. On at 4:26AM - An Observation in Resident # 35 room uncovered a voltaren medication in the living room area basket. Photographic evidence was obtained. On at 4:28AM - An interview was done with Staff O in reference to hospice resident's care supplies was unsecured in resident # 48 room. Staff O stated," she has something on her ". Class III	A 055			
A 077 SS=F	429.176 FS: 429.52(),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.	A 077			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
A 077	Continued From page 41 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least _____; 2. If employed on or after _____, have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to _____, are not required to take the	A 077	

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 077	Continued From page 42 competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the _____ of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care. Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile _____ of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test	A 077			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 077	Continued From page 43 requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to _____, are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not _____ serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, _____, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that it was under the supervision of an administrator capable of handling operations to include management of the staff and the delivery of care and services for all residents. Findings included: Observation on _____ at 3:00 PM revealed that the facility had 7 caregivers on duty. A review of the facility census revealed that there were 137 residents at the facility including 28 residents in memory care and 19 residents in hospice care.	A 077			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 077	Continued From page 44 Interviewed on _____ at 12:30 PM the Administrator stated, "We are not understaffed, we have a 1:30 staff to resident ratio. We try to respond to calls in 10 minutes." A review of the facility's resident pendant calls for assistance records revealed that 969 resident requests for assistance calls were received from _____ through _____ for which the response time was greater than 10 minutes, including a resident request call for assistance that had a response elapsed time of 4 hours and 38 minutes. A review of Resident 22's progress notes dated _____ revealed that the Resident was brought to the facility by first responders after she was found in a lake. Further review showed that the Resident arrived soaking wet and without shoes. A review of a call for service police report dated _____ at 9:34 PM revealed that Resident 22 was found in a lake and was assisted by first responders. Interviewed on _____ at 3:59 PM when asked if an investigation had been conducted after Resident 22 was found in the lake the Administrator stated, "No" When she was asked why the facility was not aware that the Resident was missing the Administrator could not provide an answer. A 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 077			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 077	Continued From page 45 Interviewed on _____ at 12:30 PM when asked why there were so many unwitnessed resident _____ at the facility and what preventive measures had been implemented the Administrator stated, "It depends on the person, we are creating a _____ prevention committee, and we have a _____ report." When she was asked if resident _____ were investigated stated, "No" Observation on _____ at 8:50 AM revealed that the facility's emergency food supply consisted of three _____ cans of peaches, three _____ cans of 3 bean salad, 27 boxes of apple juice, nine cases of ginger sodas in 12-ounce cans. Interviewed on _____ at 12:30 PM the Administrator stated that the facility had acquired an additional emergency food supply. A review of the Adverse Incident Report System (AIRS) showed no documentation of an incident report for Resident 22 on _____ after she was brought _____ to the facility by first responders when she was found by strangers asking for help to get out of the water from a lake. Interviewed on _____ at 4:00 PM when asked why an adverse incident report was not made for Resident 22's incident on _____ the Administrator stated that she had not eloped because she had left earlier with her daughter. Class III	A 077			
A 078 SS=F	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment,	A 078			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 078	Continued From page 46 newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of . testing materials satisfies the annual examination requirement. An individual with a positive . test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's	A 078			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 078	Continued From page 47 health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility _____ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff _____ by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff had updated health evaluations stating that they are free from _____ () and other communicable _____ . The facility failed to ensure that 4 out of 33 sampled staff had updated _____ testing. Staff D, Staff N, Staff F and Staff Q did not have updated _____ tests. Findings: A record review conducted on the Employee file of Staff D (Medication Technician), revealed that the last health certification stating that she was free from _____ and communicable _____ was completed in 2023.	A 078		

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 078	Continued From page 48 A record review of Staff N's (Caregiver) Employee file revealed that the Statement of freedom from and other communicable was not up to date. A record review of Staff F's (Medication aide) employee file revealed that the medical statement regarding freedom from and other communicable was not current. A review of Staff Q's (Quality Life Medication Aid) health certificate revealed that Staff Q had no current medical statement testing. On an interview on at approximately 12:50PM, the Administrator listened to the findings and took note. She did not comment. Class III	A 078			
