

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/26/2025
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 056 SS=E	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for, . . . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxed, or electronic copy of a medication order issued and signed by	A 056			

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 R 06/26/2025
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 056	Continued From page 1 the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S.,	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/26/2025
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 056	Continued From page 2 before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the refill for Resident #55 who receives assistance with self-administration was filled in a timely manner for more than two days. The facility failed to make a reasonable effort to ensure Resident #49 received her for type II diagnosis for more than six (6) days. Findings: 1) Observation on at 6:50 AM Staff N (Medication Technician) was unable to offer 75 MG and 0.5% at the prescribed time (7:00 AM) for Resident #55. Interviewed on at 6:54 AM when asked what she does when the resident (#55) do not have any medications, Staff N stated, "She needs to talk to the nurse, and she will handle it". Staff N stated further that Resident #55's medications for 7:00 AM were ordered and she (Resident #55) did not get the 75 MG and the 0.5% two days. Interviewed on at 11:40 AM when informed that Resident #55 did not receive her prescribed medications, the Director of Health Services stated that she would have to confirm it.	A 056			

Agency for Health Care Administration

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

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 056	Continued From page 3 Interviewed on _____ at 1:22 PM the Administrator acknowledged that Resident #55 was without her medications. Mayo Clinic states: "_____ 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." Mayo Clinic states: "_____ 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 _____). _____ is also used together with surgery and _____ treatment to treat a type of _____ called _____-dependent well-differentiated _____." 2) 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 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 was already on _____ before _____." A review of the medication observation record showed _____ 70-30 100IU/ML Vial started on _____, which was six days after being admitted to the facility for Resident #49.	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/26/2025
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 056	Continued From page 4 A review of the admissions and discharge log showed Resident #49 was admitted on . Interviewed . at 1:49 PM the Director of Health Services (DOHS) stated that the started on . The DOHS stated that there wasn't a prescription for the . and a problem with her (Resident #49) insurance and that was why her . was not given from the time of her admission. However, there was no documentation that there was a problem with Resident 49's insurance and any reason for Resident #49 not receiving . administration from the time of admission. A review of Resident #49's health assessment dated . showed diagnoses of (Neuropathic .), (ASHD), . Hypertensive . , Memory Changes, . , Seasonal . . The physical status showed . , ASHD, . , (HLD). The Food and Drug Administration (FDA) states: * 70-30 is a man-made (. DNA origin) which is a mixture of 70% NPH, Human Isophane Suspension and 30% regular, Human . injection that is structurally identical to the . produced by the human . that is used to control high . in patients with . If you forget to take your dose of . , your . may go too high (. , .). If high (. , .) is not treated it can lead to . , which can lead to serious problems, like loss of (passing	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/26/2025
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 056	Continued From page 5 out), or even ." Uncorrected Class III	A 056		
A 058 SS=D	429.42() FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication	A 058		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/26/2025	
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 058	Continued From page 6 practices as established in Rule 58A-5.0185, F.A.C., is documented by the 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 pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and 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 of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. 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 consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to correct three Class III deficiency cited under a complaint investigation regarding medication storage and disposal, self-administration and medication storage. The facility failed to ensure Resident #49 received her medications at the prescribed times. The facility	A 058			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/26/2025
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 058	Continued From page 7 failed to ensure Residents #49 and #55 prescribed medications were filled or refilled in a timely manner. The facility is required to contract the services of a licensed pharmacist or registered nurse who will provide at least quarterly consultation until the Agency for Health Care Administration determines that these services are no longer needed. Findings: 1) Record reviews showed the facility was cited for deficient practices for unlocked medications found in residents' room, Resident #49's medications were given out of the prescribed times on Observation on _____ at 6:50 AM Staff N (Medication Technician) was unable to offer _____ 75 MG and _____ 0.5% _____ at the prescribed time (7:00 AM) for Resident #55. Interviewed on _____ at 6:54 AM when asked what she does when the resident (#55) do not have any medications, Staff N stated, "I need to talk to the Director of Health Services (DOHS), and she (DOHS) will handle it". Staff N stated further that Resident #55's medications for 7:00 AM were ordered and she (Resident #55) did not get the _____ 75 MG and the _____ 0.5% _____ two days. 2) A review of the medication observation records showed Resident #49 missed her following medications to include, _____ 500 MG,	A 058			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/26/2025
