STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965704	09/01/2016
NAME OF PROVIDER OR SUPPLIER **SOL ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **2400 SW 137 COURT** **MIAMI, FL 33175**	

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

0000 Initial Comments

A Limited Mental Health Component Expansion Survey was conducted on / . Sol Assisted Living Facility Inc. (license # 10061) had the following deficiencies at time of the survey:

0030 Resident Care - Rights & Facility Procedures

Based on interview, record review, and observation, the facility failed treated one out of seven (#1) residents sampled with consideration, respect and with due recognition of personal dignity, individuality, and the need for privacy.
Findings included:
On / at 10:59 AM Interview with Resident #1, she stated "I live here, I have little family here."
On / at 11:02 AM interview with Resident #2 who was sitting next to Resident #1, stated "she (Resident #1) live here. She sleep on the sofa in the living . She does not go home, I do not see anyone that picks her up here."
On / at 11:05 AM, during an interview the facility's Administrator intervened and stated "she (Resident #1) slept on the sofa to rest."
On / at 11:35 AM toured the facility for the second time, found the facility had six beds but had seven residents over its licensed capacity.
Class III

Z828 Administrative Fines: Violations

Based on observation, record review, and interview, the facility failed to obtain a licensure capacity increase prior to providing personal care and meals to seven residents. The facility provided services to residents outside current license capacity of six.
Findings included:
Facility tour on / at 10:30 AM found the facility had seven residents.
On / at 10:59 AM interview with Resident #1, she stated "I live here, I have little family here."
On / at 11:02 AM interview with Resident #2 who was sitting next to Resident #1, stated "she (Resident #1) live here. She sleep on the sofa in the living . She does not go home, I do not see anyone that picks her up here. She has breakfast, lunch, diner here and she did take her medication on her time."
On / at 11:05 AM, during an interview the facility's Administrator intervened and stated "she (Resident #1) slept on the sofa to rest."
On / at 11:35 AM toured the facility for the second time, found the facility had six beds but had seven residents over its licensed capacity.
Facility finder review on / showed that the facility was licensed for 6 beds.

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Record review on _ _ _ / _ _ showed that Resident #1 (admitted on / /) had day care agreement for $720 monthly till 7:00 PM daily.
On / at 11:30 AM observed a a filing cabinet and a locked closet door, the Administrator was asked to open it. The Administrator stated this was her private personal belongs. She opened one side of the closet and in the other side observed a plastic box with hidden medications, bingo card and medication observation record (MORs). Facility's Administrator stated that she had the medications in here for Resident #1. The MORs showed Resident #1 had medications scheduled form 8:00 AM and 8:00 PM.
Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Sol Assisted Living Facility
2400 Sw 137 Court
Miami, FL 33175

Dear Administrator:

This letter reports the findings of a Limited Mental Health component expansion licensure survey that was conducted on , 2016 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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