STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106131	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Lakes Nursing & Rehabilitation Center	220 Sierra Drive Miami, FL 33179

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records reviewed and interviews, it was determined that the facility did not maintain adequate supervision to ensure a safe environment that is free from accident and hazards for 1 out of 5 residents sampled for accident hazards and supervision. On 04/28/2026, at approximately 6:20 PM, Resident #1 became dissatisfied with staff after being denied [brand] over-the-counter antacid medication that was not ordered by the physician. The resident #1 proceeded to light a cigarette in the hallway. Facility staff confiscated the cigarette and lighter and Resident #1 returned to her room unsupervised. Shortly thereafter, Resident #1 exited her room and informed staff that she had set her room on fire, and they needed to remove her roommate. The incident resulted from inadequate monitoring of Resident #1 during a supervised shopping trip on 04/22/2026, allowing her to acquire cigarettes and lighters that were brought into the facility without detection and a disregard for the facility's smoking policy. Subsequently, Resident #1 used one of these lighters to ignite a fire in her room creating the likelihood of serious injury, harm, impairment, or death of the facility's occupants. The findings included:Observational tour on 04/29/2026 starting at 10:00 AM of the facility's 3rd Floor [NAME] Unit revealed Resident #1's room had remnants of fire damage to the floor, bathroom and furniture; a bed in the room had a burnt mattress black in color. The windowpane was shattered/broken (Photographic Evidence Obtained). All the other rooms on the 3rd Floor [NAME] Unit showed no signs of damage. The 3rd Floor Dining Room had sixteen residents, (fourteen residents noted in beds and two residents sitting in chairs) there were five staff members in attendance. The 2nd Floor [NAME] Unit rooms were evacuated. The rooms and hallway were being dried by industrial type fans. The 2nd Floor Dining Room had twenty-three beds out of which nineteen residents were in bed and seven staff in attendance. Observation on the first floor revealed the smoking area attendant had cigarettes and lighters locked in a smoking cabinet, a book with the list of smokers, supervision requirement and who requires an apron. The aprons are stored in a closet in the smoking area.Review of the facility's policy and procedure titled Accidents and Incidents revisions dated 08/23, 04/29/2026 indicated:The facility will provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:1. Identifying hazard(s) and risk(s).2. Evaluating and analyzing hazard(s) and risk(s).3. Implementing interventions to reduce hazard(s) and risk(s); and4. Monitoring effectiveness and modifying interventions when necessary.1. The facility will identify each resident at risk for accidents and/or falls and adequately plan care and implement procedures to prevent accidents.2. The facility will ensure each resident receives adequate supervision and assistance devices to prevent accidents.3. The facility will develop and implement an accident and incident reporting system that will report adverse incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence.4. The reporting system will consist of:a. Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation.Review of the facility's policy and procedure titled Resident Leave revision dated 03/23 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106131	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Lakes Nursing & Rehabilitation Center	220 Sierra Drive Miami, FL 33179

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	states: Resident Leave is defined as a patient leaving the grounds of the facility for a short period of time during the day. It is the Policy of the facility to provide residents with the ability to leave the facility grounds temporarily to engage in recreational activities.Policy Process and procedures:1. The physician will determine resident's ability to leave on pass.2. Residents/family will be informed of the facility's Resident Leave policy during the admission process and will be required to sign acknowledgement of the policy upon admission.3. Residents/responsible party must sign The Release of Responsibility for Leave of Absence form before leaving the facility.4. Residents must identify where they are going. During an interview on 04/29/2026 at 10:23 AM, the Director of Nursing (DON) reported that a call was received on 04/28/2026 at approximately 6:00 PM from Staff I, Registered Nurse (RN) and Unit Supervisor for the 3:00 PM to 11:00 PM shift to report that Resident #1 asked her assigned nurse, Staff D, Registered Nurse (RN), for [brand] antacid, and Staff D, RN, informed the resident she needed a physician's order to provide any new medication. Resident #1 became upset and cursed at the staff, then lit a cigarette in the hallway. Staff I, RN, confiscated the cigarette and lighter from Resident #1, and the resident returned to her room, cursing and spitting at staff. Moments later, she exited her room and announced, You better remove my roommate because I set the room on fire. Staff rushed into the room, observed smoke and fire, removed the roommate, closed the door, called 911, and evacuated the other residents to the dining room on the 3rd Floor [NAME] wing. Fire rescue arrived during the evacuation