Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965733	A. BUILDING: _____ B. WING _____	R 06/26/2025

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

AHCA Form 3020-0001

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

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{A 152}	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment free of hazards. Finidngs included: Observation on at 4:10 am showed that on the lobby common area of the fourth floor there was a pill that could only be identified by the manufacturing marking "Xa" on the floor. (photographic evidence obtained) Observation on at 4:25am showed that on the fourth floor there was a storage area that was unlocked and in the storage area there was an electrical room that was kept unlocked. (photographic evidence obtained) Observations on at 04:28 AM showed that on the third floor, # , a shared room common to two residents. The room was observed to have unlocked cleaning supplies under the kitchen sink. The cleaning supplies consisted of laundry detergent and . (photographic evidence obtained) During an interview on at 4:30 am when asked about the pill that was found Staff N stated that she did not know and said that it was possible that a resident had dropped the pill the evening before. Observation on at 4:59am showed that on the eighth floor, there was an unlocked workshop. The workshop contained various maintenances supplies including but not limited to, paint cans and buckets, cleaning agents, a tool cart, hoses, floor tiles, a grinder, key duplicator, pluming auger, replacement doors, air conditioner, lumber and siding, bed frames,	{A 152}		

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{A 152}	Continued From page 2 mobility chair, lamps, roof tiles, truck, dollies, insulation, electrical conduit, pipe cement, tools, wall framing, and etc. (photographic evidence obtained) Observation on at 9:51 am showed that on the eighth floor, # there was a door that was missing its locking mechanism and/or doorknob. (photographic evidence obtained) Uncorrected Class III	{A 152}		
{A 000}	Initial Comments A second re-visit survey was conducted at Sterling at Aventura from through . Deficiencies were found at the time of the survey. The facility was also cited under event ID ECZE12.	{A 000}		
{A 025} SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . . for the	{A 025}		

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{A 025}	Continued From page 3 necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of	{A 025}		

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{A 025}	Continued From page 4 additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision and ensure the safety of two out of 163 sampled residents (49, 38). The facility was unaware that the Resident was missing for more than 15 hours when she was found by police on the street (49). Another Resident needed assistance with all activities of daily living and had 8 unwitnessed during a 6-week period (38) The facility also failed to contact the health care provider immediately when the Resident returned after she eloped and went missing for 15 hours (49). The facility also failed to maintain a written record of the Resident's monitoring or administration and the Resident needed to be transferred to the hospital via emergency medical services with dangerously high level (49). Findings included: Resident 49) Interviewed on at 8:53 AM Staff G stated that he had brought Resident 49 to the nursing station after she told him that she had spent the night before outside of the facility and the police had brought her . A review of Resident 49's progress notes dated documented that at 10:25 AM Staff G brought Resident 49 to the nursing station complaining of from walking reporting that she had not spent the night at the facility and the police brought her at 6:00 AM after she had left the facility at 11:15 AM the	{A 025}		

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{A 025}	Continued From page 5	{A 025}		

day before to go to the pharmacy, got lost and could not get a bus . Further review revealed that Resident 49 called 911 at 2:37 AM and asked to be taken to the hospital because she was feeling shaky and due to her levels. Further reviews showed that (Emergency medical services) was activated at 11:39 AM and the Resident was transported to the hospital after the evaluation showed a level of 451.

A review of Resident 49's hospital records dated documented, " female with past medical history significant for and type II presents to the emergency department via from nursing facility for evaluation of elevated reported the patient checked out of the facility yesterday and was missing for 24 hours with no access to her medications, police found her and brought her to the facility. was called and, on their assessment, POC (Point of Care) was 451 prompting her transfer to the emergency room"

Interviewed on at 2:45 PM the Director of Health Services (Staff C) stated that was called at around 10:30 AM to evaluate Resident 49 after the Director of Activities (Staff G) heard from the Resident that she had eloped the day before.

A review of Resident 49's health assessment dated revealed medical history and diagnoses of with Neuropathic , , , memory changes, , hypertensive , , and seasonal status showed mild . Nursing

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{A 025}	Continued From page 6	{A 025}		

requirements showed none. Special precautions showed none. The activities of daily living (ADL) showed the Resident needed supervision with bathing, ˛ and was independent for ambulation, eating, self-care, toileting and transferring. Special diet instructions showed diet and thin liquids. The Resident needed assistance with self-administration of medication.

