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
	AL11953250	A. BUILDING: _____ B. WING _____	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD RETIREMENT	1117 MASSACHUSETTS AVENUE SAINT CLOUD, FL 34769

(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 Complaint investigation #2025014510 and a generator monitoring survey were conducted at Homestead Retirement Home Assisted Living Facility on .. and .. . Deficiencies were identified at the time of the survey. Class I deficiencies were identified at A0025 and A0077 Staffing standards - Administrators. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm , or to a resident receive care in a facility. On at around 3:30 AM, resident #1 left the facility and was struck by a car while he tried to cross a busy highway in the dark, early morning hours. He was transferred to Osceola Regional Hospital where he . The facility was unaware of resident #1's whereabouts until approximately 9:00 AM, when law enforcement arrived to the facility and informed them of the resident's . The facility failed to provide care and services to prevent an elopement; and the facility's administrator failed to ensure the provision of appropriate care to all residents by failing to ensure adequate staffing and appropriated supervision was provided to meet the needs of resident #1. The Class 1 noncompliance began on The Supervisor was notified of the Class 1 deficiencies on at 5:00 PM. The census at the time of the survey was 36.	A 000		

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A 000	Continued From page 1 The following is a description of the deficiencies found at the time of the visit.	A 000		
A 025 SS=J	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 resident diets in accordance with Rule 59A-36.012, F.A.C.	A 025		

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A 025	Continued From page 2 (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 observation, interview, and record review, the facility failed to provide care and services appropriate to the needs of residents accepted for admission to the facility with a Limited Mental Health license and failed to maintain the general awareness of the residents' whereabouts for 1 of 7 sampled residents (#1). Findings: Review of resident #1's record revealed he was admitted to the facility on . His diagnoses included , , Type and , . The resident was not assessed to be an elopement risk. Resident #1	A 025		

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A 025	Continued From page 3	A 025		

was independent in all activities of daily living but required assistance with self-administration of medication.

Review of resident #1's Community Support Plan for Assisted Living with Limited Mental Health License dated and signed on , revealed under #3, the fifth item documented, "24-hour staff support and supervision on site."

On at 12:13 PM, the facility Supervisor recalled she watched video footage from a camera on which showed that at approximately 2:39 AM, resident #1 left the facility, through an unsecured patio door. She relayed that she later learned through law enforcement that resident #1 was struck by an automobile while attempting to cross a major highway approximately a South of the facility, at approximately 3:30 AM that morning. He was transferred to a local hospital where he later . The Supervisor explained, she last saw resident #1 at approximately 2:00 AM on , and she was the only staff scheduled for the overnight shift from 11:00 PM to 7:00 AM. The Supervisor reported that on at approximately 4:00 to 4:30 AM, she went to went to bed, and woke up around 7:00 AM, to assist with medications. She said she was the only staff member scheduled for the day shift from 7:00 AM to 7:00 PM and the only staff on the next overnight shift from 7:00 PM to 7:00 AM for both days, and . She acknowledged she was solely responsible for residents, medication assistance, cooking, serving, and cleaning for the 37 residents residing in the facility at that time. The Supervisor acknowledged the facility was required to always have an awake staff, as their census was over 17 residents. She remembered that morning at 8:00 AM, she went

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A 025	Continued From page 4	A 025		

to resident #1's room to check on him because he did not come to breakfast. She realized he was missing at that time; however, she said she assumed he went out for coffee so she did not instigate a search for the missing resident at that time. The Supervisor acknowledged there was no sign out sheet used for residents leaving the facility at the time of the accident. She said residents were expected to tell staff when they were leaving the facility. She said according to the household rules curfew was from 9:00 PM to 6:00 AM. The Supervisor said that morning at approximately 9:13 AM, an investigator from the Saint Cloud police department arrived at the facility to ask for resident #1's identification and next of kin contact information. She said she was informed at this time that resident #1 was struck by a car earlier that morning and had ,

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The Federal Highway where the accident took place was a very highly trafficked six-lane road with a center median, and a 45 mile-per-hour speed limit.

There were 37 residents residing in the facility on the day of the accident. The weather on at 3:30 AM was approximately 75 degrees Fahrenheit with clear skies. Sunrise was at 7:15 AM, (retrieved on from www.dateandtime.com).