and helped staff move residents to a safe area in the dining room. Staff evacuated residents from the 2nd and 3rd Floor [NAME] Units. Staff kept all other residents in their rooms with the doors closed and followed fire protocols. The roommate (Resident #2) did not exhibit any signs or symptoms of respiratory distress, but the doctor ordered staff to send Resident #2 to the hospital for an overall assessment. On 04/29/2026 at approximately 10:30 AM the DON further revealed that when the police officers arrived at the facility on 04/28/2026, they interviewed Staff I, RN, and Resident #1. The resident stated that she bought cigarette lighters during a store outing with facility staff on 04/22/2026, knew she was not allowed to possess cigarette lighters. The police officers took Resident #1 to jail around midnight and charged her with several felonies, including attempted Felony Murder, Arson in the First Degree, and Battery touch/Strike as of 04/29/26 at 2:01 AM. On 04/29/2026, at approximately 10:35 AM, the Director of Nursing reported that smoking hours are between 7:00 AM and 11:30 PM. The smoking attendant manages the distribution of cigarettes and lighters, maintains a book listing the smokers and those requiring aprons. Record review of the facility's Policies and Procedures titled: Resident Smoking. Date Issued: 2/2020. Revised: 2/22/22 documented:Policy: This facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents in accordance to State and Federal regulations.Procedure: Smoking is prohibited in all areas except the designated smoking area. A Designated Smoking Area sign will be prominently posted.2. Safety measures for the designated smoking area will include, but not limited to:a. Protection from weather conditions (i.e. covered).b. Provision of ashtrays made of noncombustible material and safe design.c. Accessible metal containers with self-closing covers into which ashtrays can be emptied.d. Accessible fire extinguisher.e. Prohibition of oxygen use in the smoking area.f. Staff Supervision.3. No smoking signs will be maintained on the door or gate where oxygen is used or stored.4. Electronic cigarettes and vaping devices will be treated the same as any other smoking product.5. Residents and family members will be notified of this policy during the admission process, and as needed.6. All residents will be asked about tobacco use during the admission process, and in conjunction with the RAI Process.7. Residents who smoke will be further evaluated by the interdisciplinary team to determine additional safety interventions warranted.8. If a resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or to evaluate whether any additional safety measures are indicated.9. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106131	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Lakes Nursing & Rehabilitation Center	220 Sierra Drive Miami, FL 33179

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	will be responsible for supervising residents while smoking.I 0. Supervision will be provided as indicated on each resident's care plan.11. Family members or visitors that do not abide by this policy or the resident's plan of care will not be permitted to supervise resident's smoking.12. If a resident or family member does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional measures such as room searches, prohibited smoking, or even discharge.13. Smoking materials of residents who smoke will be maintained by nursing staff14. Residents will be allowed to smoke at designated smoking times.15. The interdisciplinary team, with guidance from the physician, will help to support the resident's right to make an informed decision regarding smoking by:a. Including the resident, family, and/or resident representative in discussions regarding the risks associated with smoking.b. Offering pharmacological and/or behavioral interventions to assist with smoking cessation.c. Providing educational materials regarding smoking and smoking cessation.d. Developing a safe smoking plan, or an individualized plan to quit smoking.16. Documentation to support decision making will be included in the medical record, including but not limited to:a. Resident's wishes, or those of the resident's representative.b. Assessment of relevant functional and cognitive factors affecting ability to smoke safely.c. Response to smoking cessation interventions.d. Compliance with smoking policy. On 04/29/26 at 8:21 PM, Staff C, a Certified Nursing Assistant who worked the 3:00 to 11:00 PM shift on the 3rd Floor East/West Unit, stated: On the evening of 04/28/2026, before the fire alarm started going off, I saw [Resident #1] in the hallway in her wheelchair. [Resident #1] told me, I put fire on the bed. I asked her, Are you for real? She replied, Yes, go check. She then went to the elevator in her wheelchair. I checked [Resident #1's] room and saw the bed close to the window on fire. I screamed, Help, fire, fire; the fire alarm started going off. Staff came to the room to help and pulled the roommate out of the room and closed the door. Record review of Resident #1's medical records revealed the resident was initially admitted to the facility on [DATE], readmitted on [DATE] and 04/09/2026. Clinical diagnoses included but not limited to: Unspecified Cerebral Infarction due to unspecified occlusion or stenosis of right cerebellar artery, Adjustment Disorder, Bipolar Disorder, Anxiety disorder, Schizophrenia, Mood Disorder due to known physiological