A 079 SS=L	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457	A 079			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 079	Continued From page 49 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and () and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the	A 079			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 079	Continued From page 50 administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least _____ must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their	A 079			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 079	Continued From page 51 representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff	A 079			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 079	Continued From page 52 hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to provide adequate staffing to meet the scheduled and unscheduled care needs of the residents, compromising their safety and well-being for a census of 137 residents; including 28 residents on the memory care floor and 14 residents under hospice care. Also, the facility had 969 pendant calls from - for assistance which had been received from residents, and staff did not respond until after 10 minutes or more in each case. Findings Included: Observation on _____ at 3:00 am revealed seven employees included one trainee and a staffing agency employee without any training, provided care for a census of 137 residents. In an interview on _____ at 3:22 am Staff N (Medication Technician) stated out of the 137 residents there were 14 residents under hospice care and 28 residents were on the memory care floor. Staff N further stated the Staffing Floor Assignments: 2 & 4 Floors: Staff V (Agency Staff) covered both	A 079			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 079	Continued From page 53 floors by herself. 3 rd. Floor- Staff Q (Medication Aide) and Staff R (Caregiver) only covered the memory care unit. 5 & 6th Floors: Staff O (Caregiver) and Staff P (Caregiver-Trainee) 7 & 8 Floors: Staff M (Caregiver) covered both floors by herself. Floors - Staff N (Medication Technician) covered all floors and was the acting supervisor on duty. Observation on _____ at 5:23 am showed Resident #52 appeared in the hallway and yelled down the hall toward a member of staff (Staff V, Agency Staff). The resident stated, "she's been waiting for assistance since 4 o'clock this morning." A review of the facility pending calls logged dated _____ records showed 969 requests for assistance had been received from residents, and staff did not respond until after 10 minutes or more in each case. A further review of the facility pendant call logs showed that, on _____, staff responded to a resident's request after a delay of 4 hours and 38 minutes. In an interview on _____ at 12:48 pm When asked about promptness, the Administrator stated, "We tried to get to everything about and not to exceed 10 minutes. When asked if there were sufficient and adequately trained staff, the Administrator stated, "I feel we have enough staff. _____ is our staff ratio overnight." In an interview on _____ at 2:27 pm Staff B (Charge Nurse) stated, "Average time for QLS to respond to pending calls is 10 minutes or less." A review of the facility Pendant Calls Policy showed 'Promptness' in response to pending	A 079			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 079	Continued From page 54 calls. However, the facility had no set time for employees to respond. In an interview on _____ at 8:06 am when asked about the staff response time, Resident #21 stated "sometimes it takes up to 30 minutes." The resident further stated, "The staff is definitely short staffed, and they need to hire more personnel, I feel so sorry for the girls; they are overworked and underpaid." In an interview on _____ at 10:35 am Resident 13 stated, "it takes 20 minutes for the staff to respond to call light." A review of the facility Resident Incident Log showed there was a total of 87 resident from a span of three months. Including, one (Resident #6) was found with dried _____ to the _____ and _____. A review of Resident #6's hospital records dated _____ showed "the patient was suspected to be down from some time as he had dried on his _____ and _____." In an interview on _____ at 10:31 am, the family member of Resident #19 stated, "they seem to be understaffed." In an interview on _____ at 10:44 am Resident #18 stated, "The service is slow because they don't have enough people." In an interview on _____ at 10:58 am Staff AI (Certified Nursing Assistant) stated, "we do need more coverage, a couple of people quit." In an interview on _____ at 11:25 am Resident #16 Private Duty Aide #2 stated, "the	A 079			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 079	Continued From page 55 staff does a really good job, but I think they can have more staff." In an interview on _____ at 12:01 pm when asked how often the facility uses their staffing agency, Staff H (Staffing Scheduler Coordinator) stated, "the staffing agency is with clipboard; and we don't use them that often, well as of lately we have been using them a litter more, we need more staff." Class I	A 079			
