

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practitioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice	A 162			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 162	Continued From page 1 services when such residents, their representatives, or their physicians request in writing that _____ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____, (_____), CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004 . The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 162	Continued From page 2 and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have resident care records and observations for one out of twelve (Resident #11) sampled residents. Findings included:	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 162	Continued From page 3 Observation on _____ at 9:20 am showed that Resident #11 was in bed. During an interview on _____ at 9:21am Staff I (caretaker) stated that Resident # 11 was under hospice care. A review of Resident # 11's health assessment dated _____ showed that Resident #11 needed total care with ambulation, bathing, _____, eating, grooming, toileting, and transferring, transferring. Resident #11 also needed Medication Administration. There was no notation that Resident # 11 was in hospice care on the health assessment. During an interview on _____ at 9:35am Staff I stated that they gave Resident # 11 her medications, when asked if a nurse administers medications to Resident # 11. During an interview on _____ at 9:45am the Administrator stated that Resident # 11 can take her medications on her own with food, when asked why her staff was administering medications to Resident #11. The Administrator stated that the health assessment was incorrect, when asked if she was sure that Resident # 11 could take her own medications. The administrator started crying during the interview and was worried that she would not get re-licensed. Class III {A 000} Initial Comments A third revisit survey was conducted at Silver	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170			
(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}	Continued From page 4 Palm ALF Corp on . Deficiencies were identified at the time of the survey.	{A 000}			
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , or decline in mobility or function related to the use of the prescribed (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on Observation, interview and record review, the facility failed to ensure that there was a written order, consent, and care plan for the use of a physical for one out of twelve sampled residents (11).	A 033			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 033	Continued From page 5 Findings included: Observation on _____ at 9:20 am showed that Resident #11 was in bed with a full-bed rail installed. During an interview on _____ at 9:21am Staff I (caretaker) stated that Resident # 11 was under hospice care. A review of Resident # 11's health assessment dated _____ showed that Resident #11 needed total care with ambulation, bathing, _____, eating, grooming, toileting, and transferring, transferring. Resident #11 needed Medication Administration. There was no notation that Resident # 11 was in hospice care on the health assessment. A review of Resident # 11's records shows that the resident had a physician order for full bed rails from the hospice provider and a signed consent dated _____. However, the care plan for physical _____ dated _____ was signed by the administrator but was left blank and no care plan was implemented. (photographic evidence obtained). During an interview on _____ at 9:45am the administrator stated that she needed to get the physician to fill out the care plan for physical _____, when asked about the blank care plan for physical _____. Class III	A 033			
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION.	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 053	Continued From page 6 (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including _____ testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on observation, interview and record	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 053	Continued From page 7 review, facility failed to have a licensed staff administering medication for one out of twelve sampled residents (Residents #12). Finding included: Observation on _____ at 9:20 am showed that Resident #11 was in bed. During an interview on _____ at 9:21am Staff I (caretaker) stated that Resident # 11 was under hospice care. A review of Resident # 11's health assessment dated _____ showed that Resident #11 needed total care with ambulation, bathing, _____, eating, grooming, toileting, and transferring, transferring. Resident #11 also needed Medication Administration. There was no notation that Resident # 11 was in hospice care on the health assessment. During an interview on _____ at 9:35am Staff I stated that they gave Resident # 11 her medications, when asked if a nurse administers medications to Resident # 11. When asked if she was licensed staff such as a nurse, she said no. A review of the state's database shows that Staff I was not a licensed professional. During an interview on _____ at 9:45am the Administrator stated that Resident # 11 can take her medications on her own with food, when asked why her staff was administering medications to Resident #11. The Administrator stated that the health assessment was incorrect, when asked if she was sure that Resident # 11 could take her own medications. The administrator started crying during the interview	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170			
(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 053	Continued From page 8 and was worried that she would not get re-licensed. Class III	A 053			
{A 054} SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.	{A 054}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 054}	Continued From page 9 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain an updated medication observation record (MOR) for one out of twelve sampled who receive assistance with self-administration of medications or medication administration (Residents #12). Findings included: Observation on _____ at 9:20am showed that the closet containing medications for residents was locked. Individual bins contained resident medications inside them. The medications were in _____ cards that were chronologically ordered by day per _____. A review of Resident # 12's MOR dated _____ to _____ showed that _____ 50mg was ordered once per day at 12:00pm. There was no documentation for the administration of medication on _____ at 12:00om. (Photographic evidence obtained) A review of Resident #12's medication _____ card showed that the _____ for _____ _____ 50mg on _____ were punched out. (photographic evidence obtained) During an interview on _____ at 9:32am Staff I (caretaker) stated that she must have forgotten to write it in, when asked about why there was no documentation Resident #12's _____ 50mg on _____. Uncorrected Class III	{A 054}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 058 A 058 SS=D	Continued From page 10 429.42() FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the 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 pharmacist	A 058 A 058			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 058	Continued From page 11 licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and 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 of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility is required to employ the consultant services or a licensed registered nurse or pharmacist who will provide onsite quarterly consultations until it is determined that such consultation services are no longer required. The facility received a deficiency of Medication-records on _____, and a new uncorrected deficiency on Medication- records, and a new deficiency on Medication Administration. Finding Included:	A 058			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 058	Continued From page 12 A review of Resident #9's MOR revealed the staff did not initial the medications scheduled for 7:00 PM on _____ and the medications scheduled for 7:00 AM on _____. A review of Resident #9's medications _____ cards revealed that the medications were given to the residents. A review of Resident #12's MOR dated _____ to _____ showed that _____ 50mg was ordered once per day at 12:00pm. There was no documentation for the administration of medication on _____ at 12:00am. A review of Resident #12's medication _____ card showed that the _____ for _____ 50mg on _____ were punched out. During an interview on _____ at 9:32am Staff I (caretaker) stated that she must have forgotten to write it in, when asked about why there was no documentation Resident #12's _____ 50mg on _____. A review of Resident # 11's health assessment dated _____ showed that Resident #11 needed total care with ambulation, bathing, _____, eating, grooming, toileting, and transferring, transferring. Resident #11 also needed Medication Administration. There was no notation that Resident # 11 was in hospice care on the health assessment. During an interview on _____ at 9:35am Staff I stated that they gave Resident # 11 her medications, when asked if a nurse administers	A 058			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/14/2026
NAME OF PROVIDER OR SUPPLIER SILVER PALM ALF CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 11271 SW 229 TERRACE MIAMI, FL 33170		
(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 058	Continued From page 13 medications to Resident # 11. When asked if she was licensed staff such as a nurse, she said no. A review of the state's database shows that Staff I was not a licensed professional. During an interview on _____ at 9:45am the Administrator stated that Resident # 11 can take her medications on her own with food, when asked why her staff was administering medications to Resident #11. The Administrator stated that the health assessment was incorrect, when asked if she was sure that Resident # 11 could take her own medications. The administrator started crying during the interview and was worried that she would not get re-licensed. Class III	A 058			