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 |
|---|---|---|---|
| | AL11968512 | A. BUILDING: _____ B. WING _____ | 10/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE MAJESTIC SENIOR RESIDENCE LLC | 1301 NORTH 47TH AVENUE HOLLYWOOD, FL 33021 |

| (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<br><br>An unannounced Relicensure with Extended Congregate Care (ECC) and a Generator Monitoring survey was conducted at Grace Majestic Senior Residence LLC on - . The facility had deficiencies at the time of the survey. | A 000 | | |
| AE205 | 59A-36.021(5); 429.07(3)(b) ECC - Health Assessment<br><br>59A-36.021<br>(5) HEALTH ASSESSMENT. Before receiving extended congregate care services, all persons. including residents transferring within the same facility to that portion of the facility licensed to provide extended congregate care services, must be examined by a health care practitioner pursuant to rule 59A-36.006, F.A.C. A health assessment conducted no more than 60 days before receiving extended congregate care services meets this requirement. Once receiving services, a new health assessment must be obtained at least annually.<br><br>429.07 (3)(b), FS<br>6. Before the admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 429.26(5) and the facility must develop a preliminary service plan for the individual.<br>7. If a facility can no longer provide or arrange for services in accordance with the resident's service plan and needs and the facility's policy, the facility must make arrangements for relocating the person in accordance with s. 429.28(1)(k). | AE205 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968512 | A. BUILDING: _____ B. WING _____ | 10/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE MAJESTIC SENIOR RESIDENCE LLC | 1301 NORTH 47TH AVENUE HOLLYWOOD, FL 33021 |

| (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 |
|---|---|---|---|---|
| AE205 | Continued From page 1<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to obtain a new, accurate and "updated" annual Agency for Healthcare Administration (AHCA) Form 1823 Health Assessment, for 1 of 1 sampled residents reviewed for Extended Congregate Care (ECC), Resident #1.<br><br>The findings included:<br><br>Review of the facility policy titled ECC Aging in Place provided by the Registered Nurse (RN)/ Advanced Practice RN, (APRN) Administrator effective documented in the Policy Statement: Ensure that the facility develop policies, procedures and guidelines to ensure and promote the resident's dignity, choice and decision making and subsequently will affect protocols for Aging in Place. It is the Policy of Grace Majestic Senior Residence to provide increased or adjusted services to meet the resident's physical or mental decline that may occur with the aging process. The overall goal of this policy is to maximize the resident's dignity and independence and permit them to remain in a familiar home environment for as long as possible. The Grace Majestic Senior Residence ECC will make available to its residents a higher level of service as required by the Resident Healthcare Assessment (1823) .....<br><br>Resident #1 originally moved into the facility on , under a previous owner through Hospice; the resident had been residing under ECC with the current owner since .<br>Resident #1's medical diagnoses included , ( ), , ( ) and . | AE205 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968512 | A. BUILDING: _____ B. WING _____ | 10/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE MAJESTIC SENIOR RESIDENCE LLC | 1301 NORTH 47TH AVENUE HOLLYWOOD, FL 33021 |

| (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 |
|---|---|---|---|---|
| AE205 | Continued From page 2<br><br>On at 9:50 AM, an observation was conducted of Resident #1 who was sitting in her recliner in the Family sitting room watching T.V. Further observation conducted with facility staff of Resident #1's right flank area which was observed to be clean and dry with a tiny "healed" superficial opening, with no redness or observed and with a small border , in place.<br>On , the most recent AHCA Form 1823 Health Assessment documented, " ...Hospice and admit to ECC ...."<br><br>Record review of the Resident Observation Log dated documented, " ... to right is progressively ...."<br><br>Record review of the Resident Observation Log dated documented, " .... to right showing signs of increased drainage ...."<br><br>Further record review of the ECC Monthly Nurse Evaluation Form dated documented, " .... to right flank. Draining , drainage ....Resident seen by Care Advanced Practice Registered Nurse (A.P.R.N.). culture during visit. Resident started on 100mg oral twice daily for seven (7) days, for ...."<br><br>Copy of Physician's order for Right Flank , with a resultant un-stageable to ultimate dated which documented, "Clean with ½ strength Dakin's Solution. Place skin prep on edges, apply impregnate with ½ strength Dakin's Solution, place on bed. Change daily for seven (7) days. | AE205 | | |

