

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 07/01/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968320	(X3) DATE SURVEY COMPLETED R
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 Revisit Survey was conducted on 06/23/16. Our Family Assisted Living Facility II with a standard license number 12214 had the following deficiency 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 supervised.

Findings included:

Record review on showed that the facility's Administrator supervised two assisted living facilities. The facility did not have documentation that a Manager was appointed.

During a phone interview on at 10:57 AM the facility's Administrator stated that she is Administrator at this facility only and at the other facility was appointed another person as administrator. She stated I have documentation at home.

On at 1:05 PM the licensure unit from the agency confirmed that a Change of Administrator form via fax was received on

Uncorrected Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11968320	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y2 Y3
NAME OF FACILITY OUR FAMILY ASSISTED LIVING FACILITY II, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1813 SW 150 PLACE MIAMI, FL 33185	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0084	Correction	ID Prefix A0160	Correction	ID Prefix AZ814	Correction
Reg. # 58A-5.0191(5) FAC	Completed	Reg. # 58A-5.024(1) FAC	Completed	Reg. # 435.12(2)(b-d), FS	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>JS</i>	DATE 7/11/6	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 5/12/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO



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 revisit survey conducted on , 2016 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