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 058	Continued From page 8 50 MG, 81 MG, 0.1% Cream, 10 MG, 300 MG, 20 MG, 100 MG on prescribed between 8:00 AM and 10:00 AM on In addition to the missed medications, the MOR showed Resident #49 was prescribed However, Resident #49 did not receive the until which was six days later. 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 1:22 PM the Administrator acknowledged that the medications were not available and given. Class III	A 058			
{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. 429.52	{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 R 06/26/2025
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 9 (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 competency test unless specified elsewhere in this rule; and,	{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 R 06/26/2025	
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 10 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 requirements, and continuing education requirements as an administrator pursuant to	{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 R 06/26/2025
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 11 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, the delivery of care and services for all residents and the implementation of an effective correction plan for previously identified deficiency practices. The Administrator was not aware that a Resident had eloped, was missing from the facility for more than 15 hours and was brought by police (49) The Administrator did not know how much emergency food and fuel supply the facility had or how to start the emergency power generator. Findings included: A review of Resident 49's progress notes dated	{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 R 06/26/2025
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 12 revealed the Resident had left the facility at 11:15 AM to go to the pharmacy, became lost, was found by police and brought to the facility the next day at 6:00 AM but no one at the facility reported that the Resident was missing. Further review of Resident 49's progress notes 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 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. Interviewed on _____ at 6:25 AM, the Administrator stated that she became aware that Resident 49 had eloped and was missing the next day on _____ at 10:28 AM when it was reported to the Director of Health Services. A review of the facility records showed no documentation that an internal incident investigation was conducted or that corrective measures were implemented. A review of the facility survey findings on _____ and on _____ revealed that the following deficiency practices were found uncorrected on _____ :	{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 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 077}	Continued From page 13 Admissions- Continued Residency. Cited on Resident Care-Supervision- Cited on Found uncorrected on Resident Care-Rights and Facility Procedures- Cited on . Found uncorrected on Resident Care-Arrangement for Health Care. Cited on Resident Care- Elopement Standards. Cited on Medication-Assistance with Self-Administration. Cited on Medication- Storage and Disposal. Cited on Staffing Standards- Administrators. Cited on Staffing Standards-Staff. Cited on Staffing Standards-Levels. Cited on Food Service-Dietary Standards. Cited on Records- Facility. Cited on Records- Staff. Cited on Records- Resident. Cited on Emergency Action Plan-Implementation. Cited on	{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 R 06/26/2025
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 14 Observation on 0/23/2025 at 5:37 AM revealed that the Administrator showed the emergency food supply storage on the 2nd floor. Further observation showed there were water bottles, canned vegetables, sardines and boxes of cereal but an emergency food supply item inventory list or expiration dates were not available. Interviewed on _____ at 5:40 AM when asked how many servings of emergency food were available for the residents the Administrator stated that she did not know. When she was asked how much emergency food supply or weekly servings the facility must have to sustain the residents for 3 days the Administrator stated that she did not know but the Food Manager could provide an inventory list. Interviewed on _____ at 6:00 AM, the Food Manager stated that he did not know how many servings of emergency food were at _____ and he did not have an inventory list, but he would go to his office to get it. Interviewed on _____ at 5:45 AM when asked to test-start the emergency power generator the Administrator stated, "Oh, no, I don't know how to do that!" When asked who knew how to start the generator the Administrator stated, "The Maintenance Supervisor, he is coming soon" Interviewed on _____ at 5:50 AM when asked how much fuel was available for the emergency power generator the Administrator stated, "I don't know but [Maintenance Supervisor] is coming, the maintenance staff know. We received a Diesel delivered not long ago"	{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 R 06/26/2025
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 15 Observation on _____ at 5:55 AM revealed a fuel level gauge on the emergency power generator fuel tank indicating that it was full. Class III	{A 077}		
{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 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	{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 R 06/26/2025
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 16 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 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	{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 R 06/26/2025
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 17 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 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	{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 R 06/26/2025