Interviewed on at 1:05 PM Resident 49's daughter stated that the Resident was admitted to the facility on when the family decided that she needed help taking her medications and administering . Resident 49's Daughter also stated that the family provided a list of the Resident's medications and the to the facility when she was admitted on . Resident 49's Daughter further stated that she did not know if the Resident was receiving at the facility. She stated, "The home health [Agency] was supposed to start [administering medications] It was one of the concerns why we moved her there, her medications." Resident 49's Daughter reported that her sister was notified about the Resident's elopement on Saturday at around 10:30 AM. She stated, "[Staff C] called my sister about 10:30 AM". Resident 49's Daughter further stated that the Resident had never eloped before, and she did not know where she could have been when she eloped. "She could not walk that far, she has , ˛"

A review of Resident 49's record showed she was admitted to the facility on .

A review of Resident 49's MOR (Medication observation record) showed a start date of for 70-30 100 IU/ML 10 units

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{A 025}	Continued From page 7 once a day for Further review of Resident 49's records showed no documentation of level monitoring or administration from /3035 through . Interviewed on at 2:00 PM the Director of Health Services (Staff C) stated that Resident 49's administration at the facility started on after she returned from the hospital. When asked why the Resident's monitoring and administration did not begin when she was admitted to the facility and the family had provided the and her medication list Staff C stated that it was due to the Resident's insurance coverage. Staff C stated, "There was an insurance issue regarding the doctors' order and the home health agency." Asked about an entry on on Resident 49's MOR for injectable Stacy stated, "That was a medication documentation error" According to the Mayo Clinic, level monitoring (testing) is a key part of care and helps people with manage their condition and prevent health problems. According to the National Library of Medicine, incorrect administration or a total lack of for a prolonged time can lead to a life-threatening complication called -related (DKA) and increased risk of long-term complications of including damage to the and .	{A 025}		

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{A 025}	Continued From page 8 Resident 38) A review of Resident 38's progress notes showed that from through Resident 38 had 8 unattended at the facility.: at 6:15 AM- The Nurse found the Resident lying on the floor in the hallway, with a walker nearby and she reported that she had . There were no visible injuries, and the Resident did not voice , complaints. The CNA (Certified Nurse's Aide) stated the Resident could not sleep at all and continued to walk around the lobby. The family was notified and expressed concern about his mother not being able to sleep at night. The PCP was notified via text message. at 10:20 PM- The Nurse was called to the Resident's room, and she was observed sitting on the floor next to her bed without footwear or socks. The Resident stated that she was attempting to go to the bathroom and . No injuries or concerns were noted, and the Resident was assisted into bed. The PCP was notified and did not give any new orders. The POA (Power of Attorney) was notified. at 4:37 AM- At approximately 9:30 PM the Nurse was called and found the Resident lying in the floor in front of her apartment door reporting that she had . Further review showed that no injuries were noted, and the doctor was notified via text message. at 8:55 AM- At approximately 9:18 AM the nurse was called to the Memory Care dining room and observed the Resident lying on her side on the floor. Further review showed that when asked what happened the Resident stated that she forward when attempting to stand up.	{A 025}		

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{A 025}	Continued From page 9	{A 025}		

Further review showed no injuries were noted, the Resident was returned to her bed, and the doctor was notified via text message.

/202 at 6:00 PM- At approximately 10:43 AM the Nurse was called to the Resident's apartment and observed the Resident laying on the side of the bed on her left side stating that she on the floor while trying to transfer to her bed. Staff reported that an X-ray Technician left the Resident in her apartment and when she came the Resident was on the floor.

at 6:19 AM Staff N notified the Nurse that Resident 38 was on the floor in her apartment close to the bathroom. The paramedics were notified, no injuries were reported, and the Resident remained in the facility.

at 8:22 PM Nurse was called to the Resident's room and observed the Resident on the floor; no injuries were reported the PCP and the POA were notified.

at 9:30 PM Nurse was called to the Resident's room and found the Resident lying on the floor with Staff who reported that she observed the Resident on the floor when she was making rounds. No injuries were noted, and the PCP was notified and recommended to send the Resident to the hospital for further evaluation. Paramedics arrived at 10:00 PM and transported the Resident to the hospital.

