STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968041	R **09/05/2018**
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

A monitoring survey revisit was conducted on . . . . . Troy and Greg corp. with limited mental health component (license #12007) had the following deficiency identified at the time of the survey:

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation and record review, the facility failed to ensure that licensed staff administer medications to one of out five sampled residents (Resident #1).

Findings included:

On . . . . at 12:10 PM observed Staff B wearing gloves, from . . . . packets she placed the medication in a small plastic cup. The resident was unable to grab medication. The staff placed the medication in the resident's mouth.

A review of Resident #1's health assessment showed the resident needs assistance with self-administration of medications.

A review of Resident #1's hospice record showed the resident's medication to be administered and coordinated by the assisted living facility.

Class III