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 18 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 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 ensure adequate and sufficient staffing to meet both the scheduled and unscheduled care needs of the residents, compromising their safety and well-being for 136	{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 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 079}	Continued From page 19 out of 136 sampled residents (Residents #1-#136). Findings Included: Observation on _____ at 4:12 am revealed nine employees, which included two staffing agency staff (LPN and CNA); the Staffing Agency LPN, oversaw the facility without any training, provided care for a census of 136 residents. Interviewed on _____ at 4:12 am Staff S stated, "I believe the census is 136 residents." Staff S was unable to provide a census of hospice residents, memory care residents, and residents that were in the hospital. Staff S further stated the Agency Staff LPN was in charge and it was supposed to be staff on each floor. Interviewed on _____ at 4:14 am when asked for the census of residents in the facility. The Agency Staff LPN stated, "I don't have that information." The Agency Staff (LPN) further stated, "I'm not sure of the staff names; this is only my third night working here." Observation on _____ at 4:15 am revealed two staff assigned to the memory care unit which had a total of 26 residents. Interviewed on _____ 4:22 Staff AH (Caregiver) stated, "we're understaffed; only two people work this floor at night and it's a challenging floor. In memory care, you need more people to work we have double rooms." A review of the facility staffing scheduled dated _____ showed the staff floor assignments 11 pm to 7 am:	{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 R 06/26/2025
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 20 Floors : Nurse: Agency Staff (LPN) Floors : Staff N (Medication Technician) 2nd & 8th Floor: Agency Staff (CNA) 3rd Floor Memory Care Unit: Staff P (Caregiver) & Staff AH (Caregiver) 4th Floor: Staff R (Caregiver) 5th Floor: Staff M (Caregiver) 6th Floor: Staff AJ (Caregiver)- Staff F (Medication Technician) covered 7th Floor: Staff E (Caregiver) Observation on ... at 4:56 am uncovered there were no staff on the 8th floor. Uncorrected 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.firules.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	{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 R 06/26/2025
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 21 residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, 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	{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 R 06/26/2025
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 22 choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care 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 hand. (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 hand 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	{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 R 06/26/2025
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 23 obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a 3-day supply of nonperishable food, based on the number of weekly meals the facility has _____ with residents to serve. The facility also failed to have sufficient emergency water for drinking and food preparation for all residents in the facility. The facility also failed to serve food at safe and palatable temperatures. Findings: Interviewed on _____ at 5:47 AM, the Administrator did not know how many emergency meals were available. Observation on _____ at 5:37am showed emergency food being stored on the 2nd floor inside a resident room, resident room showed to not have a number and was converted to a storage (no resident living there). Observation on _____ at 5:37 AM, showed various canned goods and water stored in the rooms. However, there was no discernable way to tell how many meals were available. Interviewed on _____ at 05:37 AM, Staff D stated he kept a list of inventory items with expiration dates. However, he did not have it with him. Interviewed on _____ /20205 at 9:09 AM, Resident #12, (Anna Lenna) from _____ stated that her meals are sometime room temperature.	{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 R 06/26/2025
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 24 Interviewed on /20205 at 9:10am Resident #30 from , (Carmen Mccalla) stated, that she does not mind the food . Hotcakes are her favorite but "prefers them hot". Interviewed on06/23/20205 at 10:00am Resident #51 (Ronnie Mittleman) from stated that the food is good, but dinner is sometimes . Review of the Facility's current Census as of showed to be 136 residents. Record review of Emergency Food inventory list showed a chart with items, Quantity and expiration date, however the list did not show how many meals are available. Uncorrected 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 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	{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 R 06/26/2025
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 25 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. (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,	{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 R 06/26/2025
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 26 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. (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.;	{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 R 06/26/2025