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 |
|---|---|---|---|
| | AL11968512 | A. BUILDING: _____ B. WING _____ | 10/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE MAJESTIC SENIOR RESIDENCE LLC | 1301 NORTH 47TH AVENUE HOLLYWOOD, FL 33021 |

| (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 |
|---|---|---|---|---|
| AE205 | Continued From page 3<br><br>Record review of the Doctor Nurse Practitioner (DNP) Care notes of the "beginning" to the right (flank) upper showed the following initial description and measurements on: ---moderate , , , level 3, 75% adherent yellow , dry black Eschar %, 2.7 x 2.5 x 0.2 cm, no or undermining and change weekly by , . Then, on /25of the un-stageable (following debridement) as: improving, moderate , , , level 3, 75% adherent yellow , dry black Eschar %, 2.5 x 2.5 x 0.2 cm (surgical debridement done with measurements afterwards of: 2.6 x 2.5 x 0.3 cm). And, with the most recent "un-healed" measurements of 0.5 x 0.5 x 0.2 cm, Surface area 0.25cm2, no , undermining 11 to 3 o'clock @ 1.5 cm, scant , , level 2, 100% and improving dated , following the Administrator's intervention.<br><br>Subsequent record review of the ECC Monthly Nurse Evaluation for Resident #1's left with redness and drainage dated , documented, " ....left ..."<br><br>Further record review of Physician's order for left redness with drainage dated , documented, "Clean and paint right with daily."<br><br>However, there was no new, updated annual AHCA Form 1823 Health Assessmentcompleted by Resident#1's physician, following the initial date of , which captured and reflected Resident #1's beginning right flank , first identified on . Subsequently, this was documented as having progressed to an un-stageable, draining and . | AE205 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968512 | A. BUILDING: _____ B. WING _____ | 10/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE MAJESTIC SENIOR RESIDENCE LLC | 1301 NORTH 47TH AVENUE HOLLYWOOD, FL 33021 |

| (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 |
|---|---|---|---|---|
| AE205 | Continued From page 4<br><br>Neither, had Resident#1's left , first identified on , been noted on the AHCA Form 1823 Health Assessment.<br><br>An interview was conducted on at 2:19 PM with Staff A, Home Health Aide (HHA) regarding the previous presence of Resident #1's left redness with drainage, and of the current presence of the Resident #1's Right Flank / _, and she acknowledged that the resident was observed to have/had both skin conditions, during her personal care of the resident. And, Staff A added that the areas were both being cared for by Licensed Nurses.<br><br>Interview and side-by-side record review with RN, APRN Administrator on at 3:11 PM in which she revealed that the most recent "outdated" AHCA Health Assessment for this resident was dated , and she stated that she does not have a subsequent updated annual AHCA Health Assessment for this resident. The RN APRN Administrator further revealed that the resident's right flank area also began as a , it then progressed or worsened to a which required oral for fourteen (14) day with initial _ changes performed 3 times per week, and she also revealed that the left began as a reddened with small amounts of _ drainage noted on the resident's pillow in the mornings and an order was obtained from the Doctor on to cleanse with normal and apply daily and leave open to air.<br><br>The RN APRN Administrator also revealed that she did not have, nor was she aware that she needed a "separate" ECC Log, for this resident.<br><br>The RN APRN Administrator further recognized | AE205 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968512 | A. BUILDING: _____ B. WING _____ | 10/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE MAJESTIC SENIOR RESIDENCE LLC | 1301 NORTH 47TH AVENUE HOLLYWOOD, FL 33021 |

| (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 |
|---|---|---|---|---|
| AE205 | Continued From page 5<br><br>and acknowledged on at 3:23 PM that both skin areas (left and right upper flank area) indicated a change in the resident's skin status or condition, which should have both been updated on an annual AHCA 1823 Health Assessment Form, for the resident.<br><br>Class III | AE205 | | |
| AE206 | 59A-36.021(6) FAC ECC - Service Plans<br><br>(6) SERVICE PLANS.<br>(a) Before receiving services, the extended congregate care administrator or manager must develop a preliminary service plan that includes an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, , , and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs.<br>(b) Within 14 days of receiving services, the extended congregate care administrator or manager must coordinate the development of a written service plan that takes into account the resident's health assessment obtained pursuant to subsection (5); the resident's unique physical, , , and social needs and preferences; and how the facility will meet the resident's needs including the following if required:<br>1. Health monitoring,<br>2. Assistance with personal care services,<br>3. Nursing services,<br>4. Supervision,<br>5. Special diets,<br>6. Ancillary services,<br>7. The provision of other services such as transportation and supportive services; and,<br>8. The manner of service provision, and | AE206 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968512 | A. BUILDING: _____ B. WING _____ | 10/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE MAJESTIC SENIOR RESIDENCE LLC | 1301 NORTH 47TH AVENUE HOLLYWOOD, FL 33021 |

