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
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 complaint investigation (complaint number 2023003557 and 2023004224) was conducted at Palace at Homestead on through . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=K	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide care and services and supervision appropriate to the needs of one out of ninety (Resident #1) sampled residents that resided on the Memory Care Unit. Resident #1 was found unresponsive, from apparent , did not have . . . . . in file, and staff on duty did not perform or call 911 until after 15-20 minutes had passed. Resident #1 had a history of attempt and received no follow up care or services. Findings Included:	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 025	Continued From page 2 1) A review of the facility report dated revealed on at approximately 8:44 AM, Resident #1 was found unresponsive, standing in a shower, with a tied around his . A review of Resident #1's record showed the resident admitted to the facility on . Review of the 1823 AHCA health assessment dated showed the resident had diagnoses of and prostatic hyperplasia. The resident required assistance with ambulation, bathing, , grooming, transfers, and assistance with self-administration of medications and independent with eating. The record revealed the resident did not have a ( ) on file. Resident #1's progress notes showed on at 8:55 AM, "the concierge went to Resident #1's room, after breakfast. He was observed in the shower fully dressed leaning on the shower wall towards him. Concierge spoke to the resident, and he did not respond, he called the on-call nurse, not present in facility, who called a home health nurse who was in the facility at the time, to request her to check the resident. At 8:59 AM the home health nurse went to check on the resident and found him leaning on the wall fully dressed. At 9:00 AM another team member came to assist to sit down the resident on a chair and it was when observed resident had a shoelace around his attached to the shower . The home health nurse cut the string and observed resident had no , , fixed and dilated and extremely pale skin and . Team member called the 911." A review of an ambulance report dated	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 025	Continued From page 3 . . . . . revealed 911 was dispatched at 9:04:19 AM. The report showed, " [patient] sitting on a chair in the shower of [facility]. was apneic, pulseless, , fixed and dilated. Lividity no blotchy on lower extremities, ligature marks around , cool to touch. Staff sts [states] was hanging in the shower from . . . . and cloth and small waste bucket inside. Staff cut , down and placed on a chair. was . . , ... X3. R77 made , a DOA (on Arrival) and asked for the police immediately." Further review of the ambulance report showed, "Causes- . . . . . attempt. Complaints- Duration 2 hours. Symptom: ." Interview conducted with Staff D (on call nurse) on . . . . . at 10:55 am, she stated on she received a telephone call at 8:45 AM from Staff B (Concierge) who informed her that Resident#1 was unresponsive and standing in the shower. Staff D (on call nurse) stated she then called a Home Health Nurse Practitioner, who was at the facility providing services to another resident, to go to the Resident #1 room and assess the Resident. Staff D (on call nurse) stated when she arrived at the facility around 9:00 AM, she went to the resident room and observed the Home Health Nurse Practitioner and Staff C (Unit Secretary) trying to put the resident in a chair. Staff D (on call nurse) stated as they were placing the resident on a chair, they observed a . . around his and tied to the shower . . . . Staff D (on call nurse) stated she assessed the resident, and the resident was to touch, and Staff C (Unit Secretary) called 911. An interview conducted with the Home Health Nurse Practitioner on at 11:10 am, she stated that . . . . . she received a phone call from Staff D (on call nurse) around 9:00 am	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 025	Continued From page 4 to go to Resident #1's room and check on the resident. She stated upon entering the room, she observed the resident leaning on the wall in the shower. She stated the resident was fully clothed, had shoelaces tied around the shower and his . She stated she cut the shoelaces from around the resident . She stated she assessed the resident and observed the resident to be unresponsive, his , were dilated, and livor mortis was occurring. She stated," The resident was . There was no need to give because it was too late". She stated Staff C (Unit Secretary) called 911 and the police arrived at the facility and pronounced the of the resident. She stated from her professional and educational experience she believed the resident was for about an hour or so. According to the National Institutes of Health "Livor mortis, also known as postmortem or postmortem lividity, is a passive process of accumulating within the in the dependent parts of the body because of gravity, causing a discoloration of the skin that varies from pink to dark purplish. It begins to be apparent about an hour after , is well-formed about 3 to 4 hours after , and gets fixed about 6 to 8 hours after ." Interview conducted with Staff C (Unit Secretary) on at 12:25 pm, she stated on she received a call around 8:15 AM or 8:40 AM /8:50 AM from Staff D (on-call nurse), who instructed her to go check on Resident #1. Staff C (Unit Secretary) stated she went to Resident #1's room and observed the Home Health Nurse Practitioner, who also received a call from the on-call nurse, already in the room. Staff C (Unit Secretary) stated when she entered the room, she observed the resident was	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 025	Continued From page 5 standing in the shower, unresponsive, with a ◡ tied around the resident's and the Home Health Nurse Practitioner and herself lowered the resident to a chair. Staff C (Unit Secretary) stated she saw the Home Health Nurse Practitioner cut the ◡ from around the resident's , assessed the