STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105541	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Manor A Palace Community	1330 NW 1st Ave Homestead, FL 33030

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31581 Based on observation, interview and record review the facility failed to promote resident's dignity and respect for one resident (Resident number 10) out of eleven residents during dining in the [NAME] wing. This practice has the potential to affect all seven residents out of eleven residents who eat orally and required assistance with feeding on the [NAME] wing at the time of the survey. The findings included: Record review of the Dining Room Policy and Procedures revision date 11/01/2016, review date 1/08/2024 documented: Policy-The facility residents will be provided with nourishing, palatable and attractive meals to meet resident's daily nutrition and special dietary needs; Procedure: 3) Positioning and assistance at mealtime must be appropriate for the resident's needs and 4) Treat residents with dignity and respect. Review of the Demographic Face Sheet for Resident number 10 documented the resident was admitted on [DATE] with a diagnosis of cerebral Atherosclerosis end stage, alzheimer's disease, Cerebrovascular disease, dementia, hypertension and encounter for palliative care. Review of the Minimum Data Service (MDS) Quarterly assessment dated [DATE] for Resident number 10 documented the resident's Mental Status (BIMS) Summary Score was 00, indicating severe cognitive impairment, required dependent assistance for ADLs (activities daily living) and eating and received hospice care. Observation of Resident #10 on 8/05/24 at 12:13 PM revealed the resident sitting up in bed and being fed a pureed lunch by the Hospice CNA standing over her. On 8/05/24 at 12:14 PM, interview with the Hospice CNA. She stated, I know I am not supposed to feed her standing up but there is not a chair for me to sit. She was observed continuing to stand over the resident and feeding the resident. On 8/07/24 at 8:43 AM, interview with the Director of Nursing (DON). She stated, I was told about the Hospice CNA standing over the resident and feeding the resident. They have been educated about dignity when feeding the resident. If there is no chair in the room, they should ask for a chair. They are to sit at the resident level and feed the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Homestead Manor A Palace Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1330 NW 1st Ave Homestead, FL 33030	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 8/08/24 at 10:06 AM, interview with Staff B, Registered Nurse (RN). She stated, She is a hospice resident. She is total dependent for ADLs and for feeding. When feeding a resident that needs assistance, we reposition the resident, take a chair and sit beside the resident to feed them.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on record review and interview the facility failed to ensure an accurate Level I Preadmission Screening and Resident Review (PASRR) was completed in a timely manner for two residents (Resident #31 and Resident #46) out of 18 residents sampled as evidenced by Level I PASRR dated 2/13/15 for Resident#31 omitted diagnosis of Depression and Psychotic disorder with delusions due to known physiological condition and Level I PASRR dated 4/3/24 for Resident#46 omitted diagnosis of Major depressive disorder, and Psychotic disorder. There were 85 residents residing in the facility at the time of survey. The findings included: Resident #31 Record review of Level I PASRR for Resident #31 Screen and Determination Admitting diagnosis: Paralysis Agitation others: Altered Mental status: PASRR: Section I: Guide for Determining an indication of, or a Diagnosis of, a serious mental illness (MI), Mental Retardation (MR) or Related Condition: check those that apply: none checked. Section II: Part A: Mental Illness: No Part B- Mental Retardation: No. Signed by Social Worker from Hospice on 2/13/2015. Record review of demographic sheet for Resident #31 revealed an admitted [DATE] and readmitted [DATE] with diagnosis that included Depression and Psychotic disorder with delusions due to known physiological condition. Record review of an Annual Admission Minimum Data Set (MDS) with a reference date of 7/8/24 Section A (Identification) revealed the resident is not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section N (medications) revealed Resident #31 was taking antidepressant medication during the last seven (7) days. Section O (special treatments and therapy) revealed the total number of minutes Psychological Therapy (by any licensed mental health professional) administered to the resident in the last 7 days was Zero (0). Record review of Care Plan with Start Date 02/11/2022 and Reviewed/Revised date of 08/04/2024 revealed Resident #31 was at risk for alteration in thought process secondary to diagnosis that included depression, psychotic disorder with delusions. Interventions included: Psychiatry/neurology consult and follow up as needed and anticipate all possible needs and provide them to resident accordingly. Record review of physician orders dated 10/13/2023 revealed Seroquel 25 milligram(mg) tablet directions: one tablet by mouth twice a day for Delusions and Sertraline 25 mg tablet directions: take one tablet by mouth once a day for Depression. Record review of a physician progress note dated 10/19/17 revealed family requested Resident #31 be followed up by a Neurologist from psychiatric point of view. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Report of Consultation dated 7/7/23 revealed a consulting physician Neurologist Report with findings of a diagnosis that included: Depression. Record review of a Psychiatric Note dated 2/2015 with diagnosis that included: Anxiety. On 08/08/24 10:09 AM The Director of Nursing (DON) stated Resident #31's diagnosis of Depression and Psychotic disorder were secondary to Parkinson Disease, and therefore the PASRR did not need to be reviewed. There is no documentation specifying that this resident's diagnosis of Depression is secondary to Parkinson Disease. The Gradual Dose Reduction (GDR) from pharmacy indicated that the hallucinations were secondary to Parkinson. Review of Consultant Pharmacist Services Note to Attending Physician/Prescriber for Resident #31 dated 1/14/24 revealed a recommendation to review the following medications and consider for GDR: Zoloft 25mg QD (daily) and Seroquel 25 mg (milligrams) BID (twice daily). Physician response dated 2/27/24: cannot be reduced or discontinued (d/c) for treatment of Depression and Seroquel cannot be reduced of discontinue (d/c) for treatment of hallucinations secondary to Parkinson disease. Resident #46 Record review of demographic sheet for Resident #46 revealed an admitted [DATE] with diagnosis that included Major depressive disorder and Psychotic disorder. Record review of Preadmission Screening and Resident Review (PASRR) for Resident #46 dated 2/19/24 PASRR: Section I: PASRR Screen Decision Making: no diagnosis checked Section IV: PASRR Completion: No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability Indicated. Level II PASRR evaluation not required. Electronically signed by Social Worker of local hospital on 4/3/24. Record review of a significant change MDS with reference date of 4/10/24 revealed Section A 1500: PASRR: The resident was not considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Further Record review of a quarterly MDS with reference date of 07/09/2024 Section I (Active diagnosis) revealed Depression. Section N revealed antidepressants and anticoagulants were taken in last 7 days and Section O the number of days psychological therapy (by any licensed mental health professional) was administered for at least 15 minutes a day in the last 7 days was 0. Record review of a Care Plan started on 3/20/24 and revised / reviewed on 7/29/24 revealed R#46 had the potential for changes in mood related to a diagnosis of Depression and history of Psychosis. Interventions included: Approach resident in a calm friendly manner, administer medications as ordered, and encourage interactions with others. Record review of physician orders revealed an order on 4/04/2024 for Trazodone 50 mg directions: take a half of tablet at bedtime for diagnosis of Depression. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Homestead Manor A Palace Community		STREET ADDRESS, CITY, STATE, ZIP CODE: 1330 NW 1st Ave Homestead, FL 33030	

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Psychiatric Initial Evaluation/Consultation observation date 4/11/24 and recorded date of 4/27/24 revealed reason for initial psychiatric evaluation was for psychotropic use and a past medical history that included Depression. On 08/08/24 10:09 AM The DON and Director for Admissions revealed they both work together to ensure an accurate PASRR is completed for all residents. The process is to review the PASRR before admission by reviewing all the medications to determine if there is any psychiatric diagnosis and if the resident has a qualifying mental diagnosis, check the appropriate box and submit the PASRR to Atrezzo and they report if a Level II is required. The PASRR stays with the resident for the duration while residing in the facility unless there is a change in behavior or if the psychiatrist is involved or a mental illness history is discovered. Then a resident review of PASRR is performed after consent from the family is obtained. Then the clinicals are submitted to Atrezzo and they inform us if a Level II is required and if the needs for the resident can continued to be met in the facility. A review did not need to be submitted for [Resident #46] prior because her Depression and Psychosis are secondary to a medical diagnosis. Record review of the facility's policy titled Resident Assessment and PASAAR effective date: November 2016 Last revision date: January 7, 2017 last review date: January 7, 2017, April 11, 2017, January 11, 2024 revealed Policy: The facility must make a comprehensive assessment of each residents' needs, strengths, goals, life history and preferences, using the residents assessment instrument (RAI) specified by CMS. Procedure: 2. Preadmission Screening for Individuals with a Mental Disorder and Individuals with Intellectual Disability d. A nursing facility must notify the state mental health authority or a state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental disorder or intellectual disability for resident review.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Keep all essential equipment working safely. 31581 Based on observations, interviews and record review the facility failed to prepare food under sanitary condition by ensuring the gas burner stove was cleaned and maintained on a regular basis. The gas burner contained brown-like food stains and food particles on top and black like buildup on the side panel of the stove and grill. This has the potential to affect 84 out of 85 residents who eat orally residing in the facility at the time of the survey. The findings included: Observation of the gas stove burners on 8/07/24 at 11:24 AM with the Dietary Supervisor revealed brown-like food stains and food particles on top and black like buildup on the side panel of the stove and griddle. Photographic evidence submitted. On 8/07/24 at 11:26 AM, interview with the Dietary Supervisor. She revealed the gas stove is cleaned everyday and that the facility is purchasing a new stove. On 8/07/24 at 1:38 PM, interview with the Registered Dietitian (RD). She revealed the stove is cleaned daily and weekly with a deep clean monthly. On 8/07/24 at 1:43 PM, interview with the Administrator. He revealed he could probably produce kitchen cleaning task sheet for weekly and monthly that the staff has done but not for daily cleaning. He revealed that the black like buildup was soot and was accumulated from cooking on it at breakfast and lunch. Record review of the Kitchen Cleaning Task Weekly dated 7/05/24, 7/12/24, 7/19/24, 7/26/24 and 8/02/24 and Kitchen Cleaning Task Monthly dated 1/01/24, 2/01/24, 3/01/24, 4/01/24, 5/01/24, 6/03/24, 7/01/24 and 8/01/24. No documentation of the Kitchen Cleaning Task Daily was provided. Kitchen Cleaning Task Weekly and Kitchen Cleaning Task Monthly documented wash behind your ovens and fryers to eliminate grease and clean underneath any appliances and other surfaces. Second observation of the gas stove burners on 8/08/24 at 7:31 AM during breakfast preparation with the Dietary Supervisor and the Administrator revealed attempts were made to clean the black like buildup on the side panel of the stove. The grill still contained black like buildup on the side panel. Photographic evidence submitted. On 8/08/24 at 7:32 AM, interview with the Dietary Supervisor. She stated, At the end of the shift at 7:00 PM yesterday, I cleaned the stove. I spray with degreaser, scrubbed and wash it out. On 8/08/24 at 7:33 AM, interview with the Administrator. He stated, She cleans daily for particles and soot. She cleans weekly and scrubs every part of the stove. Once a month, we remove the burners and clean them with [ ] from Corporate and do a complete cleaning of the stove. Third observation of the gas stove burners on 8/08/24 at 11:11 AM during lunch preparation revealed attempts were made to clean the black like buildup on the side panel of the stove. The grill still contained black like buildup on the side panel. Photographic evidence submitted.