Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965733	A. BUILDING: _____ B. WING _____	R 09/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A 2nd re-visit to a complaint investigation (complaint numbers #2025001170 and #2025001601) was conducted at Sterling at Aventura from through . Deficiencies were found at the time of the survey.	{A 000}		
{A 032} SS=J	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all	{A 032}		

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{A 032}	Continued From page 1 facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow it's own elopement-policies and procedures and assessed for 5 out of 15 sampled residents (#63, #64, #65, #66, #67). The residents, who were diagnosed with and other conditions, and who were living on the memory care unit' in order to receive a higher level of supervision did not have	{A 032}		

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{A 032}	Continued From page 2 identification on their person. Findings: Observations and interviews on at 8:38 AM showed Residents #63, #64, #65, #66, #67) did not have identification on their person. In an interview on at 8:51 AM, Staff AX (Caregiver) was asked why residents did not have identifiers on their person. She stated, "Because they like to take it off." A review of a facility record showed 15 residents on the 'Elopement Risk' list, 10 residents on the 3rd. floor, 3 residents on the 6th. floor and 2 residents on the 7th. floor. (photographic evidence obtained) A review of Resident #63's showed a health assessment, dated . The resident was diagnosed with , , ( ), history of (HLD) and . The health assessment indicated the resident was at risk of and was not an elopement risk. A review of Resident # 64's health assessment dated showed diagnoses of severe ( ), adult , and , . The health assessment indicated he was at risk of and was not an elopement risk. A review of Resident #65's undated health assessment showed diagnoses are , , , unspecified and 's . The resident was not identified as an elopement risk.	{A 032}		

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{A 032}	Continued From page 3 A review of Resident #66's health assessment done on showed diagnoses are , , ( ), major , , right , and deficiency of . The health assessment indicated he was a risk and was not identified as an elopement risk. A review of Resident # 67's health assessment dated showed the resident's diagnoses were , major , , , , , , , ( ), and , . The health assessment indicated he was dysphagic, needed risk precautions and was not identified as an elopement risk. A review of the facility's Elopement-Missing Resident program showed: "The community will assure residents 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. Under the General Considerations B: "Identification of Elopement Risk (NUR075PP)" policy and procedure asserting the need for residents at risk of elopement to have identification on their person". Uncorrected Class III	{A 032}		
{A 056} SS=E	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS.	{A 056}		

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{A 056}	Continued From page 4 (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, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the	{A 056}		

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{A 056}	Continued From page 5 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., before dispensing any sample or complimentary prescription drug, the resident's health care	{A 056}		

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{A 056}	Continued From page 6 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, interview and record review, the facility failed to follow the doctor's orders for prescribed medication for 1 out of 79 sampled residents for more than sixty days. (Resident #21) The facility failed to ensure (Resident #21) only receive , 100mg once a day instead of three times a day. Findings Included: Review of Resident #21 Health Assessment dated , showed that the resident was diagnosed with , , , , , , ( ) and has an to . Resident #21 is identified as being a risk, needs assistance with ambulating and performing activity of daily living (ADL). Review of progress notes on showed the resident ran out of her 30-day supply of 100mg of , . The facility reached out to the pharmacy, and it was advised there were no refills available until . The pharmacy informed the facility that "the patient should be receiving 1 capsule daily at bedtime". There was no further documented or updated order reflecting the dose change. (photographic evidence obtained) Review of the Medication Observation Record (MOR) for Resident #21 revealed she was receiving , 100mg three times a day starting and was discontinued on	{A 056}		

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{A 056}	Continued From page 7 Review of Resident #21's physician orders showed a prescription for 100mg dated , "take one Capsule (100mg) by, nightly. (photographic evidence obtained) Review of Mayo Clinic prescription fact sheet showed: "This medicine may cause serious reactions, including and angioedema, which can be life-threatening and require immediate medical attention. Call your doctor right away if you have a , itching, trouble breathing, trouble swallowing, or any of your , , or while you are using this medicine. may cause vision changes, clumsiness, unsteadiness, , drowsiness, sleepiness, or trouble with thinking. Make sure you know how you react to this medicine before you drive, use machines, or do anything else that could be dangerous if you are not alert, well-coordinated, or able to think or see well. This medicine may cause some people to be agitated, irritable, or display other abnormal behaviors, such as feeling or hopeless, getting upset easily, or feeling nervous, restless, or hostile. It may also cause some people to have thoughts and tendencies or to become more depressed, even after stopping the medicine. This medicine may cause , , , a serious breathing problem that can be life-threatening." Interview on at 12:51pm the	{A 056}		

