STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968387	R 11/02/2017
NAME OF PROVIDER OR SUPPLIER **A PLACE TO GROW LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **109 VALLEY DR** **BRANDON, FL 33510**	

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

0000 - Initial Comments

Assisted Living Facility

On , an unannounced revisit was conducted for complaint survey, (CCR# 2017008333) of , at A Place to Grow, LLC. (License #12293), an Assisted Living Facility located in Brandon, Florida. There were deficiencies identified during the survey.

(License # 12293)

0051 - Medication - Pill Organizers - 58A-5.0185(2) FAC

Based on observation and interview, the facility failed to ensure that a licensed staff removed medications from the primary packaging and into pill organizers for five (#1, #2, #3, #4 and #5) of six residents who received supervision or assistance with self-administration.

Findings included:

On at 06:07 a.m., five pill organizers containing with unspecified tables/capsules observed on the kitchen counter. Pill organizers were marked (handwritten with marker), with names of Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5 (image taken).

During interview with Staff A, on at 06:07 a.m., staff stated that another, unlicensed, resident care aide placed the medications inside the pill organizers. Staff A stated that she forgot the medications on the kitchen counter overnight.

During interview with the Administrator, on at 06:45 a.m., she confirmed that staff who removed medications form primary packaging and placed medication in pill organizers was a resident care aide and not licensed.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968387	R 11/02/2017
NAME OF PROVIDER OR SUPPLIER **A PLACE TO GROW LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **109 VALLEY DR** **BRANDON, FL 33510**	

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

Based on record review and interview, the facility failed to maintain an accurate and up-to-date Medication Observation Records (MORs) that reflected each time medications were provided to residents for six (#1, #2,#4, and #5), of six residents residing at the facility.

Findings Included:

Review of Residents' MORs, conducted on , revealed that prescribed medications were not documented as given for the following residents:

Resident #1's MORs revealed that seven scheduled medication dosages were not documented as given on at 12:00 p.m., and 8:00p.m.

Resident #2's MORs revealed that seven scheduled medication dosages were not documented as given on at 11:00 a.m., 12:00 p.m., and 8:00p.m.

Resident #3's MORs revealed that five scheduled medication dosages were not documented as given on at 12:00 p.m., and 8:00p.m.

Resident #4's MORs revealed that two scheduled medication dosages were not documented as given on at 8:00p.m.

Resident #5's MORs revealed that one scheduled medication dosages were not documented as given on at 8:00p.m.

During interview with the Administrator, on at 06:45 a.m., she reviewed and confirmed the medication dosages were not documented as given to Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to ensure that centrally stored medications were locked overnight for five (#1, #2, #3, #4 and #5) of six residents who received supervision or assistance with self-administration.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968387	R 11/02/2017
NAME OF PROVIDER OR SUPPLIER **A PLACE TO GROW LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **109 VALLEY DR** **BRANDON, FL 33510**	

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

Findings included:

On at 06:07 a.m., five pill organizers containing with unspecified tables/capsules observed on the kitchen counter (image taken).

During interview with Staff A, on at 06:07 a.m., staff stated that she forgot the medications on the kitchen counter overnight after providing the 08:00p.m. Medications.

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on interview and record review, the facility has ongoing deficient practice related to the assistance with self-administration of medications.

Findings included:

During a survey conducted on , the facility was cited with one Class III deficiency for Medication - Records. During a revisit, conducted on , the facility was cited for Medication - Records at an uncorrected Class III.

Review of Residents' Medication Observation Record (MOR), conducted on , revealed that prescribed medications were not documented as given for the following residents, (Images MORs taken).:

Resident #1's MORs revealed that seven scheduled medication dosages were not documented as given on at 12:00 p.m., and 8:00p.m.

Resident #2's MORs revealed that seven scheduled medication dosages were not documented as given on at 11:00 a.m., 12:00 p.m., and 8:00p.m.

Resident #3's MORs revealed that five scheduled medication dosages were not documented as given

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968387	R 11/02/2017
NAME OF PROVIDER OR SUPPLIER **A PLACE TO GROW LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **109 VALLEY DR** **BRANDON, FL 33510**	

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

on at 12:00 p.m., and 8:00p.m.

Resident #4's MORs revealed that two scheduled medication dosages were not documented as given on at 8:00p.m.

Resident #5's MORs revealed that one scheduled medication dosages were not documented as given on at 8:00p.m.

During interview with the Administrator, on at 06:45 a.m., she reviewed and confirmed the medication dosages were not documented as given to Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5

Based on uncorrected class III deficiencies concerning assistance with accurate documentation of self-administration of medications, the facility shall be required to employ the consultation services of a licensed pharmacist or a registered nurse.

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.

This serves as a written notification of the requirement for the above described consultation services.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation and interview, the facility failed to maintain a written work schedule that accurately reflected the direct care staffing pattern. Posted schedule was for the month of , of 2017.

Findings included:

Upon entry, on at 06:01 a.m., it was revealed that Staff A was the only employee who worked the night shift.

