STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965733	**04/18/2018**
NAME OF PROVIDER OR SUPPLIER **STERLING AVENTURA**	STREET ADDRESS, CITY, STATE, ZIP CODE **2777 NE 183rd ST** **AVENTURA, FL 33160**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A Standard Biennial and Complaint Survey was conducted on , , 2018 and concluded on , , 2018. Sterling Aventura (License #10117) had the following deficiencies identified at time of the survey:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview the facility failed to maintain a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, or other changes that resulted in the provision of additional services for two out of 36 (#28 and #30) sampled residents.

Findings included:

Record review for Resident #28 revealed the progress notes dated 8:00 AM stated the "resident transferred to hospital on . Family aware." The facility did not document the reason why Resident #28 was transferred to the hospital.

Record review revealed Resident #30 on the progress notes stated "Notified by night shift that resident slid off the bed while going to , noted to left leg. doctor's office called awaiting orders." The facility did not document that they received the orders from the doctor for care or that the Resident #30 received .

Interview on at 1:30 PM the findings were reviewed with the Administrator who acknowledged the facility did not have updated progress notes in the records.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, interview, and record review the facility failed to obtain a physician order authorizing the use of a half bed rails for one of 36 sampled residents (Resident #32).

Findings included:

On at 10:12 AM observed Resident #32 lying down in a hospital bed with half side rails.

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A review of Resident #32's file on revealed Resident #32 had a physician order for full bed rails dated and signed a consent to the use of half bed rails dated .

On during the exit interview at 12:34 PM, the Administrator stated "we do not allow full bed rails in the facility." The Administrator acknowledged the facility did not have the half bed rail orders for Resident #32.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, record review, and interview the facility failed to have a licensed staff to administer the medications for 1 out of 36 sampled residents that required medication administration (Resident #17).

Findings included:

During tour of the facility on at 10:05 AM observed Resident #17 in in bed with a pillow under her right side and a private aide at her side.

Record review revealed Resident #17 was under hospice services. The care plan was reviewed on stated that the resident was dependent on 6 out of 6 activities of daily living included medication administration.

On at 9:27 AM Staff M stated that the med techs are the one administering the medications to Resident #17.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review and interview the facility failed to ensure that one out of 16 (H) samples staff received the initial 4 hours training on providing assistance with self administered medications prior to assuming this responsibility; two out of 16 (B and F) sampled staff failed to have a minimum of 2 hours of continuing education training on providing assistance with self administered medications.

Findings included:

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Record review found the 4 hours of medication training for Staff B was dated and expired on . Staff F was dated and expired on . Staff B and F did not have documentation showed they received the required 2 hours update for medications annually. Staff H did not have documentation of the initial 4 hours training for medication.

Interview on at 10:49 AM the Administrator stated," Staff B, F, and H are med techs and only the med tech assist with medications." She acknowledged they did not have the medication training in their files.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on record review and interview the facility failed to ensure that one out of 16 sampled staff who provide direct care to residents with 's and Related (ADRD) obtained four hours of initial training within three months of employment and an additional 4 hours of training within nine months of hire (Staff G and Staff K).

Findings included:

On a review of the facility's personnel files revealed that Staff G, hired on , did not have the training (ADRD) level II certificate in file and Staff K, hired on , did not have the training (ADRD) level I and level II in file.

During an interview on at 12:34 AM, the Administrator acknowledged Staff G and K did not have proof of completion of level I and II ADRD training in file.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview the facility failed to ensure staff had an understanding of the ( ) training for one out of 16 (Staff N) sampled staff.

Findings included:

Interview conducted on at 10 :46 AM Staff N could give an description of what a order was. When asked if she had taking the training she stated, What's that, I don't remember."

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Record review of Staff N's file found she had received the training on .

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on record review and interview, the facility failed to provide proof of training for five out of 16 sampled staff (Staff C, D, F,G, and H).

Findings included:

Record review of the facility's personnel files from to revealed that Staff C's, hired on , expired on ; Staff D's, hired on , expired on ; Staff F, hired on , had no certificate in file; Staff G's, hired on , expired on ; Staff H, hired on , had no certificate in file.

During an interview on at 12:34 PM, Staff A stated "25 staff members received training on , the records should be in the files."

On the facility faxed copies of First Aid and training for staff, the training documentation had varies dates.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview the facility failed to have the records readily available for inspection upon request.

Findings included:

On arrived to the facility at 8:35 AM, prior to starting the tour records for the inspection were requested (staff files, census, local inspections, hospice resident files, home health files, incidents reports). Toured facility from 9:05 AM to 11:30 AM. Employee record review could not be completed on the first day of the survey, facility did not provide all information.

On arrived to facility at 8:00 AM and there was only one person in the office, requested

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Grievance log
Incident report, Admission and discharge log and Communication log; stated she did not know where all the requested records were.

On Administrator arrived at 10:45 AM, provided required records.

During exit conference on at 12:30 PM the Administrator stated, "We have different records for the residents and they are stored in different places, that's how the company works."

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation, record review, and interview the facility failed to have completed health assessments for two out of 36 sampled residents (Resident #2 and #29). The facility failed to have an accurate health assessment for one out of 36 sampled residents (Resident #17).

Findings included:

Review of Resident #2's health assessment completed on reveled it was missing the height and the weight.

Review of Resident #29's health assessment completed on revealed or behavioral status and the nursing/treatment/ service requirements sections were left blank.

During tour of the facility on at 10:05 AM observed Resident #17 in in bed with a pillow under her right side and a private aide at her side.

Record review revealed Resident #17 was under hospice services; care plan was reviewed on stated the resident was dependent on 6 out of 6 activities of daily living. The health assessment completed on stated that the resident required assistance with self-administration of medications and with the all of her activities of daily living; she was able to transfer from bed to chair with assistance.

On Staff M stated at 9:25 AM that at the time of the survey the resident required total assistance with activities of daily living and that she was bed bound and required medication administration..

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On during the exit conference at 12:25 PM the administrator stated that the health assessment for Residents #2, #17 and #29 needed to be completed.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to file a one day and a fifteen day report with the agency for two of 36 sampled residents (Resident # 23 and # 28).

Findings included:

Review of Resident #23's record revealed on the resident became aggressive and grabbed another resident by the neck; 911 was called and the resident was and sent to the hospital.

Review of Resident #28's record revealed the resident had a on and hit the back of her head and was transferred to the hospital for further evaluation.

Review of the incident report book revealed the facility did not submit incident reports to the Agency for Residents # 23 and #28.

On during the exit conference at 12:30 PM the Administrator stated that the incident reports for both residents will be filed with the agency.

Class III