

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Sierra Lakes Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for actual harm Residents Affected - Some	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, record reviews and interviews, the facility failed to prevent accidents and hazards as evidenced by unsecured housekeeping carts on the Fourth Floor East and [NAME] Hallways. 2) Resident #77 was observed unattended in high positioned bed. 3) A hand sanitizer dispenser observed located directly above a light switch in the facility's conference room of the facility. There were 160 residents residing in the facility at the time of survey. The findings include. On 1/12/2026 at 9:51 AM an observation was made of an unattended housekeeping cart with key in the lock on the fourth-floor East hallway (photo evidence). Staff E, Housekeeping was immediately notified about identified concern and interviewed about facility's protocol for keeping the housekeeping cart secure. Staff E, Housekeeping stated, When I walk away from the cart I am supposed to keep the key in my pocket. I don't keep it locked while I'm working. I lock it when I go to break or go home and give the key to the boss. The surveyor requested to have the top section of the cart be opened and Staff C, Housekeeping opened it without a key, and several bottles of disinfectants were observed in the top section (photo evidence). Observation on 1/12/2026 at 10:08 AM on the fourth-floor [NAME] hallway, Staff D, Housekeeping exited a resident's room, opened the top section of the housekeeping cart without a key and placed a cleaning disinfectant spray bottle inside, then returned to the resident's room without locking the cart. On 1/12/2026 at 10:14 AM, an observation was made of an unattended housekeeping cart on the third-floor East hallway (photo evidence). Staff B, Housekeeping was observed in a resident's room; when the surveyor asked if the cart was locked, Staff B, Housekeeping opened the top section of the cart without a key, and the surveyor observed bottles with disinfecting chemicals. Observation on 1/12/2026 at 10: 30 AM, revealed an unattended housekeeping cart on the second-floor [NAME] side hallway. Staff C, Housekeeping was in a resident's room, and the surveyor asked housekeeping staff if the cart was locked. Staff C, Housekeeping opened the top section of the cart without a key. The surveyor asked Staff C, Housekeeping about facility's protocol for housekeeping carts and staff replied, I am supposed to lock the carts for the residents' safety. Interview on 1/13/2026 at 3:33 PM with the Housekeeping Director revealed there were seven housekeeping carts in the facility. Housekeeping worked 7:00 AM to 3:30 PM and 3:00 to 11:30 PM and staff are to keep the housekeeping carts locked at all times when unattended to prevent residents from encountering the chemicals kept in the cart. On 1/12/2026 at 9:37 AM An observation was made of Resident#77 in bed with arms folded and the bed was in a high position. On 1/12/2026 at 9:38 AM Staff F, Certified Nursing Assistant (CNA), (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
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entered the room. The surveyor asked about the bed being left in a high position while no staff is present. Staff F, CNA replied, I left the bed high because I went to get the lifter. I am supposed to leave the bed down. On 1/12/2026 at 10:07 AM. the Restorative Nurse was notified about identified concern and stated, I will speak to the staff about this. Resident #77 was admitted on [DATE] and readmitted on [DATE] with diagnosis that included Seizures. Record review of The Annual Minimum Data Set (MDS) reference dated 12/8/2025 revealed Resident #77 had a Brief Interview for Mental Status (BIMS) score of 9 indicated moderate cognitive impairment and was dependent for all Activities of Daily Living (ADLS). Further review revealed Resident #77 was care planned on 01/06/2022 for at risk for falls related to: seizure disorder, impaired mobility, anemia, impaired vision, psychotropic drug use, aggressive behaviors at times. unaware of safety measures, history of falling, potential side effects of medications with Interventions/Tasks that included: Keep bed in lowest position. On 01/14/2026 at 10:21 AM, an interview with the Director of Nursing revealed staff are to keep the bed in a low position when leaving a resident's room to get assistance to transfer that resident. Observation on 01/12/2026 at 03:05 PM, one hand sanitizer dispenser that was fully operational was observed directly above a light switch in the facility's conference room. Interview on 01/14/2026 at 12:36 PM, the Maintenance Director and Maintenance Assistant stated The issue with the hand sanitizer dispenser occurred after the facility changed companies, maintenance staff were not present during installation. which resulted in the placement being missed. The inspector informed us of the three-foot requirement, and although we do not currently have a specific policy addressing this. The potential hazard identified was that sanitizer could have entered an outlet and caused the breaker to malfunction. Record review of facility's policy titled, Reporting Accidents and Incidents date issued 3/2020 revised 6/2023 revealed: PROCEDURE: The facility will ensure that: a. The resident environment remains as free from accident hazards as is possible.