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 27 (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 interview and record review the facility failed to maintain a complete Admission and Discharge log. The facility failed to document the discharge address of discharged residents for three out of 61 sampled residents (Residents #46, #60, #61). Findings Included: A review of the admission and discharge log showed Resident #46 was discharged from the facility on _____ with a discharge to labeled 'North Carolina'. However, there was no address to where the resident was discharged to. A review of the admission and discharge log showed Resident #60 was discharged from the facility on _____ with a discharge to labeled 'Family'. However, there was no address to where the resident was discharged to. A review of the admission and discharged showed Resident #61 was discharged from the facility on _____ with a discharge to labeled 'To Family'. However, there was no address to where the resident was discharged to. During the exit conference on _____ at 1:22 pm the Administrator acknowledged the admission and discharge log did not have the addresses listed. Uncorrected	{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 R 06/26/2025
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 28 Class III	{A 160}			
{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, 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	{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 R 06/26/2025
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 29 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 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	{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 R 06/26/2025
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 30 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 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	{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 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 162}	Continued From page 31 health assessment for three out of 61 residents (Resident's #38, #7, #55). Findings included: 1) A review of the facility Resident Incident Log showed Resident #38 had six from A review of Resident 38's health assessment dated showed the resident needed assistance with all activities of daily living. In the special precaution section showed it was left blank. 2) A review of Resident 7's progress notes showed on the resident had been admitted to hospice care. Further review of progress notes showed the resident had several which resulted in the resident being transferred to the hospital. A review of Resident 7's health assessment dated showed physical or sensory limitations were left blank. Nursing treatment , , service requirements were left blank. In the special precaution section showed 'N/A'. The Resident needed assistance with all activities of daily living. 3) A review of Resident's 55 health assessment dated showed diagnosed , and Physical or sensory limitations showed 'new'. or behavioral status showed 'new'. Nursing, treatment, and , requirements showed 'new'. The special precaution section showed 'new'. Resident #55 needed supervision	{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 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 162}	Continued From page 32 with all activities of daily living expect eating she was independent. During the exit conference on _____ at 1:22 pm the Administrator acknowledged the residents' health assessments were not accurate and up to date. Uncorrected Class III	{A 162}		
A 182 SS=D	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to have all staff trained and failed to have knowledge of how to implement an emergency management plan for 2 out of 32 sampled staff (Administrator, Staff AI) Findings: Interviewed on _____ at 5:46am, Administrator stated "only plant ops (maintenance) know how to turn on generator she could not say how much fuel was available or whether the tank was full. "	A 182		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/26/2025
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 182	Continued From page 33 Interviewed on _____ at 5:46am, when asked if there were any 'plant ops' personnel at the facility, she said the "[Staff AG] is on his way." When asked if there were any plant ops personnel during the evening times, she said no. Interviewed on _____ at 6:05, Staff AI who was sitting at the front desk, stated he did not know how to start the generator and stated that only maintenance knows how to start the generator. Uncorrected Class III	A 182			
(A 078) SS=G	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF: (a) Within 30 days after beginning employment, 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	(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 R 06/26/2025
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 34 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 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	{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 R 06/26/2025
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 35 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 interview and record review the facility failed to ensure all staff had a current signed communicable form from a health care provider, indicating that the employee was negative for for two out of 36 (Staff R and Staff N) sampled staff and agency staff (LPN). Findings Included: A review of Staff R (Caregiver) personnel record revealed Staff R had a () exam completed on with a 'Positive Abnormal' result. Further review of personnel records showed Staff R did not have further evaluation by a healthcare provider. According to the Centers for Control and Prevention (CDC), "If you have a positive test result, you have germs in your body. Your health care provider will do other tests to determine if you have inactive or active . These tests may include a and a test of the (phlegm) you up." A review of Agency Staff/ Manager on Duty (LPN) personnel records showed the last examination was completed on . A review of Staff M (Caregiver) personnel records showed the last examination was completed on . During the preliminary exit on at 1:22 pm the Administrator acknowledged the staff and	{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 R 06/26/2025
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 36 agency staff did not have a current examination on file. Uncorrected Class II	{A 078}		
{A 161} SS=F	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 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	{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 R 06/26/2025