condition, unspecified, Cocaine Abuse, uncomplicated. Resident # 1 was discharged on 04/29/2026.Record review of Resident #1's medical records revealed that on Saturday, 04/25/2026 the local police department removed Resident #1 from the facility for aggressive behavior and took her to a local hospital and the resident was readmitted to the facility later the same day.Review of Resident #1's Physician's Orders Sheet for April 2026 revealed the resident included but not limited to: Paroxetine Oral Tablet 30 Milligram (mg)-Give one tablet by mouth at bedtime related to Major Depressive Disorder. Clonazepam Tablet 1 mg-Give 1 tablet by mouth every eight hours for Anxiety related to Major Depressive Disorder, Trazodone Tablet 100 mg-Give one tablet by mouth at bedtime related to Schizophrenia and Oxycodone-Acetaminophen Tablet 10-325 mg-Give 1 tablet by mouth every four hours related to pain. Record review of Resident #1 's Discharge Return Anticipated Minimum Data Set (MDS) dated [DATE] documented in Section C for Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating the resident is cognitively intact and communicated her needs effectively. Section E for Behaviors documented verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) occur 1-3 days. Section GG for Functional Abilities documented the resident is dependent for care. Section H for Bowel and Bladder documented: Frequently incontinent of bowel and bladder. Section J for Health Conditions documented the resident received scheduled and as needed pain medications, no shortness of breath, no falls. Section N for Medications documented resident is taking anxiety, antidepressant, opioid, and antibiotic medication. Section O for Special Treatments and Procedures documented no special treatments received. Section P for restraints and Alarms documented none used. Section Q for Participation in Assessment and Goal Setting documented resident participated in assessment. Review of Resident # 1's most recent Smoking assessment dated [DATE] documented (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106131	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Lakes Nursing & Rehabilitation Center	220 Sierra Drive Miami, FL 33179

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the resident is a dependent smoker that requires supervision.Interview on 04/29/2026 at 3:30 PM Staff Z, CNA/Smoking attendant revealed resident's cigarettes are kept in individually labeled lock boxes with their names and lighters in a separate lockbox. All the lockboxes are stored in a locked file cabinet with the smoking aprons which can only be accessed using the smoking attendant's key. When a resident comes to the smoking area if they are alert, they have the code to their individual lock boxes to retrieve their cigarettes only two cigarettes are allowed at a time. If the resident is not alert the attendant gives out the cigarettes. The attendant lights all cigarettes and supervises smoking for every resident.Review of Resident #1's Level I Preadmission Screening and Resident Review (PASRR) completed by the facility's Registered Nurse on 02/11/2026 documented Level II PASRR evaluation requested related to serious mental illness.On 02/25/2026 a Level II PASRR was completed by the authorized Mental Health Agency, Licensed Mental Health Counselor (LMHC). Based on the information provided for this review, Specialized Services were determined to not be needed as the patient did not appear to be at risk for inpatient hospitalization. It is recommended that the following rehabilitative services, of a lesser intensity than Specialized Services, are added or continued, on the patient's Comprehensive Person-Centered Nursing Care Plan: Psychiatric Medication Management. Individual Therapy and Substance Abuse Counseling/12 Step Program if available and if this is deemed needed by the multidisciplinary team and if available at the facility.Review of Resident #1's psychological consultations revealed the most recent consult was completed 04/22/2026 indicating: Resident's aggressive behaviors were explored and addressed. Interventions/techniques used Cognitive Behavioral Therapy, Motivational, Interpersonal, and Psychoeducational. The consultation documented the resident continued to have negative and irrational responses to facility staff. The consultation documented the resident was having excessive anger toward staff when she didn't receive her pain medication.Record review of Resident #1 's Care Plans Reference Date 01/20/2026 revealed the resident is at risk for drug related side effects due to use of psychotropic medications for the diagnosis of: Anxiety, Major Depressive Disorder, Insomnia, Bipolar Disorder, Schizophrenia, Psychosis uncomplicated, and Opioid abuse. Resident will remain free of drug related side effects through next review date. Interventions include- License Nurse to follow up behavior monitoring sheet. Medicate as ordered. Monitor behavior and mood every shift and document. Monitor for adverse side effects of drugs (lethargy, dizziness, increase in confusion, gait disturbance). Provide non-pharmacological interventions as needed. Report changes to MD as needed. Resident is a smoker. Resident will not suffer injury from unsafe smoking practices through the review date. Interventions include: The resident will not smoke without supervision through the review date. Instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Notify charge nurse immediately if it is suspected resident has violated facility