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations record review and interviews, the facility failed to maintain accurate narcotic accounting records, failed to record and implement narcotic disposal/wasting protocols in accordance with professional standards of practice for one (4th Floor East Cart) of four medication carts reviewed. As evidenced by Medication Monitoring Control Records for the 4th Floor East Cart were inaccurate when compared to the corresponding bingo cards and staff failed to have a witness before disposing narcotic. There were 160 residents residing in the facility at the time of the survey. The findings include: On 01/12/2026 at 5:51 PM, Staff Q, RN, revealed she was assigned to the 4th Floor East Cart and had completed giving all the 6:00 PM medications. A narcotic count review of the 4th Floor East Cart was conducted with Staff Q, RN and the following discrepancies were identified. Resident #76 Tramadol-50 milligram (mg) tablet; Give 1 tablet every six hours for acute pain Medication Monitoring Control Record Log on Hand documented: 13 Bingo Card Medication Count = 11 On 1/12/2026 at 5:58 PM, when asked about the discrepancy identified related to Resident #76's Tramadol-50 mg tablet ordered to be given every six hours for acute pain. Staff Q, RN stated: I gave it at 18:00 (6:00 PM) but I didn't sign. I am supposed to sign when I remove the medication. The patient dropped the medication on the floor, and I flushed it and I had to pull another one and give it, but I did not sign it. I should not have flushed it. I am going to let the supervisor know I should have had a witness to waste narcotic. Resident # 77 Lacosamide 100 mg one tablet by mouth twice daily. Bingo Card Medication Count = 8 Medication Monitoring Control Record Log documented amount on hand: 9 Resident # 103 Lorazepam 0.5 mg Bingo Card Medication Count = 10 Medication Monitoring Control Record Log documented amount on hand: 11 Resident # 34 Oxycodone/APAP tablet 10-325 mg (Give one tablet by mouth every 4 hours as needed) Bingo Card Medication Count = 22 Medication Monitoring Control Record Log documented amount on hand: 23 Resident # 11 Lorazepam 1 mg tablet (one tablet by mouth twice daily) Bingo Card Medication Count = 9 Medication Monitoring Control Record Log documented amount on hand: 10 Resident # 17 Xanax (alprazolam) 1 mg tablet Bingo Card Medication count = 8 Medication Monitoring Control Record Log documented amount on hand: 9 Resident # 63 Lorazepam 0.5 mg tablet _ Give One tablet by mouth at bedtime (9:00 PM). Bingo Card Medication Count = 16 Medication Monitoring Control Record documented amount on hand: 17 On 1/12/2026 at 6:05 PM for clarification Staff Q, RN was asked what time she had given the medications and again Staff Q, RN stated I give them at 1800 (6:00 PM). On 1/12/2026 at 6:10 PM, when Staff R, RN supervisor was informed of the identified concerns she stated: For wasted medication you are supposed to have a witness to sign off with before you flush the medication. The narcotic should be signed off in the book as soon as it removed. Another narcotic count was completed with Staff R, RN for the 4th Floor East Cart in the presence of Staff Q, RN and Staff R, RN acknowledged the identified discrepancies. The Director of Nursing, Assistant Director of Nursing, Regional Educator, and Regional Clinical Nurse, were also apprised of the identified pharmacy services concerns identified. Review of the facility's undated policy for Labeling, Medications Storage of drugs and Biologicals indicated: It is the policy of this facility to ensure that all medications and biologicals used in the facility will be labeled and stored in accordance with current state, federal regulations.