A review of Resident 38's hospital discharge instructions dated showed she was treated for with uncertain cause and ,

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{A 025}	Continued From page 10 A review of Resident 38's health assessment dated documented medical history and diagnoses of Front , Aneurysm, (,), (,) and . The physical limitations showed the Resident used an assistive device to ambulate. The status showed she was alert and oriented to person and place. Nursing requirements showed the Resident required assistance with medication administration. Special precautions were not documented; it was left blank. The Resident was not an elopement risk. The activities of daily living (ADL) assessment revealed the Resident needed assistance with ambulation, transferring, toileting, self-care, , eating and bathing. The Resident needed assistance with self-administration of medication and a regular diet was indicated. Interviewed on at 9:53 AM when she was asked about Resident 38's multiple unattended , the Director of Health Services (Staff C) stated that she was obtaining an updated health assessment for the Resident, and she will have a conference with her son because the Resident would benefit from a skilled nursing facility. Class II	{A 025}		
{A 030} SS=I	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary	{A 030}		

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{A 030}	Continued From page 11 provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and . ; 6. Administrative and housekeeping schedules	{A 030}		

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{A 030}	Continued From page 12 and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.	{A 030}		

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{A 030}	Continued From page 13 (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this	{A 030}		

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{A 030}	Continued From page 14	{A 030}		

paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and

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{A 030}	Continued From page 15 advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law,	{A 030}		

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{A 030}	Continued From page 16 managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure three (#49, #55, #58) out of 59 sampled residents live in a safe and decent living environment, free from neglect. The facility failed to ensure Residents #49 received adequate and appropriate health care immediately after she eloped and returned to facility 24 hours later. The facility failed to ensure Resident #49's received administration for more than six days after admission. The facility failed to ensure Resident #55's medications were refilled in a timely manner and not allow the resident to go without them for two days. The facility failed to implement and conduct a missing person search for Resident #49, an elopement risk, who missed morning and evening medications, lunch and dinner and away from the facility for more than 24 hours. The facility failed to obtain and maintain a contractual agreement before additional services were provided for Resident #49. The facility failed to make available an employee or staff on shift to effectively communicate with Resident #58 who speaks Ukraine and Russian.	{A 030}		

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{A 030}	Continued From page 17 Findings: 1) A review of Resident #49's hospital records dated documented: " female with past medical history significant for and type II presents to the emergency department brought in by emergency services (BIBEMS) from nursing facility for evaluation of elevated . Emergency Medical Services ( ) report the patient checked out of the facility yesterday ( ) and was missing for 24 hours with no access to her medications. Police Department (PD) found her and brought her to the facility. was called for general check up which is reportedly their protocol once a patient leaves and returns to the facility. On their assessment, vitals were within normal limits (WNL), point of care (POC) was 451 prompting her visit to the emergency room. Patients denies any complaints." A review of the Resident's sign in/sign out log showed Resident #49 signed out on at 11:20 AM to go to the drugstore approximately six miles away and returned on at 3:07 AM. However, Resident #49 did not receive morning medications. A review of the medication observation record (MOR) showed Resident #49 missed her morning medications on scheduled between 8:00 AM and 10:00 AM and was allowed to leave without receiving her medications (500 MG, , 81 MG, 0.1% Cream, , 10 MG, , 300 MG, 20 MG, 100 MG,	{A 030}		

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{A 030}	Continued From page 18 50 MG). Medlineplus.gov states: " is used alone or with other medications, including, to treat type 2 (condition in which the body does not use normally and, therefore, cannot control the amount of sugar in the). Medlineplus.gov states: " is used with a diet and exercise program and sometimes with other medications, to treat type 2 (condition in which the body does not use normally and therefore cannot control the amount of sugar in the). A review of Resident #49's health assessment dated showed diagnoses of (Neuropathic ,), and Memory Changes, . The physical status showed . The status showed mild . The resident was an elopement risk. A review of the facility records showed no documentation that rounds were conducted including a missing person search after Resident #49 missed her medications, lunch and dinner. A review of the facility's elopement policy states: "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 caregiving environment unnoticed or unsupervised. Missing Resident: A resident whose whereabouts are unknown can be	{A 030}		

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{A 030}	Continued From page 19 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." Interviewed on at 10:26 AM when asked if rounds were conducted on Resident 49's floor, # , the Administrator stated, "We don't have round sheets for the , and 31, 2025, throughout the day. A review of the sign-in/sign-out log showed Resident #49 returned to around 3:07 AM on . Interviewed on at 4:36 AM when asked about Resident #49, Staff S (Receptionist) stated that she reported to work on). Staff S stated, "I came at 11:00 PM. I don't remember the police department. I know they wore brown uniform. She signed out earlier. I had to do the report. [resident #49] called around 11:00 PM. She told me she was with a friend and that she was waiting for a bus. She was brought with the police at 4:00 AM. I offered her some snacks because she was complaining that she was hungry. I got her some foods from the kitchen, and she went upstairs." When asked if she was seen by a nurse, Staff S stated, "I am not sure." When asked if the nurse on duty was notified that she returned, Staff S stated that she was not sure. Interviewed on at 9:15 AM the Charge	{A 030}		