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 37 429.174, 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), 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 observation, interview, and record review the facility failed to maintain documentation verifying that staff members, in accordance with their respective roles, had fulfilled all required training one out of 36 (Staff N) sampled staff and Agency Staff (LPN). Findings Included: Observation on _____ at 7:01 am showed Staff N (Medication Technician) assisted Resident 23 with self-administration of medication. A review of Staff N personnel records showed that she did not have the continued education 2-hour training on file for 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 R 06/26/2025
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 38 medication. A review of the Agency Staff's [Manager on duty] (LPN) personnel file revealed no documented training, despite having provided care to the residents. During the exit conference on _____ at 1:22 pm the Director of Nursing stated, "we just completed this." However, the documentation for the updated training was not in the file. Uncorrected Class III A 165 SS=D 429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. _____ ; 2. _____ or _____ damage; 3. Permanent _____ ;	{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 R 06/26/2025
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 165	Continued From page 39 4. _____ or _____ of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) _____, neglect, or _____ must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/26/2025
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 165	Continued From page 40 involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on Interview and record review, the facility failed to submit an adverse incident report within 1 business day after the elopement of Resident #22. (1 out of 39 sampled residents) Findings: Interviewed on _____ at 01:20 PM, The administrator stated " I didn't know I still had to submit that"	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/26/2025
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 165	Continued From page 41 A review of the Incident Reporting System showed, Adverse incident report being submitted on _____ at 05:14:37 PM, regarding the Elopement of Resident #22 that occurred 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." Uncorrected Class III {A 000} Initial Comments A re-visit to a complaint investigation survey for Complaint #2025001170 and Complaint #2025001601 was conducted at Sterling at	A 165			
		{A 000}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/26/2025
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 42 Aventura from through Deficiencies were found at the time of the survey. The facility was also cited under Event ID IW8T13. A Class 1 deficiency was found at Tag A 032. 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 noncompliance has caused, or is likely to cause, serious injury, harm, , or to a resident receiving care in a facility. The Class 1 noncompliance began on The facility's Administrator was notified of the Class I noncompliance on The census at the start of the survey was 136 residents. The following is a description of the deficiencies found at the time of the visit: A 010- Admissions-Continued Residency A 027- Resident Care- Arranging for Health Care A 032- Resident Care-Elopement Standards A 055-Medication-Storage and Disposal A 056- Medication- Labeling and Orders A 058- Pharmacy and Dietary- Uncorrected Deficiencies A 077-Staffing Standards-Administrators A 078-Staffing Standards- Staff in Service A 079-Staffing Standards- Levels A 093- Food Service- Dietary Standards A 160-Records- Facility A 161-Records- Staff	{A 000}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/26/2025
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 43 A162- Records- Resident A 165- Risk Management and QA	{A 000}			
{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 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	{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 R 06/26/2025
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 44 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 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	{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 R 06/26/2025
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 45 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 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	{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 R 06/26/2025
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 46 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 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	{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 R 06/26/2025
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 47 review the facility failed to ensure the appropriateness of continued residency for three out of 59 sampled residents (Residents #16, #38, #54). Findings Included: 1) Observation on _____ at 4:20 am showed Resident #16 lying in bed sleeping. A review of Resident 16's health assessment dated _____ showed the resident had a diagnosis of _____. Physical or sensory limitations showed non-ambulatory. _____ or behavioral status showed _____ with behavior and physical and verbally aggressive. Resident 16's activities of daily living showed the resident needed total care for bathing, _____, self-care, toileting, and transferring; the resident needed assistance with ambulation and eating. In section C does the resident pose a danger to self or others selected answer was 'yes'. Does the resident require 24-hour nursing or _____ care selected answer was 'yes.' In section d does the individual's needs be met in an assisted living facility, which is not a medical, nursing, or _____ facility selected answer 'no.' Interviewed on _____ at 9:53 am the Director of Nursing was asked does the residents meet assisted living facility (ALF) criteria. The Director of Nursing stated "[Resident #16] has been issued a 45-day noticed." 2) A review of the facility resident incident log records showed Resident #38 had six _____ from _____	{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 R 06/26/2025