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003 , and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx . Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents,	A 093			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 56 standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care	A 093			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 57 provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on _____. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has _____ with residents to serve, must be on _____ at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.	A 093			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 58 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain a 3-day supply of non-perishable food, based on the number of weekly meals the facility has with residents to serve in the event of an emergency. The facility failed to serve food attractively at a safe and palatable temperatures. The facility failed to conspicuously post the menu for breakfast easily available to residents. Findings: Observation on at 8:06 AM 19 residents eating in the dining room eating fruits (strawberries, bananas), cereal, coffee, sausage, bacon and eggs. However, there was no available menu for breakfast on the dining tables or posted for the residents to make selections. Observations at 8:50 AM found only three cans of peaches, three cans of 3 bean salad, 27 boxes of apple juice, nine cases of ginger sodas in 12-ounce cans. Interviewed on at 8:50 AM the Chef stated that he had more emergency food on the 6th floor. Observation on at 11:07 AM only found water on the 7th floor storage for emergency use and no non-perishable foods. A review of the facility's records showed a census of 137 residents. Observation on at 8:20 AM several breakfast trays made of Styrofoam on a metal cart to be delivered to residents in the kitchen for	A 093		

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 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 093	Continued From page 59 more than 10 minutes. Observation on at 8:21 AM Staff X (Server) poured hot coffee into a plastic cup for a resident. Interviewed on at 8:21 AM when asked about coffee cups, Staff X stated that they were out of coffee cups. When asked how long it would take to deliver the trays, Staff X stated it would take one hour and a half to deliver them. Observation on at 8:29 AM Staff X delivered the first breakfast tray in Styrofoam on the 7th floor. Interviewed at 8:06 am Resident #21 stated that her food was not hot all the time . Interviewed on at 11:01 AM Resident #53 stated that his only concern was the service was odd the way the staff serve us. Resident #53 stated further, "I don't think they have enough people according to when you get the food, it's ." Interviewed on at 2:34 PM the Administrator stated that she would inform the Chef. Class III	A 093		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained	A 160		

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 160	Continued From page 60 in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a _____; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of _____. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C.	A 160			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 160	Continued From page 61 (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with _____'s or related _____, a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills.	A 160			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 160	Continued From page 62 (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an updated and accurate admission and discharge log with the identification of the facility or home address to which Resident #46 was discharged. Findings Included: A review of the Admission and Discharge log uncovered Resident #46 was discharged from the facility on . However, there was no address to where Resident #46 was discharge to. Interviewed on at 12:50 pm during the preliminary exit the Administrator acknowledged that there was no address listed showing where the resident was discharged. Class III	A 160			
A 161 SS=F	429.275(2) FS; 59A-36.015(2) FAC Records - Staff	A 161			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 161	Continued From page 63 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c).	A 161			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 161	Continued From page 64 F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on Interview and Record Review, the facility failed to maintain documentation of compliance with all training requirements for staff in their designated roles. The facility failed to have documentation on training for Assistance with Self Administration of Medication for three out of 33 sampled staff. Findings: On _____, Record review revealed that Staff U, a Medication Aide, did not have documentation on Assistance with Self Administration of Medication On _____, Record review revealed that Staff D, a Medication Aide, did not have documentation in her file regarding training on Self Administration of Medication of Medication of Medication of Medication of Medication of Medication of Medication of Medication On _____, Record review revealed that Staff F, a Medication Aide, did not have documentation of Assistance with Self Administration of	A 161			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 161	Continued From page 65 Medication On _____, a record review revealed that the staff documentation of training was in disarray and not well organized to facilitate review. Furthermore, the facility did not have the documents readily available. On Interview on _____ at 1257, the Administrator acknowledged the findings. She took note of the comment. Class III	A 161		
A 162 SS=E	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. _____, 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance _____, 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practitioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services,	A 162		

