STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968041	**06/16/2017**
NAME OF PROVIDER OR SUPPLIER **TROY & GREG CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **12260 SW 184TH ST** **MIAMI, FL 33177**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced visit was made to Troy & Greg Corp located at 12260 SW 184th Street Miami FL 33177 on , 2017 in order to conduct a Complaint Investigations Survey CCR#2017006354. Deficient practice was identified at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview, and record review, the facility failed to ensure that 5 out of 5 residents (#1, #2, #3, #4, and #5) were properly supervised and receiving care and services to meet their needs. The residents were left alone in the facility. Three of these five residents were diagnosed with a chronic mental illness and required assistance from staff with medications and activities of daily living (ADLs).

Findings include:

On at 9:45 AM, observed that Resident #1 answered the door and allowed an unknown person (agency staff) into the facility. Resident #1 stated there were five residents present. Resident #1 called the owner. Further observations found there were four additional people sitting in the living . Resident #1 identified one person as her niece and the other three as fellow residents (#2, #3, and #4). Resident #1 also stated that Resident #5 went to the park. Resident #1 stated there were no staff members in the facility.

On at 9:50 AM, observation showed that there was no staff member present. A review of personnel records and the staffing schedule showed that no staff who had completed courses in First Aid and and held a currently valid card documenting completion of such courses was present.

On at 12:56 PM, when asked why the residents were left without supervision, the owner stated that this had never happened before and that she was gone for only 20 minutes.

A review of the health assessments revealed the following: Resident #1 was diagnosed with Major , , , , , ( ), and . Resident #2 was diagnosed with , ( ), II, and Accident ( ) resulting in significant aphasia. Resident #3 was diagnosed with , , Chronic , & . Resident #4 was diagnosed with High (HBP), Atherosclerotic (ASCVD), , , , , , and , . Record review found the facility did not have a record for Resident #5.

A review of the posted staffing schedule revealed the current month's (2017) schedule was not

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posted. The most recent schedule on the bulletin board was for 2017, and it reflected that there were three staff members.

On at 9:58 AM, the owner arrived.

On at 11:11 AM the owner acknowledged that the 2017 staffing schedule was not posted. The owner stated that she did not have the current staffing calendar and that right now she is by herself. The owner further stated that the administrator was out of town and would return on , 2017, and that the other caregiver was out of town and would return on , 2017.

A review of the medication observation records (MORs) for Residents #1, #2, #3, and #4 revealed the medication sheets were not initialed showing that the facility assisted the residents with morning medications from , 2017 through , 2017. The night medications from , 2017 through , 2017 were also not initialed.

On at 12:59 PM, the owner acknowledged that the medication observation records for Residents #1, #2, #3, and #4 were not initialed by staff.

Personnel record review revealed the owner's last medication training was dated . The facility did not have any documentation that the owner had taken assistance with self-administration annually.

Observation conducted on of the medication storage location revealed medications were stored for Resident #6. A review of Resident #6's health assessment showed that the resident needed assistance with self-administration of medication. Resident #6 was diagnosed with is , , Dyslipidemia, , and . A review of the medication observation log revealed no documentation showing that staff assisted Resident #6 with medications for the month of 2017 or any previous months.

On at 10:17 AM, the owner reported, Resident #6 took a bath in the morning ( ), ate breakfast and said that he was going to see his father. But that night he did not return. The owner stated they spoke with the case worker, the found out Resident #6's father had passed a year ago. The owner stated that they immediately called the police and yesterday ( ) they received a call telling them that resident #6 was found.

A review of Resident #6's file revealed a note dated that the resident had not return. Notes on documented Resident #6 still had not returned to the facility. The facility contacted the police and a report was made.

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On at 12:59 PM, the Owner stated that the facility did not have the medication observation sheets for Resident #6. The Owner further stated that she gave Resident #6 the medications. The owner acknowledged there was no documentation showing that Resident #6 received assistance with medication as prescribed.

Class II

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview, the facility failed to follow its 'Resident Wandering & Elopement' policies and procedures for 5 out of 6 sampled residents (#1-#6). The facility failed to have photo identification for 1 out of 6 sampled residents (#6).

Findings include:

On at 10:17 AM, the owner reported, Resident #6 took a bath in the morning ( ), ate breakfast and said that he was going to see his father. But that night he did not return. The owner stated they spoke with the case worker, the found out Resident #6's father had passed a year ago. The owner stated that they immediately called the police and yesterday ( ) they received a call telling them that resident #6 was found.

A review of Resident #6's file revealed a note dated that the resident had not return. Notes on documented Resident #6 still had not returned to the facility. The facility contacted the police and a report was made. Record review found the facility did not have a photo id of Resident #6.

A review of the facility's policy and procedures for 'Resident Wandering & Elopement' revealed, "it is the policy...to establish a method of assessing residents for risk of wandering and eloping at the time of admission and as needed.

Record review revealed no document showing Residents #2, #3, #4, #5, and #6 were assessed for risk of wandering and eloping at the time of admission.

Class III