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 010}	Continued From page 48 A review of Resident 38's health assessment dated _____ showed the resident had a diagnosis of _____. The special precautions section was left blank. The residents needed assistance with all activities of daily living. A review of the facility private caregiver logs showed the resident had 24 hour care. Interviewed on _____ at 9:53 am the Director of Nursing was asked does the residents meet assisted living facility (ALF) criteria. The Director of Nursing stated, "I'm in the process of getting an updated 1823 and having a care conference with [Resident #38] son." 3) A review of the facility resident incident log records showed Resident #54 had four _____ from _____. A review of Resident 54's health assessment dated _____ showed physical or sensory limitations _____. can't get up alone; "needs aid with him at all times". Activities of daily living showed the resident needs assistance with ambulation, bathing, _____, self-care, toileting, and transferring, independent with eating. A review of the facility private caregiver log showed Resident #54 had 24-hour care. Private Duty Aid #1 was scheduled for 7 days a week and worked from 8 am- 8pm. Private duty aid #2 was scheduled for 7 days a week from 8pm- 8am. Interviewed on _____ at 9:53 am the Director of Nursing was asked does the residents meet assisted living facility (ALF) criteria. The Director of Nursing stated, "that's something we	{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 R 06/26/2025
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 49 are discussing, we'll most likely issue a 45-day notice this week for a higher level of care. Uncorrected 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 for the provision of health care services for one out of 137 sampled residents that needed care (Resident 49) The Resident needed daily , monitoring and administration, and she had to be transferred to the hospital after emergency medical services found her with dangerously high , level . Findings included: AA review of Resident 49's progress notes dated	{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 R 06/26/2025
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 50 at 10:25 AM documented that (Emergency Medical Services) was activated at 11:39 AM after Resident 49 reported that she felt , and shaky the night before. Further review showed that found Resident 49 had a level of 451 and she was transported to the hospital. 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, in their assessment, POC (Point of Care) was 451 prompting her transfer to the emergency room" 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 reasons why we moved her there, because of her medications.' A review of Resident 49's health assessment dated revealed medical history 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 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 027}	Continued From page 51 diagnoses of _____ with Neuropathic _____, memory changes, hypertensive _____ _____ and seasonal _____ status showed mild _____. Nursing 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. 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 administered _____ 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 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 _____ Staff C stated that it was due to the Resident's insurance coverage. Staff C stated, "There was an	{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 R 06/26/2025
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 52 insurance issue regarding the doctors' order and the home health agency." 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 _____ Uncorrected 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	{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 R 06/26/2025
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 53 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 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,	{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 R 06/26/2025
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 54 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 identify and prevent Resident #49 at risk for elopement, so staff can be alerted to her needs and support. The facility failed to be generally of the location of Resident #49 assessed at high risk for elopement at all times. The facility failed to conduct an immediate or any search for Resident #49 who was out of the facility for more than 24 hours. The facility failed to identify staff responsible for implementing the search based upon their elopement policies and procedures. The facility failed to identify the staff responsible for contacting law enforcement, including the resident's family. Findings: 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	{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 R 06/26/2025
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 55 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 Resident 49's progress notes dated documented: "at approximately 10:25 AM, the Director of Activities arrived at the nursing station with the resident who reported that she had not spent the night at the facility. She stated that police had brought her at 6:00 AM." Interviewed on at 6:45 AM the administrator stated that she did not get a call until 10:30 AM on that the resident was missing and she was sent out the hospital. The Administrator stated that no one knew she was an elopement risk. The Administrator stated that Resident #49 went to the [drug store] in North Miami Beach. When asked if the family was not notified, the Administrator stated that no one knew she eloped. The Administrator stated that the Staff B (Charge Nurse) was not notified. The Administrator stated, "It was until 10:30 PM () at night when the staff on duty found out while doing rounds that Resident #49 was unaccounted for. The medication technicians did not notify anyone. No one knew that the resident was not here." Interviewed on at 4:36 AM when asked about Resident #49, Staff S (Receptionist) stated that she resident resided was in Staff S Stated, "I came at 11:00 PM. I don't remember the police department. I know they wore a 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	{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 R 06/26/2025
