| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968275 | 10/28/2013 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| Osmani M Alf Llc | 26423 Sw 122 Place Homestead, FL 33032 | |
| SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) | | |

**List of Tags Cited:**
St - A - 0007 - 58a-5.0181(1) Fac - Admissions - Criteria S-S= D

**Specific Tag Findings:**

**0000-Initial Comments**

An unannounced complaint (CCR# 2013011321) survey was conducted on . Osmani M Alf Llc had deficiencies at the time of the survey.

**0007-Admissions - Criteria 58A-5.0181(1) FAC**

Based on observation, record review and interview the Assisted Living Facility failed to meet the admission criteria for one out of six sampled residents (#1).

Findings include:

1. Observation on at 8:30 a.m. revealed that resident #1 was on # lying on bed and needs total assistance for transferring.

2. Record review for resident #1's file revealed that this resident was admitted on . The health assessment (AHCA form 1823) completed on revealed that resident #1 can ambulate and eat independent, but s/he needs assistance with the rest of activities of daily living. Resident #1's weight log revealed that on until weighed 500 lbs (pounds) and on weight 510 lbs.

3. Interview with caregiver_A on at 11:40 a.m. revealed that resident #1 needs total assistance for transferring and ambulating; resident #1 cannot use , toilet or portable commode. Resident #1 has been like that since admission but to meet the admission criteria to be on an assisted living facility resident needs to be able to at least to assist with activities of daily living. Facility will get in contact with physician to discuss resident's future care. Caregiver_A stated that resident disposed his/her bowel movement on a plastic bag due to s/he is unable to use toilet or portable commode.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Osmani M Alf Llc
26423 Sw 122 Place
Homestead, FL 33032

**Re: CCR #2013011321**

Dear Administrator:

This letter reports the findings of a state complaint survey that was conducted on , 2013 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
Field Office Manager

AMD:sy
Enclosure
XG90

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