resident, and determined the resident was and then she called 911. Interview conducted with Staff B (Concierge) on at 11:44 am, he stated on at around 8:45 am or 8:50 am he went to Resident #1's bedroom to see why the resident was not at breakfast. He stated when he entered the room, he saw the resident standing in the shower, and the water was not running. He stated the resident was fully- dressed, and "acting strange." He stated he did not approach the resident, instead he left the resident alone and went [from second floor to first floor] to the front desk, because he did not know which nurse was on call for the day. Staff B (Concierge) stated he called the on-call nurse and informed her that Resident #1 was acting abnormally. Staff B(Concierge) stated after he informed the nurse of Resident #1 behavior of acting strange and abnormally, he did not return to the resident room, instead he continued his daily task. Interviewed on at 11:42 AM, Staff G (Certified Nursing Assistant) assigned to care for the resident, stated that on the day of his she saw Resident #1 at 6:00 am and 7:00 am sitting fully clothed on his bed. She stated that she did not speak with the resident. In an interview with the Administrator on at 3:24 pm, she stated the facility did not have policies and procedures regarding	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 025	Continued From page 6 responding to an unresponsive resident, however staff were trained to follow procedures in the event of an emergency. She stated if a Certified Nursing Assistant observed an unresponsive resident, they would start . . and call a nurse, and the nurse would call 911. If a non-nursing staff (clergy, concierge, kitchen staff, etc.) would observe a resident unresponsive, they would call one of the nurses, the nurse would initiate . , and call 911. She further stated that she did not have a . . policy because it was not required. The Administrator stated Resident #1 was independent and staff would assist and supervise the resident if he wanted." A review of Resident #1's 1823 health assessment dated . . . . showed he needed assistance with ambulation, bathing, ... , grooming, transfers, and assistance with self-administration of medications. The resident was independent with eating. Interviewed on . . . . . at 12:45, Staff R (medication technician) stated she signed Resident #1's medications as given that day, stated that she started giving medications at 6:00 am, but that Resident #1 never came to take his medications. Staff R stated that she accidentally signed the MOR indicating that the resident had taken the medication because "so much was going on that day." She further stated, when asked what was going on that caused the medication documentation falsification, that Resident #1's was what was going on by the time she finished passing medications on the two floors that she was responsible for. She stated that she gave medications from 6:00 am to 8:00 am. When asked what the facility's procedure was when a resident did not take medications, she stated that she reported these	A 025		

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
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 025	Continued From page 7 occurrences to the nurse on duty, but she did not report it that day because everyone was preoccupied with the ..... 2) A review of Resident #1 progress note dated ..... showed resident had previous ..... when the resident attempted to jump out of a fourth-floor window. The police were called, and the resident was taken to the hospital under the ..... Review of Resident #1 hospital records dated showed diagnosis of unspecified ..... and major ..... Review of Resident #1 records showed he returned to the facility on and was placed on the memory care unit. A review of Resident #1 progress note dated , revealed, "the Guardian informed that the psychiatrist and facility were recommending one on one care for supervision. " There was no documentation that the resident received one to one supervision or follow up care and services since the first ..... attempt. On ..... at 9:26 AM according to the Administrator a psychiatrist saw the resident last year. She stated the psychiatrist and herself suggested the resident have one-to-one supervision, for about a week, to ensure the resident had no more attempts, from jumping out the window. She further stated the resident Power of Attorney refused the one-on-one supervision; therefore, the resident was never placed on one-to-one supervision. On at 9:26 AM, the Chief Nursing	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 025	Continued From page 8 Officer stated, although the resident had attempt in the past, Resident #1, 1823 health assessment dated , did not indicate resident had issues, therefore the facility did not feel the need to provide additional support and services to the resident. Class I	A 025		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 052	Continued From page 9 helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.	A 052		

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
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 052	Continued From page 10 (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 052	Continued From page 11 health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to follow the correct procedures when assisting with the self-administration of	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 052	Continued From page 12 medication for one out of one (Resident #3) sampled resident. Findings included: On at 7:38 AM, observation showed during medication pass that Staff Q assisted Resident #3 with self-administration of medication. Staff B opened the medication cabinet, read orders on the medication observation record, took the cards, and a small cup with apple sauce. She walked to the resident room, she crushed the medications, mixed them with apple sauce, and said to the resident "these are your medications." A review of Resident #3's health assessment (AHCA Form 1823) completed on revealed she required assistance with self-administration of medication. On at 7:45 AM, Staff Q stated, "I crushed her medications and fed her." On at 11:23 AM, Staff Q stated, "The nurse is the one who administers the medications to the residents. I did it because I wanted to help and could get the work done." Class III	A 052		