Review of the facility staffing schedule revealed that a dry erase calendar broad, used for their current working schedule, did not have a month listed and the day of the survey, Thursday, , did not

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968387	R 11/02/2017
NAME OF PROVIDER OR SUPPLIER **A PLACE TO GROW LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **109 VALLEY DR** **BRANDON, FL 33510**	

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

aligned with the posted calendar, as written (second of the month was on a Saturday). Further review revealed that the Staff A, who was on site and who worked the night shift, was not included on the schedule, (image taken).

During interview with the Administrator, on at 06:45 a.m., she confirmed that schedule on board was the direct care-staffing schedule, and that it was not accurate.

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on observation, interview and record review, the facility failed to ensure that one employee (Staff A), who worked alone in the facility, completed First Aid and ( ) training.

Findings included:

Upon entry, on at 06:01 a.m., it was revealed that Staff A was the only employee who worked the night shift. Staff A stated that she worked at the facility for four days.

Record review revealed no documentation for Staff A at the facility, including training in First Aid and .

During interview with the Administrator, on at 06:45 a.m., she confirmed that there was no documentation for Staff A.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to maintain an up-to-date admission and discharge log recording the admission and the discharge date, the reason for discharge, and where the resident was discharged for one (Resident #3) of six resident who resided at the facility.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968387	R 11/02/2017
NAME OF PROVIDER OR SUPPLIER **A PLACE TO GROW LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **109 VALLEY DR** **BRANDON, FL 33510**	

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

Findings included:

Facility tour, conducted on . . . . . revealed that there was six residents slept at the facility.

Review of the facility's Admission Discharge Log revealed that five residents were listed as residing at the facility for assisted living services. Further review revealed that Resident #3 listed as a daycare participant.

During interview with the Administrator, on . . . . at 06:45 a.m., she confirmed that Resident #3 was listed as daycare, and that Resident #3 was, in fact, an assisted living resident.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on interview and record review, the administrator of a facility failed to maintain personnel records for one employee (Staff A), who worked alone in the facility, which contain at a minimum a copy of the employment application, with references furnished, documentation verifying freedom from signs or symptoms of a communicable and documentation of compliance with staff training.

Finding included:

Upon entry, on at 06:01 a.m., it was revealed that Staff A was the only employee who worked the night shift. Staff A stated that she worked at the facility for four days.

Record review revealed no documentation for Staff A at the facility.

During interview with the Administrator, on . . . . at 06:45 a.m., she confirmed that there was no documentation for Staff A.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968387	R 11/02/2017
NAME OF PROVIDER OR SUPPLIER **A PLACE TO GROW LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **109 VALLEY DR** **BRANDON, FL 33510**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview the facility failed to maintain an updated employee roster in the Agency background-screening clearinghouse for one (Staff A) employees who worked overnight by herself.

Findings included:

Upon entry, on at 06:01 a.m., it was revealed that Staff A was the only employee who worked the night shift.

Review of the AHCA Background Screening Clearinghouse Agency website revealed that Staff A was not listed on the employee roster for the provider. Further review of the website revealed that Staff A did not have a Level II background screening.

During interview with the Administrator, on at 06:45 a.m., she was informed and confirmed that Staff A was not listed on the employee roster.

Unclassified

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on record review and interview the facility failed to ensure that employee (Staff A) who worked background-screening clearinghouse for one (Staff A) employees who worked overnight by herself, supervising and providing care and having access to residents.

Findings included:

Upon entry, on at 06:01 a.m., it was revealed that Staff A was the only employee who worked the night shift. Staff A stated that she worked at the facility for four days.

Review of the AHCA Background Screening Clearinghouse Agency website revealed that Staff A was not listed on the employee roster for the provider. Further review of the revealed that Staff A did not have a

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968387	R 11/02/2017
NAME OF PROVIDER OR SUPPLIER **A PLACE TO GROW LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **109 VALLEY DR** **BRANDON, FL 33510**	

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

Level II background screening.

During interview with the Administrator, on at 06:45 a.m., she confirmed that Staff A has not completed a level II background screening and that there was no documentation for Staff A.

Unclassified

Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, interview and record review, that facility failed to correct previously identified operations while exceeding licensed capacity. Specifically, six residents received 24-hour assisted living services while the facility was licensed for a capacity of five residents.

Findings included:

Facility's license (#12293), effective from to , established that the facility was licensed for five private beds.

Facility tour, conducted on at 06:00 a.m. revealed that there were six residents sleeping at the facility. The facility had a total of six beds, five occupied. Sixth resident, Resident #3, was observed sleeping in the living a double recliner.

Review of the facility's Admission Discharge Log revealed that five residents were listed as residing at the facility for assisted living services. Further review revealed that Resident #3 listed as a daycare resident.

During interview with the Administrator, on at 06:45 a.m., she confirmed that Resident #3 was listed as a daycare resident, and that Resident #3 was, in fact, an assisted living resident with a bed at the facility.

Unclassified