STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967573	**08/11/2015**
NAME OF PROVIDER OR SUPPLIER **L & B SOLUTION CARE II, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **567 NE 137 STREET** **MIAMI, FL 33161**	

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

0000 Initial Comments

An Capacity Expansion Survey was completed on 08/11/15. L & B Solution Care II, Inc. with Limieted Mental Health component had defiencies found at the time of survey and cited under the biennial.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 21, 2015

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

Dear Administrator:

This letter reports findings of a Capacity Increase Survey that was conducted on August 11, 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates all deficiencies were cited under the biennial 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

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