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{A 030}	Continued From page 20 Nurse stated that she was working the 11:00 PM to 7:00 AM shift and was the supervisor. The Charge Nurse stated, "I was not informed Resident #49 returned to the building. I found out when I went home." When asked if the resident missed any medications, initially the Charge Nurse stated that she did not miss any medications at 5:00 AM or 6:00 AM. The Charge Nurse stated further that Resident #49 was supposed to have , , but she did not. Interviewed on at 8:49 AM the Activities Director stated that he worked that day ( ). The Activities Director stated that while he was in the lobby around 10:30 AM Resident #49 called him over. She stated that she did not spend the night in the facility. The Activities Director stated that the resident said she was out with some friends and came at 3:30 AM. The Activities Director stated that this was when he got in touch with the Director of Health services. Interviewed on at 12:47 PM when asked why Resident #49 was sent to the hospital, the Director of Health Services (DOHS) stated that the resident's levels were 541. When asked who checked the , the DOHS stated that it was fire rescue. The DOHS stated that 911 was called and she was transported by them to the hospital. A review of the progress notes dated stated that Resident #49 mentioned that she was on a bus bench after she was lost and she called 911 at 2:37 AM ( ). The progress notes mentioned that her lower extremities were due to excessive walking and that she became , and shaky because her was getting low. The progress notes	{A 030}		

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{A 030}	Continued From page 21 concluded that Resident #40 was transported to the hospital on at 12:08 PM. Interviewed on at 6:45 AM when asked how no one knew Resident #49 was missing, the Administrator stated that she did not get a call until 10:30 AM on that the resident was missing and that when she returned she was sent out to the hospital. The Administrator stated that no one knew the resident was an elopement risk. The Administrator stated that the medication technicians did not notify anyone. Interviewed on at 9:23 AM the daughter of Resident #49 stated they (facility) were supposed to watch her mother. The daughter stated, "We told them we could not have her by herself. We told them to watch and help her. She never before. When we brought her, she was able to sign out. My concern was when they did not see her for lunch and dinner, no one called her. She had her cell phone number." Observation on at 5:03 AM found a Private Duty Aide (PDA) in # assigned to Resident #49. Interviewed on /205 at 5:03 AM the Private Duty Aide stated that she had been working with Resident #49 for about a month. The aide stated further that the resident had a memory problem. The Aide stated that before Resident #49 came to the building, she heard the resident used to leave. Interviewed on at 12:12 PM regarding the hiring of the PDA for Resident #49, the Administrator stated that it was the Administrator's decision to bring in a PDA for the resident's safety. The Administrator stated, "We	{A 030}		

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{A 030}	Continued From page 22	{A 030}		

had a conversation with the family and they agreed. When asked if it was in her contract, the Administrator sated, "It was not in her contract. We will pay for it now and then we will charge it to them. We felt it was in the best interest." Interviewed on at 12:34 PM the daughter stated that the family moved Resident #49 out and they the family was sent a bill for $7,000. The daughter stated, "We did not agree to a private duty aide."

A review of Resident #49's contract dated showed no additional service charges for a private duty aide.

Interviewed on at 9:30 AM Resident #49' Power of Attorney stated that the facility gave her mother a 45-day discharge letter stating that she was unfit because of her elopement.

A review of the admissions and discharge log showed Resident #49 was admitted on .

A review of the medication observation records showed Resident #49 did not receive administration until .

Interviewed on at 1:49 PM the DOHS stated that the was started on . The DOHS stated that there was a problem with her insurance and that was why her was not given at the time of her admission.

