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 _____	02/02/2026

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

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A 000	Initial Comments A complaint investigation (2025017453) was conducted from through at Palace of Homestead. The provider had deficiencies at the time of the survey.	A 000		
A 025 SS=G	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	A 025		

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A 025	Continued From page 1 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 personal supervision and assistance for two out of 37 sampled residents after multiple and hospitalizations with and a hematoma. The facility failed to ensure daily observations by staff of the activities of Residents #32 and #33 while on the premises and awareness of their general health and safety who had precautions. The facility failed to document and explained what occurred when Residents #32 and #33 were found on the floor. The facility failed to notify two (Residents #32 & #33) out of 37 sampled residents licensed primary care physicians after multiple . The facility failed to maintain a written record, updated	A 025		

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A 025	Continued From page 2 as needed, of any significant changes, any illnesses that resulted in medical attention for Resident #34 prior to his hospitalization. Findings: 1) A review of Resident #33's hospital records dated revealed two within two days: "Patient arrived from [Assisted Living Facility] via [ambulance] due to right status post while transferring from wheelchair to bed. Patient also had from three days ago but was already seen that day for it. Arrival mode to facility: ambulance (1:46 PM). female with medical history of ( ), ( ), lower extremity, on long term with . Patient ." A review of Resident #33's hospital records dated revealed: "patient arrived via emergency medical services ( ) from [assisted living facility]. Per rescue patient while transferring from the wheelchair. Patient [had] to left forehead. Patient complains of right , and ." A review of the emergency medical services records dated revealed that Resident #33 was trying to transfer herself from the wheelchair to the toilet when she and was found on the bathroom floor. However, the resident needed assistance for toileting and bathing by a facility staff to prevent the resident from falling. A review of Resident #33's progress notes dated showed resident was sent out via	A 025		

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A 025	Continued From page 3	A 025		

rescue to the hospital status post for to the side of the . However, there was no documentation on what occurred, the time of the incident and if the resident was supervised, and no documentation her primary care physician was notified.

A review of Resident #33's progress notes dated showed resident was sent to the hospital by ambulance for to the right . However, there was no documentation the primary care physician was notified, how the incident occurred, who supervised or observed the incident, including the time of the incident.

Interviewed on at at 11:41 AM the Director of Resident Care stated that Resident #33 was found on the floor in the bathroom in her room. When asked about intervention, the Director of Resident Care stated further that she had a call button around her and she never pressed it. The Director of Resident Care stated that Resident #33 she came from the hospital on . The Director of Resident Care stated, "I had to send her right because she attempted to get out of bed on Sunday ( ). ." However, Resident #33 according to the hospital records had a history of forgetfulness.

A review of Resident #33's health assessment dated showed a diagnosis of left , post with open reduction with internal fixation (ORIF) , , D deficiency, , ( ), , Ileus, Left , , , of lower extremity. The resident's activities of daily living showed supervision with ambulation, eating and assistance with bathing,

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A 025	Continued From page 4 , self-care, toileting, and transferring. The physical status showed uses wheelchair as assistive device for mobility, unsteady gait, and generalized . The resident had precautions and , precautions on , . According to the Cleveland Clinic, are injuries that involve rips and tears in your body's tissues. While skin is the most common, these can happen to tissues inside your body, too. They can even happen without the affecting the outside body." The Cleveland Clinic states that , (,) is a drug you swallow to prevent and treat clots. A review of the facility's policy states if a resident is found on the floor the person who finds him/her will immediately call the nurse assigned to observe or review findings, including injuries if any. The nurse as appropriate will call the medical doctor and resident representative to discuss the necessary care including transfer to the hospital or other interventions as appropriate. If the incident occurs after hours and there are no visible injuries or loss of the staff will contact the nurse on call to discuss the event and residents' needs and receive authorization to assist the resident up. The nurse will follow-up with the physician services and responsible party as appropriate. In the case of any visible injuries and or loss of the staff is to call 911, remain with the resident and notify the nurse on call who will contact physician services responsible party, and entity leadership. 2) A review of Resident #32's records showed three	A 025		