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 162	Continued From page 66 therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that _____ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust	A 162			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 162	Continued From page 67 fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____, CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by	A 162			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 162	Continued From page 68 contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to maintain an accurate and up to date Resident Health Assessment for eight out of 53 sampled residents (Resident #1, #4, #5, #6, #10, #22, #32, and #37). Findings Included: #1) A review of the facility progress notes dated showed Resident #1 returned from the hospital with a . . . pressure injury located on the . . . A review of Resident 1's health assessment dated showed no documentation that the resident had any . . . #4) A review of the facility incident report log dated showed Resident #4 had two . . . A review of Resident 4's health assessment dated showed 'none' written for physical or sensory limitations, nursing/treatment/ . . . service requirements, and special precautions. Section D, regarded, if the resident needs can be met in the assisted living facility section was left blank.	A 162			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 69 #6) A review of the facility incident report log dated _____ showed Resident 6 had two _____ on _____ and _____. A review of Resident #6 hospital records showed "Date of admission _____, Hospital course: _____ male with patient medical history of _____, and _____ presenting to emergency department n 02/11with _____ 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 _____. Injuries: Acute right _____ hematoma measuring 0.6 maximum depth, L parietal _____, _____ repair measuring 0.5 cm, and _____ / _____ with staple in emergency department." A review of Resident 6's health assessment dated _____ showed no documentation of special precautions. Resident #6 activities of daily living showed that ambulation was left blank and eating showed both needed supervision and assistance boxes were marked. Section D, regarded, if the resident needs can be met in the assisted living facility was left blank. #37) A review of the facility progress notes dated _____ showed Resident #37 had a _____ and stated she had _____ in the left _____. A hematoma was also noted on the left side of the resident _____. Resident #4 was transported to the hospital. A review of the facility progress notes dated _____ showed the resident was treated for a _____ in the left _____, a closed	A 162			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 162	Continued From page 70 injury, and a . A review of Resident 37's health assessment dated showed physical or sensory limitations had a description 'not applicable.' Special precautions showed a description of 'not applicable.' Actives of daily living showed the resident was independent with ambulation, bathing, ., eating, self-care, toileting, and transferring. #32) A review of the facility incident report log dated showed Resident #37 had two . and . A review of Resident 32's health assessment dated showed the resident was independent with all activities of daily living expect; bathing the resident needed supervision. #10) A review of the facility incident report log dated showed Resident #10 had four . and . A review of Resident 10's health assessment dated showed the resident had no special precautions listed. #22) A review of the facility progress notes dated showed someone found Resident #22 in a lake and contacted 911. The resident had left the facility, and staff was not aware of the residents' whereabouts. A review of Resident 22's health assessment dated showed the resident was not	A 162			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 162	Continued From page 71 listed as an elopement risk. #5) A review of the facility progress notes dated revealed Staff was not aware of Resident #5 whereabouts. The facility searched nearby shops and was unable to locate Resident #5. The next morning the resident had returned to the facility with two unidentified women. Resident #5 told the staff he went to the store to go shopping and got lost. A review of the facility progress notes dated showed Resident #5 had left the facility and the Staff was not aware of the resident whereabouts, the resident had left to go for a walk and ended up at local sporting good shop. The police were able to contact the facility and advised the facility of Resident #5 location. A review of Resident #5's health assessment dated showed the resident was not an elopement risk. The resident's / behavioral status was not applicable. Class III	A 162			
A 190 SS=D	59A-36.023() & (3)(b); 429.14() Administrative Enforcement 59A-36.023() & (3)(b) FAC Facility staff must cooperate with agency personnel during surveys, complaint investigations, monitoring visits, license application and renewal procedures and other activities necessary to ensure compliance with Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter.	A 190			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 190	Continued From page 72 429.41(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations; or a class I, Class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. (1) Abbreviated Survey. (a) An applicant for license renewal who does not have any class I or class II violations or uncorrected class III violations, or a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program within the two licensing periods immediately preceding the current renewal date, is eligible for an abbreviated biennial survey by the agency. Facilities that do not have two survey reports on file with the agency under current ownership are not eligible for an abbreviated inspection. Upon arrival at the facility, the agency must inform the facility that it is eligible for an abbreviated survey, and that an abbreviated survey will be conducted. (b) Compliance with key quality of care standards described in the following statutes and rules will be used by the agency during its abbreviated survey of eligible facilities: 1. Section 429.26, F.S., and Rule 58A-5.0181, F.A.C., relating to residency criteria; 2. Section 429.27, F.S., and Rule 58A-5.021, F.A.C., relating to proper management of resident	A 190			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 190	Continued From page 73 funds and property; 3. Section 429.28, F.S., and Rule 58A-5.0182, F.A.C., relating to respect for resident rights; 4. Section 429.41, F.S., and Rule 58A-5.0182, F.A.C., relating to the provision of supervision, assistance with the activities of daily living, and arrangement for and transportation to 5. Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., relating to assistance with or administration of medications; 6. Section 429.41, F.S., and Rule 58A-5.019, F.A.C., relating to the provision of sufficient staffing to meet resident needs; 7. Section 429.41, F.S., and Rule 58A-5.020, F.A.C., relating to minimum dietary requirements and proper food hygiene; 8. Section 429.075, F.S., and Rule 58A-5.029, F.A.C., relating to mental health residents' community support living plan; 9. Section 429.07, F.S., and Rule 58A-5.030, F.A.C., relating to meeting the environmental standards and residency criteria in a facility with an extended congregate care license; and 10. Section 429.07, F.S., and Rule 58A-5.031, F.A.C., relating to the provision of care and staffing in a facility with a limited nursing services license. (c) The agency will expand the abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or welfare of residents are identified during the abbreviated survey. The facility must be informed when a full survey will be conducted. If one or more of the following serious problems are identified during an abbreviated survey, a full biennial survey will be immediately conducted: 1. Violations of Rule Chapter 69A-40, F.A.C., relating to fire safety, that threaten the life or	A 190			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 190	Continued From page 74 safety of a resident; 2. Violations relating to staffing standards or resident care standards that adversely affect the health, safety, or welfare of a resident; 3. Violations relating to facility staff rendering services for which the facility is not licensed; or 4. Violations relating to facility medication practices that are a threat to the health, safety, or welfare of a resident. (2) Survey Deficiency. (a) Before or in conjunction with a notice of violation issued pursuant to Part II, Chapter 408, F.S., and Section 429.19, F.S., the agency shall issue a statement of deficiency for class I, II, III, and violations which are observed by agency personnel during any inspection of the facility. The deficiency statement must be issued within 10 working days of the agency's inspection and must include: 1. A description of the deficiency; 2. A citation to the statute or rule violated; and 3. A time frame for the correction of the deficiency. (b) Additional time may be granted to correct specific deficiencies if a written request is received by the agency before the expiration of the time frame included in the agency's statement. (3(b) Dietary Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly related to dietary standards as established in Rule 58A-5.020, F.A.C., is documented by agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a registered or licensed dietitian, or a licensed nutritionist.	A 190			

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 190	Continued From page 75 2. The initial on-site consultant visit must take place within seven working days of the notice of a class I or II deficiency or within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license or registration of the consultant dietitian or nutritionist and the consultant's signed and dated review of the facility's corrective action plan, if a plan is required by the agency, no later than 10 working days after the initial on-site consultant visit. 3. If a corrective action plan is required, the facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the dietary consultant and facility administrator, that deficiencies are corrected and staff has been trained to ensure that proper dietary standards are followed and consultant services are no longer required. The agency must provide the facility with written notification of such determination. 429.14 (6) As provided under s. 408.814, the agency shall impose an immediate moratorium on an assisted living facility that fails to provide the agency with access to the facility or prohibits the agency from conducting a regulatory inspection. The licensee may not restrict agency staff from accessing and copying records at the agency's expense or from conducting confidential interviews with facility staff or any individual who receives services from the facility. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to cooperate with agency personnel	A 190			

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 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 190	Continued From page 76 during a complaint investigation by not providing resident records, medical correspondence and orders for prescriptions, and their policy and procedures for response to residents' injuries and Findings: Interviewed on _____ when asked who placed Resident #5 on the memory care unit, the Administrator stated that it was her decision. When asked for the policy and procedures for admission to the memory care unit, the Administrator stated that she was going to provide it but never did. A record review of the facility records found no staff assignment schedule for employees assigned to the all floors when residents (#1, #2, #3, #4, & #6) on _____, and _____ after several requests. A record review of the facility records found no documentation of elopement certificates for training after Resident #5 eloped Interviewed on _____ at 10:34 AM when asked about the policy and procedures for their response to residents' injuries and _____, the Director of Health Services (DOHS) stated that she had to check who wrote the policy. Interviewed on _____ at 3:59 PM when asked about the policy and procedures for their response to residents' injuries and _____, the Administrator stated, "My corporate had to weigh in on that." Class III	A 190		

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER STERLING AVENTURA		STREET ADDRESS, CITY, STATE, ZIP CODE 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