smoking policy.Resident has a serious mental illness per Preadmission Screening and Resident Review (PASRR) Level two (2) Resident will not require specialized services through next review date. Interventions include- Monitor resident's mood and/or behaviors for changes and need for specialized services. Offer Supportive Counseling, psychiatric and/or psychology services to address changes in mood and/or behavior. Provide Social Services support. Psychiatric Medication Management. Resident is displaying mood/behavior symptoms such as periods of restlessness/agitation, related to Anxiety. Constantly using the call light for the nurse multiple times after being seen. 02/07/2026 Verbally abusive behavior noted. Resident # mood/behaviors symptoms will be reduced through the next review date. Interventions include-Approach in a calm manner. Establish a trust relationship. Follow up psychiatric consult as needed. Give positive feedback for cooperating and efforts made. Monitor, report and document behavior. Resident is verbally aggressive and demanding towards staff and refuses redirection at times. Resident displays drug seeking behavior as reported by staff. Noted to fabricate stories about staff at times and calls police to report the staff. 04/25/2026: Resident displayed verbal and physical aggression toward staff - Unable to be redirected. Involuntary psychiatric examination [Baker Act] order received and sent to hospital. 04/26/2026: Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106131	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Lakes Nursing & Rehabilitation Center	220 Sierra Drive Miami, FL 33179

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	continues to be verbally aggressive with staff and calling police many times. 04/27/2026: Resident became increasingly agitated and exhibited destructive behavior on the unit. She damaged facility equipment, including telephones, a computer, and a fax machine. She also threw books onto the floor and overturned trash and laundry barrels in the hallway. Uneasy to redirect. Monitoring continues. Resident #1 will verbalize understanding of need to control verbally abusive behavior through the review date. Interventions include-Administer medications as ordered. Monitor/document for side effects and effectiveness. Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document Anticipate resident's needs and offer assistance as needed. Assess residents' understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Review of a Health Status Note dated 04/25/2026 time stamped 04:56 (4:56 AM) documented: At 3:00 AM Resident called the supervisor to the floor stating that this nurse refused to give her 12:00 AM meds, this nurse explained to her that the medication was administered with another staff as witness, just immediately the 911 arrived and made aware what happened and that the next dose is due at 4:00 AM which will be given to her as scheduled, the police assured her that her next dose will be given to her as scheduled and they left.Review of Health Status Note dated 04/25/2026 time stamped 05:22 (5:22 AM) documented: At 4:00 AM this nurse and supervisor went into the room and administered the 4:00 AM med, the resident refused to sign the paper again while in the room she threw down everything on her table on the floor and also threw the table at me but fortunately I moved back and the table landed on the floor. I walked out of the room and continued my work. Later while walking out from the pantry, she threw a bowl of water on this nurse my whole body was drained with water, she moved forward to the medication cart and threw everything on the floor. She picked up the laptop to throw on the floor when a staff quickly took it from her. The behavior continues, she brought her blue tooth speaker on the hallway and was playing music stating, I am going to wake everybody up. Few minutes later she came back to the medication cart and threw everything onto the floor again, including the cups by the side. Redirection with no effect behavior continues the resident was so aggressive at this time, very abusive, stating I hate you with passion and I pray you will be crushed before you get home today. At this time the supervisor called the police, and the resident was transferred to a local hospital for an involuntary psychiatric examination [Baker Act].Review of a Health Status Note dated 04/25/2026 timestamped 06:59 (6:59 AM) indicated: 6:30 AM resident was transferred to [local hospital]. She stated that: I will be back in 3 days Call placed to sister and message left. Call placed to MD and PA (Physician Assistant) made aware.Record review of Health Status Noted dated 04/25/2026 timestamped 08:10 (8:10 AM) indicated: The resident exhibited disruptive behavior, including making excessive noise, being verbally abusive toward staff, and physically aggressive (throwing water toward staff). The resident also contacted police regarding staff. Due to escalating behavior and safety concerns, the resident was placed under [NAME] Act and was transferred at 0610 (6:10 AM) to [local hospital] for further psychiatric evaluation and treatment. Staff maintained safety measures and followed facility protocol throughout the incident.Health Status Note dated 04/25/2026 timestamped 13:00 (1:00 PM) documented: Resident returned to facility from [local hospital] via stretcher accompanied by 2 ambulance attendants. Upon arrival, resident alert and oriented X4, vital signs stable, no acute distress