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A 025	Continued From page 5 hospitalizations (, , &) within two months for three , including two in three days and a health assessment that was not updated until three months later on . Interviewed on at 3:05 PM the Husband of Resident #32 stated that his wife four times in three weeks and on one occasion, she had a , which led to her becoming and . The Husband stated that every morning they would find his wife on the floor. The Husband stated further that one of her he did not know how long she was on the floor. When asked if they gave her (Resident #32) a prevention plan, the Husband stated, "No." Interviewed on at 11:26 AM when asked about , the Administrator stated that there was at least one which resulted in a hospitalization of Resident #32. The Administrator stated that she had to look up the amount of the resident had. Interviewed on at 11:41 AM when asked about how many times Resident #32 , the Director of Resident Care stated that she had to look at her records. The Director of Resident Care, after looking at Resident #32 records stated that Resident #32 on , , and . When asked if there was a prevention plan after Resident #32 three , the Director of Resident Care stated that she recommended to the son that he get a private duty aid. When asked why the residents (#32, #33, #34) progress notes did not document any information of the times the residents had their , who found the residents, and what happened, the Director of Resident Care stated, "We are not a nursing home. So, we	A 025		

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A 025	Continued From page 6 don't document time and how." A review of Resident #32's hospital records dated revealed: "Patient came in via [ambulance] from the [assisted living facility] for an unwitnessed . Patient is complaining of , . Patient has and is unable to provide medical history." A review of Resident #32's progress notes dated showed the resident was sent to the hospital status post . However, there was no documentation of what occurred, who found the resident, time of day, and if the primary care was notified immediately. A review of Resident #32's hospital records dated revealed: "[Resident #32] is a pleasant , female with a history of with severe features who is here today from her nursing home after she and hit her . The patient is unable to provide her history at this time, secondary to her conditions reports normal vital signs on stage, and an obvious left forehead hematoma. This apparently has happened before." A review of Resident #32's progress notes dated showed Resident #32 was sent to the hospital via ambulance after a and that the husband was notified. However, there was no documentation of what occurred, the time of the incident, who found the resident and how long the resident was on the floor, and if the primary care physician was notified immediately. Interviewed on at 11:21 AM the Husband of Resident #32 stated that his wife had a in the morning around 6:00 AM on where she was sent to the hospital.	A 025		

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A 025	Continued From page 7 The husband stated further that she had injuries to the . The Husband stated, "I remember, I got there really quickly, I will send you the pictures." A review of Resident #32's hospital records dated revealed "Patient brought over from [assisted living facility] for from chair hitting of her while having dinner. Patient had a previous on Tuesday ( ) two days ago. [Resident #1] is an female with a history of complaining of , onset tonight due to . The patient locates , to the of her . Patient's nurse informs the patient backwards out of her chair and hit her ." A review of Resident #32's progress notes dated showed the resident was sent to the hospital post and husband was made aware. However, there was no documentation about how the resident was found and who found the resident, the time of the day of the and if the primary care physician was immediately notified. A review of Resident #32's health assessment dated showed a diagnosis of , , , and . The physical status showed , vision-uses glasses to see. The status showed awake, alert and oriented times one. The resident had precautions. The resident was an elopement risk. The resident was independent in ambulation, eating, transferring, and needed assistance with bathing, , self-care, and toileting. 3) A review of Resident #34's hospital records dated revealed: "the reason for emergency	A 025		

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A 025	Continued From page 8 department (ED) visit was aggressive behavior as the patient stated he does not want to live in that , assisted living activity. While in ED, he was found to have elevated (425 mg/dl) and ( ) promoting admission. It is unknown whether or not the patient had similar symptoms in the past. It is unknown whether or not the patient has recently seen a physician. The symptom (s)/episode began/occurred at an unknown time and became worse today." A review of Resident 34's progress notes dated showed resident was only sent to the hospital but there was no documentation of any behavioral related issues during his stay at the facility and how long he was misbehaving in the facility. Interviewed on at 11:41 AM when asked about Resident #34 who was hospitalized, the Director of resident Care stated that he was a new admission and that he went out to the hospital for behavioral issues. The Director of Resident Care stated that the resident was yelling and agitated in the facility and he wanted to smoke, and that he wanted to leave because they won't allow him to smoke. A review of the admissions and discharge log showed an admission date of . A review of Resident #34's health assessment dated showed a diagnosis of (AMS), Type II, Debilitated Patient, and . The physical status showed . mobility resident used a	A 025		

