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
	AL11969192	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME SUITE HOME	9286 BIRMINGHAM DR PALM BEACH GARDENS, FL 33410

(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 An unannounced Abbreviated Relicensure and Generator Monitoring survey was conducted at Home Suite Home on . The provider had deficiencies at the time of the visit.	A 000		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage.	A 052		

AHCA Form 3020-0001

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

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A 052	Continued From page 1 (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.	A 052		

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A 052	Continued From page 2 (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to	A 052		

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

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A 052	Continued From page 4 The findings included: 1) On at 9:45 AM, Staff C was observed assisting Resident #3 with the self-administration of the following medications: , , XL 150 mg, take 1 tab by daily ( ) 40 mg tablet, take 1 tab by every other day in the morning Preservision Areds 2 softgel, take 2 capsules by once daily (supplement) 500 mcg tab, take one by daily (supplement) D 5,000 Unit tab, take one by once daily (Supplement) At this time, Staff C went to the locked medication room and dispensed the above medications in a cup for Resident #3. The medications were removed from the properly labeled container while not in the presence of Resident #3. Staff then washed her and put on gloves and brought the cup containing the medications to the resident. When presenting the medications to Resident #3, there was no verbalization by Staff C of the name of the medication and dosage. Resident #3 stated he only takes and a water pill (which is every other day) in the morning and that's it. He stated that he doesn't like to take the because he doesn't think he needs it anymore, and he doesn't like the fact that it makes him urinate frequently. When the resident placed his ( ) outside of the plate, Staff C took a spoon, picked up the medication and placed the pill on the spoon. Staff then placed the spoon, with the medication on it, in the resident's	A 052		

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A 052	Continued From page 5 without any assistance from the resident, thereby administering the medication instead of assisting with self-administration. Resident #3 was alert and orientated and physically able to place his medications into his independently. 2) On at 12:02 PM, Staff C was observed assisting Resident #4 with the self-administration of the following medications: , 1 mg tablet, take 1 tablet by four times daily ( ). At this time, Staff C went to the locked medication room and brought the , 1 mg punch card and dispensed the medication in front of Resident #4 into a small cup with a spoon. Staff C stated to the resident, "Here is your medication;" however, Staff C did not state the name of the medication or the dosage. Resident #4 was encouraged to take the medication, and when she did not do so in a timely manner, Staff C placed the medication on the spoon and placed the spoon in Resident #4's without any assistance by Resident #4, thereby administering the medication instead of assisting with self-administration. Resident #4 is alert and oriented and was physically able to place the medication into her independently. Staff C documented the provision of the medications to Resident #3 and Resident #4 in the Medication Observation Record at the time the medication was provided. On at 12:05 PM, an interview was conducted with Staff C, who is a Home Health Aide. She stated that she had worked in the	A 052		

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A 052	Continued From page 6 facility for 3 years. She stated that when she provided the medication to Resident #4, she looked in the MOR and knew that Resident #4 was to get her medication at noon. She also stated Resident #4 knows which medication she is to get at noon. On at 2:20 PM, the Administrator's Assistant (Staff D) was informed of the concerns noted during the provision of medications by Staff C. She acknowledged that Resident #3 and Resident #4 had not signed a waiver to opt out of being orally advised of the medication name and dosage. Staff D also confirmed that Staff C should not have placed the medications for the Residents #3 and #4 on a spoon and placed the medications in their , as Staff C is not a licensed nurse. She stated the staff would be in-serviced regarding the correct procedures regarding assisting with self-administered medications. Class III	A 052		
A 083	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). 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 that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National	A 083		

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A 083	Continued From page 7 Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the provider failed to ensure a staff member who had completed an approved -on , , Training was always in the facility. The findings included: During employee record review on , it was discovered that Staff B, a direct caregiver who works from 7:00 PM to 7:00 AM, did not hold a valid certification card, as her training, which expires , , had been completed online and had not required this staff member to demonstrate, in person, that she was able to perform correctly. On at 11:30 AM, the Administrator was informed of the regulation requirement for all training to be completed "in person" and provided by an approved trainer. The Administrator was asked to provide evidence that there was one staff member on the 7:00 PM - 7:00 AM shift that currently holds an approved certification card. As of the submission of this report on at 12:30 PM, no evidence of compliance was	A 083		

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A 083	Continued From page 8 submitted. Class III	A 083		