observed. Review of Health Status Note dated 04/26/2026 time stamped 09:56 AM Note Text: Resident reports that during vital sign assessment at [local hospital] yesterday, a pulse oximeter was removed abruptly from her finger, causing pain. Resident now reports concern that the finger may be injured or possibly fractured. Resident's finger contracted and painful to touch, but there are no obvious sign/ symptoms of injury, MD made aware and gave order for x-ray, will continue to monitor. Review of a Behavior Note dated 04/27/2026 timestamped 00:18 (12:18 AM) Note Text: Resident was very aggressive and verbally abusive towards nurses and CNAs. stated that no one wants to help her with care even after getting care from CNAs. She told me that she will take her medication after coming from downstairs to smoke, then accusing writer not wanting to give her (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106131	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Lakes Nursing & Rehabilitation Center	220 Sierra Drive Miami, FL 33179

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	meds. Resident call police over 5 times, screaming and crying about medication after the facts that medication was given. She trying to destroy the place and call me stupid [inappropriate language]; resident redirected but doesn't care about anything but to curse everybody out by calling employees.bad names.Review of a Behavior Note dated 04/27/2026 timestamped 09:18 (9:18 AM) Note Text: Resident became increasingly agitated and exhibited destructive behavior on the unit. She damaged facility equipment, including telephones, a computer, and a fax machine. She also threw books onto the floor and overturned trash and laundry barrels in the hallway. Due to her escalating behavior and inability to de-escalate the situation safely, the police were contacted for assistance. At this time, the situation continues to monitor.Review of a Health Status Note dated 04/27/2026 timestamped 09:45 (9:45 AM) documented: Two Police officers arrived at facility and were informed of the situation, including the observed property damage and the resident's behavior. Officers were directed to resident's room, where they spoke to her directly. During the interaction, the resident provided information that appeared inconsistent with staff observations. While police officers were present, the resident's behavior de-escalated and she became calm. After completing their assessment, the officers provided staff with a contact card.Review of a Health Status Note dated 04/27/2026 timestamped 12:09 (12:09 PM) documented: On 4/27/26 at approximately 12:00 resident reported to writer that the 3rd floor Unit Manager, beat her up an pushed her wheelchair. Resident also reported that over this past weekend the supervisor cursed her and the facility lacks sufficient towels. A comprehensive investigation has been initiated. A skin assessment has been completed for [Resident #1] with no new findings. PCP (Primary Care Physician) notified. DCF (Department of Children and Families) notified; Psychology and Psychiatry notified: Police notified; Resident and staff interviews to be conducted.Review of a Health Status Note dated 04/27/2026 timestamped 14:55 (2:55 PM) documented: Law enforcement arrived at the facility at 2: 48 PM and resident refused officer. Officer stated to call back later to have another unit, and he is unable to get report because the resident is refusing to speak with him.Review of a Health Status Note Dated 4/27/2026 timestamped 20:32 (6:32 PM) documented: Police was called as a follow up of the morning incident. The police questioned the resident about the incident; case report card was given to the resident and one left with the writer. At this time no issues raised by the resident, quiet, cleaned and kept dry.Review of a nursing progress notes completed by Staff D, RN, dated 04/28/2026 timestamped 17:51(5:51 PM) documented: Resident put call light on, and I went to the room immediately, resident ask for medication that she has no order for. Resident informed that we have to get a doctor's prescription before administered to her. Resident started cursing out and threw her food tray on the floor. Supervisor was made aware and got involved promptly.Review of a Behavior Note completed by Staff I, RN dated 4/28/2026 timestamped 18:51(6:51 PM) documented: At approximately 6:00 PM, the resident displayed aggressive and disruptive behavior toward staff. Light up cigarette on the hallway, the writer tried taking it from her she began spitting at staff members and used verbally abusive language, including calling staff slave. During the interaction, the resident also intentionally spilled water on staff stating you [.] redirection, but the resident continued to escalate. Thereby asking the staff to remove her roommate who was on oxygen out of the room because she going to burn the building, all of a suddenly we observed smoke coming out of the room. The resident is a danger to all staff and residents in the facility. she was unable to redirect. 911 called. MD and psychological Advanced Registered Nurse Practitioner (ARNP) notified, order given for an Involuntary psychiatric examination [Baker Act] the resident. Review of a Behavior Note completed by Staff D, RN dated 04/28/2026 timestamped 21:30 (9:30PM) documented: Resident observed in the hallway continued cursing, resident light up a cigarette to smoke in the hallway, cigarette removed by the supervisor, resident became more agitated, spit on the supervisor and returned to the room, new medication administered as ordered. Resident threw the remaining water at me. Shortly after, the resident wheeled in hallway and continued cursing out and stated, I put fire in the room, y'all better go get the resident out of the room Room checked by staff immediately and found the bed on fire. residents (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106131	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Lakes Nursing & Rehabilitation Center	220 Sierra Drive Miami, FL 33179