| (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 |
|---|---|---|---|---|
| AE206 | Continued From page 6<br><br>identification of service providers, including family and friends, in keeping with resident preferences.<br>(c) Pursuant to the definitions of "shared responsibility" and "managed risk" as provided in section 429.02, F.S., the service plan must be developed and agreed upon by the resident or the resident's representative or designee, surrogate, guardian, or attorney-in-fact, and must reflect the responsibility and right of the resident to consider options and assume risks when making choices pertaining to the resident's service needs and preferences.<br>(d) The service plan must be reviewed and updated quarterly to reflect any changes in the manner of service provision, accommodate any changes in the resident's physical or mental status, or pursuant to recommendations for modifications in the resident's care as documented in the nursing assessment.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure that it reviewed, maintained and updated the Resident Family-Centered Service Plan, on a quarterly basis, for 1 of 1 sampled residents reviewed for Extended Congregate Care (ECC), Resident #1.<br><br>The findings included:<br><br>Review of the facility policy titled ECC Resident Service Plan Policy provided by Registered Nurse (RN)/Advanced Practice RN, (APRN) Administrator effective<br>documented in the Policy Statement: Grace Majestic Senior Residence will ensure that residents admitted to the ECC program will have a service plan ...will be individualized to meet the specific needs. The focus of the service plan will | AE206 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968512 | A. BUILDING: _____ B. WING _____ | 10/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE MAJESTIC SENIOR RESIDENCE LLC | 1301 NORTH 47TH AVENUE HOLLYWOOD, FL 33021 |

| (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 |
|---|---|---|---|---|
| AE206 | Continued From page 7<br><br>be on the following: ....Nursing services ...The service plan will be adjusted to meet the needs of the resident. The Service plan will be reviewed and updated as the resident's care needs change.<br><br>Resident #1 originally moved into the facility on , under a previous owner; the resident had been residing under ECC with the current owner since . Resident #1's medical diagnoses included , , ( ), , ( ) and .<br><br>On at 9:50 AM, an observation was conducted of Resident #1 who was sitting in her recliner in the Family sitting room watching T.V. Further observation conducted with facility staff of Resident #1's right flank area which was observed to be clean with a tiny "healed" superficial opening, with no redness or observed and with a small border , in place.<br><br>Record review of the Resident #1's Service plan initiated ; with no ending date, did not include the previous nor current changes in the resident's skin status or condition involving her left with redness and drainage identified on , nor of the of the resident's Right upper (Flank) with resultant un-stageable first identified on .<br><br>Furthermore, record review revealed that there was only one (1) Service plan provided and reviewed for this resident with a beginning date of ; with no ending date.<br><br>There were no other subsequent "updated" quarterly Service Plans maintained, nor provided | AE206 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968512 | A. BUILDING: _____ B. WING _____ | 10/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE MAJESTIC SENIOR RESIDENCE LLC | 1301 NORTH 47TH AVENUE HOLLYWOOD, FL 33021 |

| (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 |
|---|---|---|---|---|
| AE206 | Continued From page 8<br>by the RN, APRN, Administrator, for this resident.<br><br>Additionally, it was revealed that the most recent "outdated" AHCA Form 1823 Health Assessment was dated .<br><br>During a side-by-side record review and interview with the RN, APRN Administrator on at 2:19 PM, she revealed that the most recent "outdated" Service Plan for this resident was dated , and she also stated that she does not have subsequent updated quarterly Service Plan for this resident. The RN APRN Administrator explained how Resident#1's right upper flank area began as a , that progressed or worsened to a which required oral and initial to have been changed three (3) times per week. The RN, APRN Administrator also explained that Resident #1's left had begun as a reddened with small amounts of drainage noted on the resident's pillow in the mornings.<br><br>The RN, APRN, Administrator further recognized and acknowledged on at 3:30 PM that any change in the resident's skin status or condition, should have been updated quarterly on the resident's current Service Plan.<br><br>Class III | AE206 | | |