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store food under sanitary condition by ensuring 1) two reach-in refrigerators in the kitchen did not contain thermometers on the inside out of three reach-in refrigerators and 2) failed to ensure the proper washing of the dishes and utensils by not having an operable final rinse tank temperature gauge on the high temperature dish machine. This has the potential to affect 154 out of 160 residents who eat orally residing in the facility at the time of the survey. The findings included: 1) Record review of the Dietary Food Storage Policy and Procedure (no date written); Policy Statement-It is the policy of the facility to provide care and services related to the storage of food in the Dietary Department in accordance to State and Federal regulation; Procedure: 1) Refrigerated foods will be stored at the proper temperatures and 6) The use of a thermometer, which shows that the proper temperature is being maintained will be used. Observation of the initial kitchen tour on 1/12/26 at 8:33 AM with the Dietary Supervisor revealed the following: 1) Reach-in Refrigerator #2 temperature outside was 37 degrees F and for the inside temperature, there was no thermometer noted. The refrigerator is used for sandwiches, fruits and salads for the tray line and contained a bowl of shredded cheese (Photographic evidence submitted) and 2) Reach-in Refrigerator #3 temperature outside was 38 degrees F and for the inside, there was no thermometer noted. The refrigerator is used for the cook's preparation and contained mayonnaise, tuna salad, chicken salad, butters and creamers (Photographic evidence submitted). Interview with the Kitchen Supervisor on 1/16/24 at 8:36 AM. She stated, There is no thermometer kept on the inside of the reach-in freezer and refrigerator. We only use the temperature on the outside of the reach-ins. Interview with the Dietary Supervisor on 1/12/26 at 8:34 AM confirmed the reach-in refrigerator's #2 and #3 did not contain a thermometer on the inside. She revealed the thermometer should be in there. Review of the Reach-in Refrigerator #2 Temperature Log documented for the following: January 12, 2026 at 6:00 am, the temperature was 35.5 degrees F. Review of the Reach-in Refrigerator #3 Temperature Log documented for the following: January 12, 2026 at 6:00 am, the temperature was 33.6 degrees F. 2) Record review of the Dish Machine Temperature Log Policy and Procedure (no date written); Purpose: To ensure that dishware and utensils are sanitized effectively, the facility will monitor and document dish machine temperatures at every meal service in accordance with state and federal sanitation guidelines; Policy: Food and Nutrition Services staff will monitor and document the dish machine's wash and final rinse temperatures for each meal. Any discrepancies or equipment malfunctions will be addressed immediately to maintain sanitation compliance; Procedure: 2) At each meal service, dishwashing staff will: Observe and document the final rinse temperature, which must reach a minimum of 180 degrees F (for high-temp machines). Review of the manufacturer temperatures for high temperature dish machine operating temperatures were documented: Wash 150-160 degrees Fahrenheit (F); Pumped Rinse 160 degrees F and Final Rinse 180-195 degrees F. Observation of the high temperature dish machine on 1/14/26 at 8:47 AM with Staff A, Dietary Staff and the Dietary Supervisor revealed the wash dial was at 150 degrees F and the final rinse dial was at 162 degrees F. Staff A, Dietary Staff revealed the final rinse temperature should be at 180 degree F. Staff A, Dietary Staff placed several more trays with cups and dishes to be washed through the dish machine and the final rinse dial did not move, it stayed at 162 degrees F. Several more cycles were conducted and the wash dial stayed at 150 degrees F and the final rinse dial was at 162 degrees F. The Dietary Supervisor revealed the wash temperature should be at 180 degrees F. The Dietary Supervisor immediately stopped the dish machine and called the service tech company to come to the facility and service the dish machine (Photographic evidence submitted). Interview with the Dietary Supervisor on 1/14/26 at 11:08 AM. She stated, The technician came out today and the thermostat is burned out. He is bringing a new thermostat today. We are going to use disposable wear for lunch. Review of the Dish Machine (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Temperature Log documented for the month of January 2026 documented the wash temperature was 161 degrees F and the final rinse was 180 degrees F for breakfast, lunch and supper. Interview with the Dietary Supervisor on 1/15/26 at 8:11 AM revealed that a new thermostat was placed in the high temperature dish machine on yesterday and the temperature is at 180 degrees F now. Review of the Dish machine Repair Company Invoice dated 1/14/26 documented the following: Final rinse temp was not accurate (reading 160). Thermostat for final rinse was broken and burn (booster heater for final rinse). Thermostat was replaced and tested (temp 180).		