

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 04/14/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966734	(X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER B & B Home Care III	STREET ADDRESS, CITY, STATE, ZIP CODE 11960 Sw 172 Street Miami, FL 33177	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced limited nursing services monitoring survey was conducted on . . . B & B Home Care III had deficiencies at the time of the survey.

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview the Assisted Living Facility failed to have statement from health care provider of freedom of . . . documented on an annual basis for administrator and manager of the Assisted Living Facility.

Findings include:

- Record review of administrator's personnel file revealed that statement from health care provider of freedom of . . . was completed on . . .
Record review of manager's personnel file revealed that he was hired on . . . and did not have a statement from health care provider of freedom communicable . . . including . . .
- In an interview with administrator on . . . at approximately 1:13 p.m. revealed that she did not understand why her statement from her health care provider about freedom of . . . was not in her personnel file and facility's manager went the day before to his doctor office to pick up physical examination form but the office was closed because it was Sunday.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 15, 2014

Administrator
B & B Home Care III
11960 Sw 172 Street
Miami, FL 33177

Dear Administrator:

This letter reports the findings of a state Limited Nursing Services (LNS) Monitoring survey that was conducted on May 15, 2014 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after 5/15/2014 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

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