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{A 056}	Continued From page 8 Administration stated that she contacted the resident's daughter and according to the Administrator, the daughter stated the resident came to the facility with the medication. Uncorrected Class II	{A 056}		
{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 (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.	{A 077}		

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{A 077}	Continued From page 9 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 [illegible]; 2. If employed on or after [illegible], 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 [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] 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	{A 077}		

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{A 077}	Continued From page 10 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 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	{A 077}		

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{A 077}	Continued From page 11 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 interview and record review, the facility failed to ensure that it was under the supervision of an administrator who is capable of managing operations, including the oversight of all staff and the provision of care to residents. Findings Included: During an interview on at 9:47AM, the Administrator stated that she had filed two adverse incident reports regarding two separate incidents that had previously occurred in the facility. During an interview on at 12:21PM, the Administrator stated that she reviewed the Adverse Incident Reporting System (AIRS) and did not see that she had submitted the two reports, despite previously stating that she had filed them. During an interview on at 3:27PM, the Administrator said that in , [2025], the facility changed its staffing levels after an overnight incident involving Resident #58 to one staff member per floor for the overnight shift. She stated that the facility previously did not have one staff member per floor, however when asked how many staff members were on shift during the time of the incident, the Administrator's answer varied before settling on five staff members.	{A 077}		

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{A 077}	Continued From page 12 During an interview on at 3:49PM, with the facility's Nurse Consultant , she stated that the Administrator was " " when she identified herself as the risk manager instead of providing the correct name of the staff member delegated as risk manager. A review of the facility's survey history revealed that the facility continued to have multiple uncorrected deficiencies in the areas of Resident Care - Elopement Standards, Medication - Labeling and Orders, Pharmacy & Dietary; Uncorrected Deficiencies, Staffing Standards - Administrators, Staffing Standards - Levels, Risk Mgmt. & QA. 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	{A 079}		

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{A 079}	Continued From page 13	{A 079}		

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

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{A 079}	Continued From page 14 in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The	{A 079}		

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{A 079}	Continued From page 15 facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff 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,	{A 079}		

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{A 079}	Continued From page 16 extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate staffing to meet the scheduled and unscheduled needs of the residents, compromising their safety and well-being for a census of 83 including six residents under hospice care. Findings Included: On at 5:12 AM, Staff B (Charge Nurse) stated there were 106 residents and four residents were at the hospital. Observation on at 5:00 AM revealed that five employees one Medication Technician (Med Tech) and four Certified Nursing Assistants (CNA) were at the facility to provide care to 83 residents including six residents (#20, #23, #42, #56, #74, #75) under hospice care. There was on CNA assigned to each floor on the 4th, 5th, 6th and 7th floors. A review of the facility's , staffing schedule from from 11 PM to 7 AM showed that there were five staff members on duty, including one Medication Technician ('Med Techs') and four Certified Nursing Assistants, of those, one assigned to each floor on the 4th, 5th, 6th and 7th floors to provide care to the residents. A review of the facility's records relating to residents' needs for assistance with activities of daily living for a census of 83 residents showed	{A 079}		

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{A 079}	Continued From page 17 the following: 12 residents needed assistance with ambulation, 28 needed assistance with bathing, 26 needed assistance with , 3 needed assistance with eating, 11 needed assistance with self-care , 24 needed assistance with toileting, and 14 needed assistance with transferring. Residents needing supervision showed the following: 20 residents needed supervision with ambulation, 23 residents needed supervision with bathing, 17 residents needed supervision with , 6 residents needed supervision with eating, 21 residents needed supervision with self-care, and 5 residents needed supervision with toileting, and 14 residents needed supervision with transferring. There was one resident that needed total assistance with ambulation, eating, self-care, and toileting and two residents needed total care with bathing and transferring. Class III	{A 079}		
{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	{A 058}		

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{A 058}	Continued From page 18 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 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	{A 058}		