A tour of the facility on at 1:40 PM found the door to the patio had been propped open. Four residents were sitting outside on the patio smoking. The door leading from the patio to the front of the facility was also propped open.

A review of the staff schedule for , and revealed the Supervisor

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A 025	Continued From page 5 worked seven nights a week on both the day and afternoon shifts daily, a total of approximately 15-18 hours a day. Review of the facility minimal required staffing hours from to found the facility required 335 hours per week for their census of 37. For the week of through , 255 hours were scheduled, 80 hours less than what was required. The Supervisor worked 135 of the 255 hours that week. A review of the facility's undated elopement policy revealed, an elopement was when a resident left the facility without prior authorization and/or the direct supervision of staff, family, guardian or any other authorized party. At the time of the accident the facility was not a secure facility. A review of the current House Rules revealed under #9, that all residents were required to be home by 9:00 PM, except on instances where staff were aware, and all doors would be secured at that time. On at 9:40 AM, the Supervisor confirmed she worked at the facility every day. She explained she walked around the facility to check on the residents. The Supervisor described that the residents knew they must be inside the facility by 9:00 PM. She recalled resident #1 was known to be in and out of the facility all day. The Supervisor explained resident #1 was known to panhandle for money at the nearby gas station and would go to the nearby church to get food from their food pantry. She stated occasionally she would have to go get him if he was not at the facility for lunch. The Supervisor stated she must have been in the kitchen when resident #1 left the facility. The Supervisor confirmed the door	A 025		

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A 025	Continued From page 6 to the patio was not secured per policy and explained it was propped open at all times, to allow residents access to the smoking area. On at 10:37 AM, the Supervisor confirmed she could not provide any documentation of in-service training for staff or residents after the incident. The only change in procedure implemented after resident #1 eloped was a sign-in-and-out form for the residents, no changes had been made to improve staffing, ensure enough staff, ensure staff were awake at all times and/or ensure the doors were secure after hours to prevent elopement of residents. (Photo Evidence Obtained) Class I	A 025		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency	A 077		

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A 077	Continued From page 7 test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C.	A 077		

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A 077	Continued From page 8 Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to ,	A 077		

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A 077	Continued From page 9 20, 1998, are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility's Administrator failed to supervise all staff to provide supervision and maintain the facility to prevent elopement, and to ensure appropriate care was provided to prevent elopement for 1 of 4 residents reviewed for elopement (#1), for a total 7 sampled residents. Findings: A review of resident #1's record revealed he was admitted on . His diagnoses included , , type and , . The resident was not assessed to be an elopement risk, and he was independent in all activities of daily living. The record revealed the resident only required assistance with self-administration of medication. On at 12:13 PM, an interview with the	A 077		

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A 077	Continued From page 10 Supervisor was conducted. She said on at 9:13 AM a police investigator notified her that on at 3:30 AM resident #1 was struck by a car while attempting to cross Thirteenth Street. He at the hospital. She then reviewed the camera footage with the investigator and found that resident #1 left the facility on at 2:39 AM through an unsecured patio door. The Supervisor recalled, there were 37 residents residing in the facility on the day of the accident. She confirmed she was the only staff member scheduled from 11:00 PM to 7:00 AM. She remembered seeing resident #1 at around 2:00 AM on . The Supervisor stated that morning around 4:00 AM she went to bed, and woke up at 7:00 AM, to assist with residents' medications. She said she was the only staff member scheduled for the day shift from 7:00 AM to 7:00 PM and the only staff for the overnight shift on . The supervisor confirmed she was solely responsible for residents, medication assistance, cooking, serving, and cleaning for all the 37 residents residing in the facility at that time. She acknowledged the facility required staff to be awake at all times if there was a census of 17 or more residents. The Supervisor stated that morning at 8:00 AM, she realized resident #1 was not at the facility when she went to his room to check on him when he did not come to breakfast. It was at that time she realized the resident was not in the facility. She explained she did not initiate a search for resident #1 as she assumed he went out for coffee. The Supervisor relayed that residents were expected to tell them when they were leaving the facility, and the household rules indicated that curfew was from 9:00 PM to 6:00 AM. On at 1:40 PM, a tour of the facility revealed the door to the patio was propped open.	A 077		