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 56 that she was waiting for a bus. She was brought with the police at 4:00 AM." When asked if the resident was considered missing, Staff S stated that she was not considered missing because she went out on her own, but I do not know. When asked if the family was contacted Staff S stated, "I don't know. Staff S stated, "that day I remembered she signed out around 11:00 AM. I don't have no idea where she was going." A review of Staff S's personnel records showed a hire date of _____ and elopement training on _____. A review of Staff S's job description states: "Solve issues presented by residents, guests, vendors, and suppliers in a manner so that both the organizational objectives are met, as well as the individuals feel they were served appropriately. Keep difficult situations from escalating. Maintain security for admittance to all entries accessible to public. Follow residents' rights policies at all times. Maintain visitor log-in sheets of software." Interviewed on _____ at 9:33 AM Staff Y (Receptionist) stated that she was working that date of _____ from 7:00 AM to 7:00 PM. Staff Y stated, "She signed out. She went out twice. She went to the drug store. She went again to [a drug store] in North Miami Beach. She did not come _____ on my shift. It was not the first time she signed out. I was not aware she was not an elopement risk." When asked if anyone took the opportunity to reach out to the resident when she did not return, Staff Y stated that there was a new policy in place to find out how long a resident was going to be out. When asked what her job responsibility was, Staff Y stated that to make sure each resident was safe and follow them when a resident leaves and return.	{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 R 06/26/2025
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 57 Interviewed on _____ at 9:15 AM Staff B (Charge Nurse) stated that she was working the 11:00 PM to 7:00 AM shift and was the supervisor. Staff B stated, "I was not informed that the resident returned to the building. I found out when I went home. Interviewed on _____ at 11:09 AM Staff O (Caregiver) stated that she worked on from 11:00 PM to 7:00 AM. Staff O stated that she reported to the floor that Resident #49 was not in her room. Staff O stated that she went downstairs and found out the resident signed out. Staff O stated, "I did not know she was an elopement risk. I was on break when she returned. It was between 3:00 AM and 3:30 AM on _____." Interviewed on _____ at _____ at 3:52 PM Staff AE (Caregiver) stated that she only worked three days, Fridays, Saturdays and Sundays. Staff AE stated that when she worked that day on _____, Resident #49 was there. Staff AE stated when she was doing rounds, Resident #49 was not there. Staff AE stated that she went downstairs to the front desk and asked the receptionist, and she was told that the resident was out with her family. Staff AE stated that when she doesn't see a resident, she goes down to the front desk. Staff AE stated that she did not find out that she (Resident #49) was missing until she went home. A review of the facility records and Resident #49's progress notes showed no elopement search was ever conducted, including immediate contact to the family and the police department. Interviewed on _____ at 9:23 AM the	{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 R 06/26/2025
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 58 daughter of Resident #49 stated that her mother left the property in the morning and did not return until 3:00 AM and the family did not receive a call until 9:00 AM that morning. The daughter stated, "They supposed to watch her. 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. She called them at night." A review of Resident 49's health assessment dated showed diagnoses of (ASHD), Hypertensive (Neuropathic), Seasonal Memory Changes, The physical status showed ASHD, (HLD). The status showed mild. The resident had no special precautions. The resident was an elopement risk. 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 considered to be missing. Residents at-risk for elopement will be listed in the community's communication systems, as on the white board.	{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 R 06/26/2025
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 59 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." Uncorrected Class I	{A 032}			
{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 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;	{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 R 06/26/2025
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 60 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 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.	{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 R 06/26/2025
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 61 (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 record review, facility failed to maintain centrally stored medications in a locked and secure area. Medications were found unlocked in one of 61 sampled resident's rooms (Resident #56). Finding included: Observation on _____ at 5:15am in _____ # _____ Resident #56 kept unlocked medications in a pill organizer in a drawer in the restroom. The pill organizer had separate containers for the days of the week for morning and evening. The containers for Thursday, Friday, and Saturday AM contained pills that could only be identified by their manufacturing markings. One of the pills had the discernable marking of "LUPIN" and "20"	{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 R 06/26/2025
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 62 which would identify the pill as 20mg (photographic evidence obtained). Review of the health assessment showed that Resident #56 needed assistance with medication. The resident had a diagnosis of _____ and _____. Uncorrected Class III	{A 055}			