Interviewed on at 12:3 PM Resident #49's daughter stated that her mother was on . The daughter stated that her mother gave herself her . The daughter stated that they brought a list of her mother's medications including the to the facility when she was

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{A 030}	Continued From page 23 admitted. The daughter stated that one of the reasons why they brought her to the facility was to make sure she got her . The daughter stated, "She (Resident #49) was already on before ." 2) Observation on at 6:50 AM the prescribed medications 75 MG and 0.5% were not available for 7:00 AM because the prescriptions were not refilled for two days. Interviewed on at 6:54 AM Staff N stated that Resident #55 went without these medications for the prior two days. A review of data from the Mayo Clinic showed: " is used alone or together with other medications to treat increased pressure in the that is caused by open-angle or a condition called ocular ( ) . This medication is a blocker." A review of data from the Mayo Clinic showed: " is used to treat , a condition where the does not produce enough hormone. This medicine os also used to help decrease the size of enlarged glands (also called a). is also used together with surgery and treatment to treat a type of called -dependent well-differentiated ." Interviewed on at 1:22 PM the Administrator acknowledged that the medications were not made available. At 9:53 am on /3035, the DON stated it was the family's	{A 030}		

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{A 030}	Continued From page 24 decision to hire the PDA and there was a language barrier. 3) Interviewed on at 10:31 AM the private duty aide for Resident #58 stated that she speaks only Ukraine and Russian. The private duty aide stated further she was hired by the family because of the language barrier. The private duty aide stated that she does not assist with the activities of daily living, but she translates for the resident. Interviewed on at 1:00 PM regarding the language barrier, the Administrator stated that the son was paying for the private duty aide. The Administrator stated further, No, I am sorry we have no one that speaks Russian." Uncorrected Class II	{A 030}		
A 031 SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to	A 031		

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A 031	Continued From page 25 coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the	A 031		

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A 031	Continued From page 26 timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to maintain documented communications about residents' conditions and response to services ordered by a physician. Third party documented communications were not kept at the facility for one out of 61 sampled resident (#49) Findings Included: A review of resident #49 assessment showed a diagnosis of " " A review of resident #49 medication observation record showed ( ) was a prescribed medication. A review of resident #49 hospital discharge summary dated showed that residents had elevated levels. During an interview on at 10:42am Staff C stated that "they did not have those records and would need to request them," when asked for Resident #49 testing	A 031		

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A 031	Continued From page 27 log. A review of resident #49 log shows that was faxed to the facility on at 1:05pm. The report also shows that the first test was administered on at 8:02am. During an interview on at 12:47pm Staff C stated that Resident #49 started after . During an interview on at 1:00pm Resident #49's daughter stated that her mother was on before admission to the facility. Class III	A 031		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have;	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965733	A. BUILDING: _____ B. WING _____	R 06/26/2025

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

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A 054	Continued From page 28 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and review of records, the facility failed to keep medication observation records (MOR) accurate. Medication Observation Record (MOR) for one of 61 sampled residents (#49) was not accurate. Finding included. Observations on at 9:30am showed Resident #49 sitting in the lobby of the facility with a private duty aide at her side. During an interview on /205 at 9:31 am Resident #49 stated that she was leaving the facility that day and that her daughter was picking her up. During an interview on at 9:40 am the daughter of Resident #49 stated that her mother left the facility for more than sixteen hours on and was leaving that day "without choice." The daughter stated that her mother had and . The daughter also stated that "they were supposed to watch her."	A 054		

Agency for Health Care Administration

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A 054	Continued From page 29	A 054		

A review of Resident #49's progress notes showed that Resident #49 left the facility twice on . Resident #49 first left at 9:15am and returned at 11:00am, and then left again at 11:20am and returned to the facility on at 3:07am. On at 11:56am she was sent to the hospital with dangerously high levels. The record also shows that Resident #49 received a 45-day notice on .

A review of the resident health assessments dated showed that Resident # 49 needed assistance with medications and was an elopement risk. The assessment also showed that Resident # 49's primary diagnosis are with neuropathic , , , and memory charges.

A review of resident #49 MOR showed that on Resident #49's 8am-10am doses of 10mg, 81mg, 20mg, 300mg, 100mg, 500mg, and 30mg were not administered and were marked as "out of facility OOF" at 1:26pm on .

During an interview on 06/242025 at 12:47pm, Staff C revealed that Resident # 49 started taking after when she started receiving third party services. According to Staff C the facility did not administer injectables and only assisted with oral medications.

A review of Resident #49"s MOR showed that Resident #49 started taking ( ) on .

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A 054	Continued From page 30 A review of Resident #49's ˅ log showed that the first ˅ test was administered on at 8:02am. During an interview on at 1:00 pm Resident # 49's daughter stated that her mother was on before entering the facility on and that her medications were turned over to the facility in order to maintain her countinous medical treatment. Class III	A 054		