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations, interviews and record review the facility failed to ensure the high temperature dish machine final rinse cycle was working properly. This has the potential to affect 154 out of 160 residents who eat orally residing in the facility at the time of the survey. The findings included: Record review of the Dish Machine Temperature Log Policy and Procedure (no date written); Purpose: To ensure that dishware and utensils are sanitized effectively, the facility will monitor and document dish machine temperatures at every meal service in accordance with state and federal sanitation guidelines; Policy: Food and Nutrition Services staff will monitor and document the dish machine's wash and final rinse temperatures for each meal. Any discrepancies or equipment malfunctions will be addressed immediately to maintain sanitation compliance; Procedure: 2) At each meal service, dishwashing staff will: Observe and document the final rinse temperature, which must reach a minimum of 180 degrees F (for high-temp machines). Review of the manufacturer temperatures for high temperature dish machine operating temperatures were documented: Wash 150-160 degrees Fahrenheit (F); Pumped Rinse 160 degrees F and Final Rinse 180-195 degrees F. Observation of the high temperature dish machine on 1/14/26 at 8:47 AM with Staff A, Dietary Staff and the Dietary Supervisor revealed the wash dial was at 150 degrees F and the final rinse dial was at 162 degrees F. Staff A, Dietary Staff revealed the final rinse temperature should be at 180 degrees F. Staff A, Dietary Staff placed several more trays with cups and dishes to be washed through the dish machine and the final rinse dial did not move, it stayed at 162 degrees F. Several more cycles were conducted and the wash dial stayed at 150 degrees F and the final rinse dial was at 162 degrees F. The Dietary Supervisor revealed the wash temperature should be at 180 degrees F. The Dietary Supervisor immediately stopped the dish machine and called the service tech company to come to the facility and service the dish machine (Photographic evidence submitted). Interview with the Dietary Supervisor on 1/14/26 at 11:08 AM. She stated, The technician came out today and the thermostat is burned out. He is bringing a new thermostat today. We are going to use disposable wear for lunch. Review of the Dish Machine Temperature Log documented for the month of January 2026 documented the wash temperature was 161 degrees F and the final rinse was 180 degrees F for breakfast, lunch and supper. Interview with the Dietary Supervisor on 1/15/26 at 8:11 AM revealed that a new thermostat was placed in the high temperature dish machine on yesterday and the temperature is at 180 degrees F now. Review of the Dish machine Repair Company Invoice dated 1/14/26 documented the following: Final rinse temp was not accurate (reading 160). Thermostat for final rinse was broken and burn (booster heater for final rinse). Thermostat was replaced and tested (temp 180).		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, facility failed to ensure a dignified dining experience for one (Resident #40) out of 11 sampled residents as evidenced by Resident #40's lunch tray was not served at the same time as other residents in the same dining table. On 01/12/2026 at 12:31 PM, lunch trays arrived at the third-floor dining room. On 01/12/2026 at 12:32 PM, staff began passing out meal trays to residents sitting at the first dining table. On 01/12/2025 at 12:35 PM, all residents in first dining table were served a meal tray except for Resident #40. On 01/12/2026 at 12:36 PM, staff began passing meal trays to residents sitting in second dining table. On 01/12/2026 at 12:44 PM, staff served meal tray to Resident #40 who was sitting at the first dining table. On 01/12/2026 at 1:21 PM, Restorative Nurse was notified about the dining concern and stated: When meal trays come out of the cart, all the residents who are sitting at one table should be served at the same time. There should not be any reason why all residents should not be served together. Record Review of a demographic sheet revealed Resident #40 was admitted on [DATE] and readmitted on [DATE] with diagnosis that included Muscle Wasting and Atrophy, Multiple Sites. Record Review of Quarterly Minimum Data Set (MDS) reference dated 12/30/2025, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive impairment and needed supervision or touching assistance when eating. Record Review of a Care Plan dated 12/17/2025, revised 12/19/2025 revealed Resident #40 was at risk for nutritional and or hydration deficits as evidenced by HTN, Dementia, Anxiety, Major Depressive Disorder with Interventions that included: encourage/assist to eat as needed. On 01/12/2026 at 1:27 PM, Staff H, Certified Nursing Assistant (CNA) stated: When serving meal trays, we always have to make sure that all residents sitting at a dining table are served together or at the same time. Record Review of facility's policy titled, Promoting/Maintaining Resident Dignity, dated 05/2020, revised 04/2023 revealed POLICY: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. COMPLIANCE GUIDELINES: All staff members are involved in providing care to residents to promote and maintain resident dignity and respect for residents' rights.