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A 025	Continued From page 9 wheelchair for ambulation. The ˬ status showed awake, alert and oriented two times. The nursing status showed home health administration. The special precautions showed precautions. The activities of daily living showed assistance needed with ambulation, bathing, ˬ, self-care, toileting, and independent with eating and supervision with transferring. The resident had a diet. Class II	A 025		
A 079 SS=E	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 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,	A 079		

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A 079	Continued From page 10	A 079		

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 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

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A 079	Continued From page 11 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 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	A 079		

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A 079	Continued From page 12 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 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:	A 079		

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A 079	Continued From page 13 Based on observation, interview and record review the facility failed to provide adequate and sufficient staffing to meet both the scheduled and unscheduled care needs of the residents, compromising their safety and well-being for all 181 residents. Only three staff members were scheduled to provide care for a total of 100 residents in the memory care unit. Findings Included: Observation on at 6:31 AM showed several employees in the employee break area. Staff stated they were starting their shift at 6:00 AM. Interviewed on at 7:01 AM Staff J (Registered Nurse/ Night Shift Supervisor) stated that there were 100 residents on the memory care floor. When asked how many employees worked memory care, Staff J stated there was one employee per floor. The Night Shift Supervisor confirmed that there were three employees assigned to the memory care unit. When asked how many residents were on the AL (assisted living) side, Staff J stated there were 70 residents, with one staff member per floor. He stated the total resident census was between 170-180 residents, with four residents currently hospitalized. A review of the facility's hospice list showed that there were 43 residents under hospice care. Of the 43 residents, 28 were in the facility's memory care unit. A review of the facility staff schedule dated 'Sunday, ' for the overnight shift showed six employees were scheduled to work from 10:00 PM to 6:30 AM.	A 079		

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(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 14 Observation on at 1:00 PM showed the Director of Resident Care reviewed the staffing schedule and highlighted overnight staff scheduled to work from 10:00 PM to 6:30 AM. The Director confirmed there were six staff members who worked that shift. Class III	A 079		
A 190 SS=G	59A-36.023( ) & (3)(b) 429.14(6) FS Administrative Enforcement 59A-36.023( ) & (3)(b) FAC Facility staff must cooperate with agency personnel during surveys, complaint investigations, monitoring visits, license application and renewal procedures and other activities necessary to ensure compliance with Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. 429.41(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations; or a class I, Class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. (1) Abbreviated Survey. (a) An applicant for license renewal who does not	A 190		

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	AL11969105	A. BUILDING: _____ B. WING _____	02/02/2026

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A 190	Continued From page 15 have any class I or class II violations or uncorrected class III violations, confirmed long-term care ombudsman program complaints, or confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date, is eligible for an abbreviated biennial survey by the agency. For the purpose of this rule, a confirmed long-term care ombudsman program complaint is a complaint that is verified and referred to a regulatory agency for further action. Facilities that do not have two survey reports on file with the agency under current ownership are not eligible for an abbreviated inspection. Upon arrival at the facility, the agency must inform the facility that it is eligible for an abbreviated survey, and that an abbreviated survey will be conducted. (b) Compliance with key quality of care standards described in the following statutes and rules will be used by the agency during its abbreviated survey of eligible facilities: 1. Section 429.26, F.S., and Rule 59A-36.006, F.A.C., relating to residency criteria; 2. Section 429.27, F.S., and Rule 59A-36.013, F.A.C., relating to proper management of resident funds and property; 3. Section 429.28, F.S., and Rule 59A-36.007, F.A.C., relating to respect for resident rights; 4. Section 429.41, F.S., and Rule 59A36.007, F.A.C., relating to the provision of supervision, assistance with the activities of daily living, and arrangement for , , and transportation to , , ; 5. Section 429.256, F.S., and Rule 59A-36.008, F.A.C., relating to assistance with or administration of medications; 6. Section 429.41, F.S., and Rule 59A-36.010, F.A.C., relating to the provision of sufficient staffing to meet resident needs;	A 190		

