STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967079	R **02/26/2018**
NAME OF PROVIDER OR SUPPLIER **L & B SOLUTION CARE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **565 NE 137 STREET** **MIAMI, FL 33161**	

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

0000 - Initial Comments

A Third Follow Up Visit to a Complaint Investigation Survey CCR#2017001700 and 2017002215 was conducted on . L & B Solution Care, Inc. with a Limited Mental Health component and license# 11186 had the deficiencies at the time of the survey.

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview, the facility failed to follow procedures outlined by the state while assisting one of four sampled residents with assistance with self-administration of medications (Resident #2).

Finding included:

On . At 12:21 Staff A was observed assisting Resident #2 with self-administration of medications. Staff A failed to immediately signed the MOR after assisting the Resident.

On at around 12:22 pm, Staff A stated "I am going home to get the book (MOR)."

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation and interview the facility failed to maintain an updated medication observation record (MOR) for four out of four sampled residents (Resident #1, 2, 3, & 4).

Finding included:

During an interview on at 10:00 AM Staff C stated "I gave the residents their medications when they were having their breakfast. I did not sign the MOR because I don't have the book. Staff A usually signed for me."

At 12:21 Staff A assisted Resident #2 with self-administration of medications. Staff A did not sign the MOR. Staff A stated "I am going home to get the book (MOR)."

Uncorrected
Class III

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0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to complete and submit adverse incident reports.

Findings included:

A review of the facility records on revealed that there were no incident reports filed.

On at 12:00 PM resident #2 eloped from the facility for over a week and was found 27 miles away from the facility.

On at 1:11 PM a phone interview was conducted with the Hospital risk manager, who stated that Resident #2 was found by police at a bus stop in Pompano Beach. She was disoriented and and was taken to a hospital in Broward under .

A review of the hospital records for Resident #2 showed grossly , illogical and judgment severely , .

A review of the facility's record for resident #2 revealed that the resident was diagnosed with; , , , , , . Further record review showed that on at 6:15 PM was observed that the resident was not at home and at 6:30 the caregiver notified the Administrator. At 10:02 PM facility called the police to report it. On resident also eloped for a few hours and no notes neither record of it were in the facility.

A review of the incident report database showed that the incident reports had still not been filed as of .

During an interview on at 11:22 AM, Staff A stated "I completed the incident report but it was returned to me because I had to fix it. When I contacted the agency, I was told to take it off because the facility was closed and do not need to do it again."

During a tour of the facility on at 6:00 AM, observed that the facility and its sister facility were operated in one continuous building, as one house. Throughout the day on , observed that residents from both sides of the home ate meals together at a dining table, were assisted by the same staff, and had medications stored in one common medication cabinet.

Record review showed that, prior to Staff A closing one side of the facility and surrendering the license ,

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there was one admission and discharge log, containing all residents from either side of the facility, although each side of the facility had its own state license number. There was no documentation of a separate admission and discharge log for each separately licensed facility.

On at 12:30 PM, the Administrator/Owner stated that it was too expensive to merge the facilities because this merge would require walls and one of the duplex's kitchens to be removed. To avoid the expense, she had obtained two separate licenses, one for each side of the duplex, but operated the site as one contiguous facility. She stated that this was why there was only one admission and discharge log, containing residents from both houses

Uncorrected
Class III