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 _____	R 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

(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 A revisit to a re-licensure survey was conducted from through at Palace at Homestead. The provider had deficiencies at the time of the survey.	{A 000}		
{A 052} SS=D	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}		

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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, record review and interview, the facility failed to ensure that a Staff K orally advised three out of 37 sampled residents who needed assistance with self-administration of medications on the name and dosage of their scheduled meds. The facility failed to ensure that Staff K provided assistance with self-administration of medication	{A 052}		

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{A 052}	Continued From page 4 for Resident #35. Findings: On at 06:52 AM Staff K was observed assisting Resident #22 with her schedule medication. Staff K did not advise Resident #22 on the name of the medication she was receiving. On at 07:16AM, Staff K was observed to administer Resident #35 her scheduled medication. Staff K did not advise Resident #35 on the name of the medication she was to receive. On at 07:24AM Staff K was observed to offer scheduled meds to resident #36. Staff K did not advise resident #36 of the med. Record review of the MOR for resident #35 revealed that her scheduled medication was , , , Periactin, , , and , Record review of the MOR for resident #36 revealed that she was scheduled to receive , Methenam, . On at 07:16 AM, Staff K was observed crushing the medication of Resident #35. On at 07:16AM, Staff K was observed administering Resident #35 medication. Staff K was observed spoon feeding Resident #35 the medication. Record review of Staff K revealed that she received a 6-hour training on Assistance with Self	{A 052}		

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{A 052}	Continued From page 5 administration of Medication on Record review of Staff K revealed that she was hired as a med Tech. on . On Record Review of the residents file of Resident #36, 35 and 22 there was no Medication Waiver form to indicate that Resident Opted out of being advised on medication Interviewed on at 3:19 PM the Administrator acknowledged that the employee did not name the medications and dosage and left the medication cart unlocked. Uncorrected Class III	{A 052}		
{A 055} SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications	{A 055}		

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{A 055}	Continued From page 6	{A 055}		

being stored pursuant to such a request;
3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or
6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C.
(c) Centrally stored medications must be:
1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and,
4. Kept separately from the medications of other residents and properly closed or sealed.
(d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future

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{A 055}	Continued From page 7	{A 055}		

use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider.
(e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f).
(f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.
(g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on Observation, Interview and Record Review, the facility failed to ensure that the unit where medication is stored was kept secure.

Findings:

On at 7:22 AM Staff K was observed to remove medications from the medication cart and entered a resident room and left the medication cart unlocked.

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{A 055}	Continued From page 8 On at 7:23 AM when interviewed regarding the unlocked cart, Staff K stated, "Please I was nervous." Record review of Staff K revealed that she received a 6-hour training on Assistance with Self Administration of Medication on Uncorrected Class III	{A 055}		
A 058 SS=F	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	A 058		

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A 058	Continued From page 9 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 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:	A 058		

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A 058	Continued From page 10 Based on Observation, interview and record review, the facility failed to ensure that two medication deficiencies cited at a previous survey were corrected. The Facility failed to ensure that Tag 0052- Assistance with self-Asmin. and Tag 0055 - Storage and Disposal were corrected. Findings: Record review revealed that during a Complaint Investigation and Revisit conducted at the facility from 10-13-2025 to 10-16-2025, the Facility was cited on deficiencies for Tag 0052 -Medication Assistance with Self Administration and Tag 0055-Medication storage and Disposal. On , at 7:22AM, a medication cart was observed to be unlocked. On during med pass at 6:52AM, 7:16AM and 7:24AM, Staff K failed to advise three out of 37 sampled residents on the medications they received On at 7:16AM Staff K was observed to administer medication to Resident #35. Staff K orally spoon fed Resident #35. Resident #35 needed Assistance with Self Administration of Medication. On interview 0n , at 3:19PM during the preliminary interview, when the deficiencies were being reviewed, Staff H, the Nursing Director Consultant stated "training, training, training". On interview on , at 3:19PM Staff H the Nursing Director Consultant stated that Staff K had received training separately	A 058		

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A 058	Continued From page 11 Class III	A 058		
{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 practioner 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	{A 162}		

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{A 162}	Continued From page 12 receiving assistance with the activities of daily living must have their ˬ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ˬ 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	{A 162}		

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{A 162}	Continued From page 13 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 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 and record review the facility failed to maintain an accurate and up to	{A 162}		

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

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{A 162}	Continued From page 14 date health assessment for one out of 37 sampled residents (Resident #35). Findings Included: Observation on at 7:16 AM showed that Staff K (Medication Technician) had crushed medication for Resident 35, mixed it with applesauce, and spoon-fed the resident the medications. A review of Resident 35's health assessment dated showed diagnoses of amyloid, , and angiopathy. Further review of the health assessment revealed the resident needed assistance with self-administration of medication. Uncorrected Class III	{A 162}		
{A 165} SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:	{A 165}		

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{A 165}	Continued From page 15 (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.	{A 165}		

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{A 165}	Continued From page 16 (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview and record review the assisted living facility failed to complete and submit 1-day initial adverse incident report for two out of 37 sampled residents (Resident #32 and	{A 165}		

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{A 165}	Continued From page 17 #33) due to multiple . Findings Included: 1) A review of Resident 33's progress notes dated showed that the resident was sent to the hospital by ambulance due to a and sustained a to the side of the . Further review of Resident 33's progress notes showed that on the resident returned to the facility, and on the resident was sent to the hospital by ambulance due to a to the right . Interviewed on at 11:41 AM the Director of Resident Care stated that the resident [Resident #33] was found on the bathroom floor in her room. She also stated that the resident returned to the facility and had been sent to the hospital after attempting to get out of bed, noting the resident was . A review of Resident 33's emergency medical services ( ) records dated revealed that the resident was found lying on the bathroom floor, and the caretakers informed the first responders that the resident had been in her wheelchair and tried to transfer herself over to the toilet but from her chair. A review of Resident 33's hospital records dated showed "Patient was apparently being transferred from a chair and she felt forward sustaining to the right forehead." A review of Resident 33's hospital records dated showed "Chief Complaint Patient	{A 165}		

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{A 165}	Continued From page 18 arrived from the palace via AMR due to right s/p falling while transferring from wheelchair to bed. Patient also has lac from 3 days ago but was already seen that day for it." A review of the agency's adverse incident database showed no incident reports were filed for Resident #33's which occurred on and . 2) A review of Resident 32's progress notes dated showed that the resident had been sent out to the hospital post . A review of Resident 32's progress notes dated showed that resident had been sent out to the hospital post . Further review of Resident 32's progress notes showed that on that resident had been sent out to the post . Interviewed on at 11:41 AM the Director of Resident Care stated that Resident #32 experienced resulting in hospitalizations on , , and . A review of Resident 32's hospital records dated showed "Patient's nurse informs the patient backwards out of her chair and hit her . The patient's nurse states she had a previous 3 days ago." Further review of the hospital records showed that, under the Assessment and Plan section, the patient was diagnosed with an orbital and a , . A review of Resident 32's hospital records dated	{A 165}		

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{A 165}	Continued From page 19 showed that the resident had a diagnosis of closed injury and hematoma of forehead. Further review of the hospital records showed that the resident and hit her with an "obvious left forehead hematoma." A review of Resident 32's hospital records dated showed "Patient had an unwitnessed at the [Facility Name]." Further review of the hospital records showed that, under the Assessment and Plan section, the patient was diagnosed with a injury and a of , . A review of the agency's adverse incident database showed no incident reports were filed for Resident #32's which occurred on , , and . Uncorrected Class III	{A 165}		