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide adequate activities of daily living (ADLs) care for one (Resident #71) out of three sampled residents. Resident #71 had long, uncleaned fingernails that dug into the skin on the palm of his hand. This deficiency increased the risk of self-injury and infection. There were 160 residents residing in the facility at the time of the survey. The findings include: On 01/12/2026 at 10:46 AM Resident #71 was observed seated in bed and expressed concerns regarding not getting his nails trimmed by staff. Observation revealed the resident's left hand was contracted with long fingernails digging into the palm of his hand (Photographic evidence taken). Record review revealed Resident #71 was admitted (re-entry) on 6/30/2025 clinical diagnosis included but not limited to: Spastic Hemiplegia Affecting Left Dominant Side and Epileptic Seizures. Review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident # 71 is cognitively intact, requires setup or clean-up assistance with eating, oral hygiene, upper body dressing, personal hygiene; requires supervision or touching assistance with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. Review of care plan with review start date 11/19/2025, target completion date 11/27/2025, and completed date 11/28/2025 revealed that: Resident #71 has a self-care deficit requiring staff assistance with ADLs secondary to encephalopathy (unspecified), spastic hemiplegia affecting left dominant side. epileptic seizures. Goal is for Resident #71's ADL needs to be met through the next review date. Interventions included allowing the resident to perform tasks at own pace, providing assistance only in areas of difficulty; setting up basic hygiene items within reach daily and as needed and showering as scheduled and as needed. Interview on 01/14/2025 at 01:20PM, Staff I, Certified Nursing Assistant (CNA) revealed nail care is primarily assigned to CNAs, although nurses may also cut residents' nails when necessary. On 01/14/2025 at 01:32PM, Staff J, CNA revealed CNAs are responsible for nail care, although there is a designated staff member assigned to cut nails and shave residents, if that staff member is off, it remains the CNAs' responsibility to provide this care and not wait for someone else. If a resident refuses nail care, the CNA must report it to the nurse. For residents with diabetes, CNAs only cut fingernails; toenail care is performed by podiatry. During an interview on 01/14/2025 at 01:50PM, Staff K, CNA stated that CNAs are responsible for cutting residents' nails and for cleaning the nail cutter before and after use. Documentation is not required; CNAs only need to notify the nurse if a resident refuses nail care. On 01/15/2025 at 10:51AM, an interview was conducted with Staff L, Registered nurse (RN). She stated that CNAs are responsible for cutting residents' nails. For residents with diabetes, podiatry performs toenail care. On 01/15/2025 at 11:01AM, an interview was conducted with Staff M, Registered nurse (RN) - unit supervisor. She stated that anyone can cut residents' nails, although there is usually a light-duty nurse assigned to this task. Review of the facility's Policy and Procedure titled Activities of daily living (ADLs) maintain abilities dated 03/2020 revealed that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, a personal and oral hygiene.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations records reviewed and interviews, the facility failed to maintain a medication error rate of less than 5%. This consisted of nine (9) medication errors out of 88 opportunities, resulting in a medication error rate of 10.23%. Staff crushed medications together and administered them mixed in applesauce to Resident # 85; also identified were two omissions (Resident # 85 and Resident # 117) and one medication administered in the wrong dose form (Resident # 27). There were 160 residents residing in the facility at the time of survey. The findings include. Observation on 01/12/2026 at 9:34 AM of Staff N, Registered Nurse (RN) performing medication administration for Resident # 85 revealed physician ordered Zunveyl Oral Tablet Delayed Release, one tablet to be given two times a day for Alzheimer Disease was not available on the cart. Staff N, RN prepared and placed the following medications in a medication cup: one Aspirin 81 milligram (mg) chewable tablet, one Iron tablet 325 mg (Ferrous Sulfate), one Carvedilol 3.125 mg tablet, one Amlodipine 5 mg tablet, one Sinemet 25- 100 mg (Carbidopa- Levodopa) tablet and one Clopidogrel Bisulfate 75 mg tablet. Staff N, RN entered Resident #85's room identified resident. Staff N, RN placed the medications on the overbed table and left