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A 077	Continued From page 11 Four residents were observed sitting on the patio smoking. The door leading from the patio to the front of the facility was also propped open. A review of the staff schedule for , and revealed the Supervisor was scheduled to work seven of seven nights a week, as well as day and afternoon shifts daily. For 15-18 hours a day. Review of the minimal required staffing hours for Assisted Living Facilities revealed the facility required 335 hours per week for their census of 36-37 residents. During the week in which the accident occurred, to , only 255 staff hours were scheduled. Of these 255 hours, the supervisor worked 135 of the hours. The schedule indicated the Administrator was on the schedule but was not available to work because he had been out of the country since . A review of the facility's undated elopement policy revealed, an elopement was when a resident left the facility without prior authorization and/or the direct supervision of staff, family, guardian or any other authorized party. At the time of the accident the facility was not a secure facility. A review of the current House Rules revealed under #9, that all residents were required to be home by 9:00 PM, except on instances where staff were aware, and all doors would be secured at that time. On at 9:40 AM, the Supervisor confirmed she worked at the facility every day. She explained she walked around the facility to check on the residents. She recalled resident #1 was known to be in and out of the facility all day. She stated occasionally she would have to go get	A 077		

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A 077	Continued From page 12 him if he was not at the facility for lunch. The Supervisor confirmed the door to the patio was not secured per policy and explained it was propped open at all times, to allow residents access to the smoking area. On at 10:37 AM, the Supervisor confirmed she could not provide any documentation of in-service training for staff or residents after the incident. The only change in procedure implemented after resident #1 eloped was a sign-in-and-out form for the residents, no changes had been made to improve staffing, ensure there was emough staff, ensure staff were awake at all times and/or ensure the doors were secure. Interview with the Supervisor on at 9:45 and 10:40 AM revealed the Administrator was currently out of the county since and she (the Supervisor) who was left in charge, was not core trained. She confirmed she had not passed the Core training test. She confirmed there was not sufficient staff to provide care and services to meet the needs of the residents and ensure there was always awake staff in the facility at all times. The Supervisor confirmed she worked seven days a week and often more than 16 hours a day. The facility currently does not have a core trained staff supervising the facility, as required. (Photo Evidence Obtained) Class I	A 077		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing:	A 079		

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A 079	Continued From page 13 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 6-15 — 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	A 079		

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	AL11953250	A. BUILDING: _____ B. WING _____	10/08/2025

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A 079	Continued From page 14 ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be 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	A 079		

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A 079	Continued From page 15 facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The 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	A 079		

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A 079	Continued From page 16 resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, 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 interview, and record review, the facility failed to ensure there were 335 minimum staffing hours per week, as required, failed to ensure at least one staff member was awake at all hours, and failed to ensure no staff member was in charge of the 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. Findings: On at 12:13 PM, the Supervisor confirmed she was the only staff working in the facility for the overnight shift on to . She reported she had worked from	A 079		

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A 079	Continued From page 17 7:00AM to 1:00 PM on and returned to work five and a half hours later at 6:30 PM for the overnight shift into . The Supervisor confirmed she stayed up cleaning and preparing for the next day's meals, but went to sleep between 4:00 AM and 4:30 AM the morning of . She said she woke up on at approximately 7:00 AM, to assist residents with self-administration of medication. Review of the facility schedule for the week of to revealed there were only 255 hours scheduled. Of those 255 hours, the Supervisor worked 135 of those. Review of the facility schedule for the week of to revealed there only 255 hours were scheduled. Of those 255 hours, the Supervisor worked 135 of those. On Saturday and Sunday the Supervisor was the only staff at the facility. She was scheduled to work 24 hours each day. On at 12:50 PM, the Supervisor confirmed the Administrator was out of the country and had been gone over a month, since . She confirmed he was on the schedule to work but he had not been at the facility. The Supervisor added there was also a staff member who had been out sick for over a month. The Supervisor explained she had taken the core test numerous times but had not been able to pass the test. She acknowledged she did not have the credentials to be left in charge of the facility for more than 21 days. (Photo Evidence Obtained)	A 079		

Agency for Health Care Administration

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A 079	Continued From page 18 Class III	A 079		