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{A 058}	Continued From page 19 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 deficiencies related to medication. The facility must maintain 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 Included: Review of the facility survey history showed several prior inspections where the facility had citations related to medications. Review of progress notes on showed the resident ran out of her 30-day supply of 100mg of , . The facility reached out to the pharmacy, and it was advised no refills were available until . The pharmacy informed the facility that "the patient should be receiving 1 capsule daily at bedtime". The Primary Care Physician (PCP) was notified that facility does not have an updated order reflecting the dose change. The Primary Care Physician to provided an updated order to facility so they can have it on record during the time of the survey. "(photographic evidence obtained)	{A 058}		

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{A 058}	Continued From page 20 Review of the Medication Observation Record (MOR) for Resident #21 revealed she was receiving , 100mg three times a day and was discontinued on . Review of Resident #21's physician orders showed a prescription for , 100mg dated , "took one Capsule (100mg) by, nightly. (photographic evidence obtained) Uncorrected Class III	{A 058}		
{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 ; 4. or of bones or joints;	{A 165}		

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{A 165}	Continued From page 21 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 involved conduct by a health care professional	{A 165}		

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{A 165}	Continued From page 22 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 to the Agency for one out of 73 sampled residents. Furthermore, the Facility failed to file a full report of an incident for one out of 73 sampled residents. Findings: A review of the Agency's survey history on the ASPEN system, revealed that the facility has a	{A 165}		

Agency for Health Care Administration

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{A 165}	Continued From page 23 history of failing to submit Incident reports on the AIRS system. From to , on 6 separate surveys conducted by the Agency, the facility was found to have failed to submit incident reports . Furthermore, the facility failed to submit a report on one resident on the current survey dated . A review of a complaint that was submitted for investigation revealed Allegations of difficult interactions between 2 residents and one employee. Review of the complaint revealed that Staff BD had difficult interractions with residents #10 and #62. A complaint review revealed that staff BD had a difficult interaction with Resident #62 on . The complaint review revealed that Staff BD had a difficult interaction with resident #10 on An interview with Resident #10 on at approximately 830AM revealed that the resident was unable to hear despite speaking to him up close. He was unable to understand the questions of the Surveyor. Resident #10 stated that he had lost his . On an interview with Resident #62 on at 9:00AM she stated that she did not recall the incident of . She stated that if she were asked about something that happened today she could probably have remembered. Review of Resident #10 's health assessment AHCA Form 1823 revealed that Resident #10 had Diagnoses of	{A 165}		

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{A 165}	Continued From page 24 , Wedge , difficult walking, , and a history of falling,. He had periods of alertness with , he required supervision with ambulation, bathing , , toileting and transferring. A review of the health assessment of resident #62 revealed a diagnosie of , Type 2 , and . Based on interview on at 11 AM, when asked, the Administrator stated that she believed that she filed an incident report on resident #10. Based on interview on at 12noon, the Administrator stated that even though she thought that she filed an incident report, on resident #10, She stated that she must not have. The administrator stated that she may have combined it with the report to the Department of Children and families. A review of a paper document provided by the Administrator revealed that a report to the Florida Department of Children and Families was submitted on Resident #10 on at 8:15PM. The incident with resident #10 was reported to have occurred on 06- 24-2025. The report was submitted one month after the incident. Record review of the AIRS AHCA Incident Reporting System, revealed that there was no AIRS report submitted or filed on resident #10 Record review of the AIRS system revealed that more information regarding the incident on	{A 165}		

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{A 165}	Continued From page 25 resident #62 was requested. The report revealed that the facility did not provide it. The Agency closed the case. On an Interview with the Administrator on at approximately 9:30AM, she recounted that one of the Consultants that works for the Facility saw that resident #62 wanted to go to her room and that Staff BD was trying to redirect her. On at approximately 9:45AM, The Administrator stated that a consultant that works for the facility witnessed Staff BD talking forcefully at Resident#10 while he was seated in a wheelchair. Staff BD was hovering over Resident #10 with both her bracing the resident's wheelchair. On at 9:45AM, the administrator stated that Staff BD was placed on administrative leave for two weeks, provided training and reassigned from her position as a Life Enrichment Coordinator to a position as a Food and dining server. Uncorrected Class III	{A 165}		