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	evacuated by the staff while fire rescue involved. Safety measures maintained, all residents evacuated and now resting comfortably in a safe place. Doctor, DON, Assistant Director of Nurse (ADON) and all the staff were notified. Monitoring continues.Review of Behavior Note completed by Staff I, RN on 04/29/2026 timestamped 00:40 (12:40 AM) documented: Resident left the facility via stretcher along with three local police officer to the hospital. Review of an Incident Note completed by the DON dated 04/30/2026 timestamped 12:29 PM documented: This note is a clarification of the events that occurred including the interventions for the resident on 4/28/2026 at approximately 6:05 PM, Resident is displaying disruptive behavior towards the staff using profanities and spitting at the staff members. Resident lit a cigarette in the hallway. Nursing Supervisor removed the cigarette and the lighter from the resident and explained she cannot have a lighter or smoke in the building. Resident cursed out the Supervisor and went to her room. Psych/NP was called and stated to have an Involuntary psychiatric examination [Baker Act] for the resident. At approximately 6:09 PM, Nurse entered the room and administered the [antacid] she requested. Resident accepted the [antacid] and used profane language to the staff member and threw a glass of water at the nurse. At approximately 6:18 PM, Resident exited her room approached the CNA and stated you need to go get the roommate out of the room because I just lit my mattress on fire because I want to burn this place down and continued using profanities towards the staff. Staff immediately removed the roommate from the room, the fire alarm sounded and sprinklers in the room turned on and extinguished the fire. Resident was placed on 1:1 (one to one observation). At Approx 6:30 PM, local Fire Department and Police Department arrived. Police Department was notified of the incident and taken to where the resident was with the staff member. Police Officers interviewed the resident who stated she purposely set the fire. Police Officers interviewed the staff and Nursing Supervisor who reported that the resident had been displaying negative behavior with use of foul language and throwing her food tray and water at staff and that earlier resident attempted to smoke inside the building and that the Supervisor removed her cigarette and lighter, resident returned to her room and a few minutes later reported to remove the roommate because she lit her mattress on fire. Police Officers placed the resident in their custody and assumed the 1:1 with the resident from this point on. At approximately 9:00 PM, Resident remains on 1:1 with Sherrif's Department. Medication was administered by the nurse. At approximately 11:00 PM, The CNAs provided care to the resident. Fluids provided to the resident. Resident remains with Sherrif Department. On 4/29/2026 at approximately 12:30 AM Resident was arrested and transported to jail via ambulance accompanied by Police Officers. Telephone interview on 04/30/2026 at 12:32 PM Staff D, RN who worked on the 3rd Floor [NAME] Unit, 3:00 PM to 11:00 PM shift stated: On 04/28/2026 I was assigned [Resident #1], I did rounds around 3:15 PM, the resident was in the smoking area downstairs. Shortly after my rounds [Resident #1] came on the unit, put the call light on in her room requesting to be changed out of her clothes, her assigned CNAs changed her, I administered medications to the resident. The resident received her dinner tray; I set up the food for the resident and left the room. Around 5:40 PM the call light in the resident's room was on again, I went to the room, the resident requested [brand antacid], I checked the resident's orders, she did not have an order for [brand antacid], I went to let the resident know that I needed to call the doctor to get an order for the [brand antacid]. The resident got upset and agitated, threw her food tray on the floor, and started cursing me out. I left the room and called my supervisor, (Staff I, RN). [Staff I, RN] came to the room, [Resident #1] started cursing at both of us using really bad words. [Staff I, RN] started calling the doctor to get the order for [brand antacid]. [Resident #1] then requested help to get in her chair from bed and wanted her hair bonnet fixed. Immediately after [Resident #1] wheeled her chair in the hallway by her room and lit a cigarette, [Staff I, RN] told her she cannot smoke in the hallway and took the cigarette from [Resident#1]. The resident threw the lighter at [Staff I, RN] spat on her and kept cursing. [Resident #1] then wheeled her chair back into her room, approximately 4-5 minutes later I went in the room to give the resident [brand antacid] approved by the MD, [Resident #1] threw the water I gave her to take the medication on my clothes and told me, get out of my room and started cursing at me again. I w