STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968320	05/12/2016
NAME OF PROVIDER OR SUPPLIER **OUR FAMILY ASSISTED LIVING FACILITY II, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1813 SW 150 PLACE** **MIAMI, FL 33185**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on and concluded on . Our Family Assisted Living Facility II with a standard license had the following deficiencies found at the time of the survey:

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appoint a separate Manager for each facility the Administrator supervises.

Findings included:

Record review revealed the Administrator supervised two assisted living facilities. Record review found the facility did not have an appointed a Manager.

On / at 2:36 PM the Administrator was contacted over the phone. The Administrator stated she was the manager at this facility, and that her brother was the Manager at the other facility. It was explained that she needed to have two separate managers for each facility. She acknowledged the finding.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on record review and interview the facility failed to ensure one out of four (Staff C) sampled staff received 2/hours continuing education training for assistance with self-administration of medication.

Findings included:

On at 11:20 AM record review revealed that Staff C did not have the continuing education training for assistance with self-administration of medication training. The initial training was dated / and expired /.

On at 1:15 PM in an interview the Administrator stated that she was not aware of this training that was missing, and that she was going to try and correct it immediately.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968320	05/12/2016
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0160 Records - Facility

Based on record review and interview the facility failed to have an annual satisfactory health inspection.

Findings included:

On at 9:00 AM the Health Inspection was posted was dated , which expired . The facility failed to have an annual satisfactory health inspection.

On at 1:15 PM in an interview the Administrator stated that she had requested already the new one but she had not received it yet, she was still waiting for it.

Class III

Z814 Background Screening Clearinghouse

Based on record review and interview the facility failed to register one out of four sampled staff (Staff D) in the background screening's clearinghouse.

Findings included:

On at 11:20 record review showed Staff D was put on the staff schedule as to work every night during the month of from 7:00 PM to 7:00 AM.

On at 11:30 AM the clearinghouse review showed that the facility did not have Staff D registered.

On / at 1:15 PM during the exit conference with the administrator, she stated that she had not registered the employee on the clearing house because the employee had just come back to work a month ago.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Our Family Assisted Living Facility Ii, Inc
1813 Sw 150 Place
Miami, FL 33185

Dear Administrator:

This letter reports the findings of a Standard Biennial 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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