A 076 SS=I	59A-36.009 FAC ( ) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An	A 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 076	Continued From page 13 assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005. (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (2) LICENSE REVOCATION. An assisted living	A 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 076	Continued From page 14 facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896. (3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences or , , staff trained in , , ( ) or a health care provider present in the facility, may withhold (, , , and). (b) In the event a resident is receiving hospice services and experiences or , , , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have written policies and procedures that explain its implementation of state laws and rules relative to ('s). Resident #1 was found unresponsive, did not have a executed, and staff on duty did not perform . Findings included: A review of the facility report dated revealed on at approximately 8:44 AM, Resident #1 was found unresponsive. A review of Resident #1's record showed the resident was admitted to the facility on . Further review of the record showed	A 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(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 076	Continued From page 15 the resident did not have a . . . . . ( ) on file. A review of facility document, " list", showed 103 residents listed as having a . . on file. A review of the facility's records revealed there was no documentation of . . . . . policies and procedures in place. In an interview with the Administrator on . . . . . at 3:24 pm, she stated the facility did not have policies and procedures regarding responding to an unresponsive resident, however staff were trained to follow procedures in the event of an emergency. She stated if a Certified Nursing Assistant observed an unresponsive resident, they would start . . and call a nurse, and the nurse would call 911. If a non-nursing staff (clergy, concierge, kitchen staff, etc.) would observe a resident unresponsive, they would call one of the nurses, the nurse would initiate . . , and call 911. She further stated that she did not have a . . . . policy because it was not required. Class II	A 076		
A 079 SS=F	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	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 16	A 079		

0-5 168
212
16-25 253
26-35 294
36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 17 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least . . . . . must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required 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	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 18 service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire 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	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 19 agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure there is enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with residents scheduled and unscheduled service needs for 75 out of 90 Residents that reside on the memory care unit. Finding Included: On at 5:46 am, observed Staff V (Certified Nursing Assistant) working alone on the 3rd floor of the memory care unit with a census of 30 residents. In an interview conducted with Staff V (Certified Nursing Assistant) on at 5:46 am, she stated she was working on the 3rd floor alone and responsible for providing care for 30 Residents from 10:00 pm to 6:30 am. Staff V stated she visited the residents every two hours and spent	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 20 about 20 minutes with each resident. On . . . . . at 5:56 am, observed staff T (Certified Nursing Assistant) working alone on the 4th floor of the memory care unit with a census of 30 Residents. In an interview with Staff T (Certified Nursing Assistant) on . . . . . at 5:56 am, she stated she was working alone on the 4th floor and responsible for providing care for 30 Residents from 10:00 pm to 6:30 am. Staff T stated 25 of the resident's needed assistance with care. A review of the facility's record showed the facility had a census of ninety residents residing in the memory care unit. A review of the facility staffing schedule dated revealed, from 10:00 PM to 6:30 AM, one staff member was scheduled to work on the memory care unit three floors and each floor had a census of 30 residents. A review of 1823 health assessments for 75 residents residing on the memory care unit, revealed the number of residents that needed supervision, assistance, and total assistance with activities of daily living as follows; -Ambulation: 8 Residents needed supervision with ambulation. 59 Residents needed assistance with ambulation. 14 Residents needed total assistance with ambulation. -Transfers: 9 Residents needed supervision with transfers. 60 Residents needed assistance with transfers. 14 Residents needed total assistance with	A 079		

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
	AL11969105	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT HOMESTEAD, LLC	3100 NE 8TH ST HOMESTEAD, FL 33033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 21 transfers. -Toileting: 7 Residents needed supervision with toileting. 67 Residents needed assistance with toileting. 14 Residents needed total assistance with toileting. -Bathing: 75 Residents needed assistance with bathing. 14 Residents needed total assistance with bathing. - 3 Residents needed supervision with 72 Residents needed assistance with 14 Residents needed total assistance with -Grooming: 6 Residents needed supervision with grooming. 70 Residents needed assistance with grooming. 14 Residents needed total assistance with grooming. -Eating: 17 Residents needed supervision with eating. 44 Residents needed assistance with eating. 14 Residents needed total assistance with eating. Class III	A 079		