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A 190	Continued From page 16 7. Section 429.41, F.S., and Rule 59A-36.012, F.A.C., relating to minimum dietary requirements and proper food hygiene; 8. Section 429.075, F.S., and Rule 59A-36.020, F.A.C., relating to mental health 'residents' community support living plan; 9. Section 429.07, F.S., and Rule 59A-36.021, F.A.C., relating to meeting the environmental standards and residency criteria in a facility with an extended congregate care license; and 10. Section 429.07, F.S., and Rule 59A-36.022, F.A.C., relating to the provision of care and staffing in a facility with a limited nursing services license. (c) The agency will expand the abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or welfare of residents are identified during the abbreviated survey. The facility must be informed when a full survey will be conducted. If one or more of the following serious problems are identified during an abbreviated survey, a full biennial survey will be immediately conducted: 1. Violations of Rule Chapter 69A-40, F.A.C., relating to firesafety, that threaten the life or safety of a resident; 2. Violations relating to staffing standards or resident care standards that adversely affect the health, safety, or welfare of a resident; 3. Violations relating to facility staff rendering services for which the facility is not licensed; or 4. Violations relating to facility medication practices that are a threat to the health, safety, or welfare of a resident. (2) Survey Deficiency. (a) Before or in conjunction with a notice of violation issued pursuant to Part II, Chapter 408, F.S., and Section 429.19, F.S., the agency shall	A 190		

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A 190	Continued From page 17 issue a statement of deficiency for class I, II, III, and violations which are observed by agency personnel during any inspection of the facility. The deficiency statement must be issued within 10 working days of the agency's inspection and must include: 1. A description of the deficiency; 2. A citation to the statute or rule violated; and 3. A time frame for the correction of the deficiency. (b) Additional time may be granted to correct specific deficiencies if a written request is received by the agency before the expiration of the time frame included in the agency's statement. (3)(b) Dietary Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly related to dietary standards as established in Rule 59A-36.012, F.A.C., is documented by agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a registered or licensed dietitian, or a licensed nutritionist. 2. The initial on-site consultant visit must take place within seven working days of the notice of a class I or II deficiency or within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license or registration of the consultant dietitian or nutritionist and the consultant's signed and dated review of the facility's corrective action plan, if a plan is required by the agency, no later than 10 working days after the initial onsite consultant visit. 3. If a corrective action plan is required, the facility must provide the agency with, at a	A 190		

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A 190	Continued From page 18 minimum, quarterly onsite corrective action plan updates until the agency determines after written notification by the dietary consultant and facility administrator, that deficiencies are corrected and staff has been trained to ensure that proper dietary standards are followed and consultant services are no longer required. The agency must provide the facility with written notification of such determination. 429.14 (6) As provided under s. 408.814, the agency shall impose an immediate moratorium on an assisted living facility that fails to provide the agency with access to the facility or prohibits the agency from conducting a regulatory inspection. The licensee may not restrict agency staff from accessing and copying records at the agency's expense or from conducting confidential interviews with facility staff or any individual who receives services from the facility. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to cooperate in a complaint investigation as it pertained to supervision and quality of treatment which resulted in multiple with injuries (& Hematomas) for two (32, and 33) out of 37 sampled residents. Findings: A record review of Resident #33's hospital records showed she was hospitalized after multiple on and . A record review of Resident #32's hospital records showed she was hospitalized after	A 190		

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A 190	Continued From page 19 multiple on , , and . Interviewed on at 11:26 AM when asked for their internal communications log, a list of the last three months of of residents, including Resident #34, the Administrator never returned with any of the requested information. The Administrator further stated that she misunderstood what was requested and needed more clarity. Interviewed on at 11:41 AM when informed that the progress notes did not document any information of how the residents , the times the residents had their and who found them, which included Residents #32, and 33, the Director of Resident Care stated, " "We are not a nursing home, so we don't document time and how." The Director of Resident Care stated further that times of were documented in their internal communication log. When asked for the information in the internal communication log to investigate the complaint investigation, the Director of Residence Care stated that it was internal and that she would have to ask. Interviewed on at 3:05 PM the Husband of Resident #32 stated that every morning his wife was found on the floor. The Husband stated further that on one of the , he did not know how long she was on the floor. Class II	A 190		