| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11968320** | **02/03/2016** |
| NAME OF PROVIDER OR SUPPLIER<br>**OUR FAMILY ASSISTED LIVING FACILITY II, INC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**1813 SW 150 PLACE**<br>**MIAMI, FL 33185** | |

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

**0000 Initial Comments**

A Complaint Survey (CCR#2015013365) was conducted on / . Our Family Assisted Living Facility II with Limited Mental Health component had the following deficiency found at the time of the survey:

**0054 Medication - Records**

Based on observation, record review, and interview the facility failed to accurately maintain the medication observation record (MOR) for 6 out of 6 sampled residents (Residents # 1-6). The facility completed the MORs prior to the residents taking their medications.

Findings included:

On at 7:20 AM observed medication dispensation cards (bingo cards) for Residents #1 through #6. Medications (pills) for the date for the morning were still in the bingo cards. The medication orders on the MORs stated that medications were to be taken at 7:00 AM.

On at 7:25 AM Medication Observation Record (MOR) was observed. It was marked as if the medications had already been given to residents, however no medications had been given yet.
On at 7:25 AM, Caregiver B stated that she had marked the book already because she got up early and she thought that she was going to do it earlier.
On at 11:00 AM the Administrator stated that she did not know why the caregiver was marking the MORs before the medications were provided to the residents.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Our Family Assisted Living Facility Ii, Inc
1813 Sw 150 Place
Miami, FL 33185
**RE: CCR #2015013365**

Dear Administrator:

This letter reports the findings of a complaint licensure survey that was conducted on 3, 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure
XG90

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