STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967079	08/05/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
L & B Solution Care, Inc	565 Ne 137 Street Miami, FL 33161	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D

Specific Tag Findings:

0000-Initial Comments

An complaint inspection (#2014006602) was conducted on . . / . L & B Solution Care, Inc had no deficiencies found at time of survey.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on observation and record review, the facility failed to have an accurate health assessment regarding 1 of 3 sampled residents Activities of Daily Living status.

Findings include:

Observation during the tour on / at 9:18 am revealed # had 2 beds. One was occupied by resident #3. He was in bed sitting up but was doubled over. According to staff A, he is unable to walk. She said he has been here about two years and he used to be able to walk but as he has gotten older he has gotten worse. Staff A and staff B were observed transferring the resident from his a couch in the living . The resident could not bear any weight himself. Staff was visibly tired after performing the transfer. It was approximately 18 feet from the resident's the couch. The resident did not verbalize anything during the transfer. Staff kept instructing him to step, but had to position his legs for him multiple times. Staff members started the transfer one person one each side of the resident, but after they took the resident through the kitchen, one staff member moved to the resident's front. He was leaning heavily and his body was bent forward. The two staff members then took him and placed him on the couch. Once on the couch, he sat down, doubled over with his face in his hands and remained in that position.

Review of resident #3's most recent health assessment dated revealed it indicated that the resident required assistance with his Activities Daily Livings, which was not consistent with the above observation where the resident was completely dependent on staff for transferring.

Interview with staff A on / at 10:56 am revealed she confirmed that staff has to do everything for resident #3.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
L & B Solution Care, Inc
565 Ne 137 Street
Miami, FL 33161

RE: CCR #2014006602

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 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 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, RN
Field Office Manager

AMD:kb
Enclosure 2014006602
XG90

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