them unattended (Photographic evidence). Staff N, RN attempted to give the resident all the medications at once but was unsuccessful. Staff N, RN left the room with the medications and was observed at the medication cart where she placed and crushed all the medications together in a pill crusher pouch then mixed them together with applesauce in a medication cup, returned to the room and administered the medications. Review of Resident #85 clinical records revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses include but not limited to: Parkinsonism, Heart Failure unspecified, Alzheimer Disease, Dysphagia unspecified and schizoaffective disorder. Review of Resident #85's January 2026 Orders Summary Report revealed ordered medications included but not limited to: Aspirin 81 mg (milligram) Chewable Tablet: Give 1 tablet by mouth one time a day; Carvedilol Tablet 3.125 mg: Give 1 tablet by mouth two times a day for HTN (Hypertension); Amlodipine Besylate Tablet 5 mg: Give 1 tablet by mouth two times a day for HTN (Hypertension); Sinemet Tablet 25- 100 mg: (Carbidopa- Levodopa): Give 1 tablet by mouth three times a day for Parkinsons; Clopidogrel Bisulfate Tablet 75 mg: Give 1 tablet by mouth one time a day for Blood thinner, Iron Tablet 325 (65 Fe) mg (Ferrous Sulfate): Give 1 tablet by mouth one time a day for Supplement and Zunveyl Oral Tablet Delayed Release. (Benzgalantamine Gluconate) Give 10 mg by mouth two times a day related to Alzheimer's Disease. During an interview on 01/12/2026 at 9:59 AM, Staff N, RN acknowledged the identified concerns and revealed the Zunveyl Oral Tablet Delayed Release (Benzgalantamine Gluconate) 10 mg tablet will be ordered and should have been ordered in advance. Observation on 01/15/2026 at 8:02 AM of medication administration performed by Staff S, Licensed Practical Nurse (LPN) for Resident # 27 revealed Staff S, LPN prepared Multivitamin with Mineral one tablet from the facility's stock over the counter supply and administered it to the resident with other ordered medications. Clinical records revealed Resident #27 was admitted to the facility on [DATE]. Clinical diagnoses include but not limited to Alzheimer Disease. Review of the Electronic Health Record medication orders revealed an order for Multivitamin and Mineral Liquid (Multiple Vitamins-Minerals): Give 15 ml (milliliters) by mouth one time a day for Supplement. On 01/15/2026 at 8:25 AM during an interview and review of Resident # 27's medication orders Staff S, LPN acknowledged the wrong form of medication was administered. On 01/15/2026 at 9:11 AM during medication administration observation performed by Staff P, RN for Resident #117, physician ordered Losartan Potassium 25 mg oral tablet: give 2 tablets (50mg) one time a day related to Hypertensive Heart Disease without Heart Failure was not available in the medication cart. Staff P, RN informed the supervisor and checked the emergency kit and the automated medication dispensing machine, but the medication was not readily available. Clinical records revealed Resident #117 was admitted to the facility on [DATE], Clinical diagnoses included but not limited to Hypertensive Heart Disease without (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Sierra Lakes Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heart failure. Review of the facility's undated policy titled: Medication Preparation for Dispensing PROCEDURE: D. Medication Inspection. 1. Confirm that medication name and dose are correct. G. Prior to Medication Administration: 1. Verify each medication preparation that the medication is the RIGHT DRUG, at the RIGHT DOSE, the RIGHT ROUTE, at the RIGHT RATE, at the RIGHT TIME, for the RIGHT CUSTOMER. 2. Verify that the MAR reflects the most recent medication order		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to demonstrate an effective plan of action was implemented to correctly identify quality deficiencies in the problem area related to repeated deficient practices for F761 (Label/Store Drugs & Biologicals). These deficient practices have the potential to affect 160 residents residing in the facility at the time of the survey. The findings included: Record review of the facility's policy and procedures titled Quality Assurance and Performance Improvement (QAPI) Plan issued 6/10/2021 revealed Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Review of the facility's survey history revealed, during a recertification survey exit dated 07/18/2024 F761 Label/Store Drugs & Biologicals was cited. An interview with the Administrator on 01/15/2026 at 2:21 PM revealed the members of the QAPI team included the Medical Director, Administrator and all management team. Meetings are held monthly to discuss any concerns for each department and develop next plan for improvement; data was analyzed to determine which interventions are working or not.		