STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968275 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OSMANI M ALF LLC	26423 SW 122 PLACE HOMESTEAD, FL 33032

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 A0026 Reg. # 58A-5.0182(2) FAC LSC	Correction Completed	ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) J	DATE 7/29/14	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968275	R 07/14/2016
NAME OF PROVIDER OR SUPPLIER **OSMANI M ALF LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **26423 SW 122 PLACE** **HOMESTEAD, FL 33032**	

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

0000 Initial Comments

A Standard Biennial Survey Revisit was conducted on 07/14/2016. Osmani M Alf Llc (license #12215) had the following deficiencies identified at the time of the survey:

0032 Resident Care - Elopement Standards

Based on record review and interview, the facility failed to assess residents at risk for elopement for one out of four (Resident #1) sampled residents.

Findings include:

Review of Resident #1 record review showed that she was admitted at the facility on . Health Assessment dated indicated that the resident was diagnosed with and memory . The resident requires supervision with bathing and independent with the rest of the activities of daily living.

The progress notes document that Resident #1 went for a walk and did not return on / . The facility called the police. The resident was and still was in jail on . The hospital contacted the facility letting them know that Resident #1 was there on .

Record review found that the facility has a written elopement policy and procedure which requires that "The residents will be assess for risk of wandering and eloping at the time of the admission."

Resident record review for Resident #1 revealed that there was no documentation that the assessment for risk of wandering and eloping was conducted at the time of the admission.

Interview conducted with the owner on at 10:40 AM stated " The social security gave the information of the facility that he resided before he had been admitted at the hospital. I talked to them and the lady told me that they did not want him back to the facility because he had problems with elopement. I do not remember the facility or administrator name. He remains at the hospital. "

Interview conducted on at 10:40 AM, administrator confirmed elopement policy and procedure which requires that every resident be evaluated for risk of wandering and eloping was not being followed.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968275	R
NAME OF PROVIDER OR SUPPLIER **OSMANI M ALF LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **26423 SW 122 PLACE** **HOMESTEAD, FL 33032**	

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

0079 Staffing Standards - Levels

Based on observation, interview, and record review, the facility failed to maintain an accurate written work schedule that reflects its 24-hour staffing pattern.

Findings included:

Observation on at 9:55 AM revealed Staff D was alone in the facility taking care of the residents.

The Staff B arrived at 10:14 AM.

Interview conducted on at 10:19 AM, Staff B stated "I went to the store to buy laundry supplies. I live here."

Review of facility's record revealed the staff schedule for 2016 was posted in the bulletin board did not show beginning or ending of week date; work schedule for 2016 showed on all Thursday Staff A/Administrator is scheduled from 12 PM- 8 PM, Staff B from 7 AM- 4 PM, Staff C from 8 PM- 7 AM and Staff D from 7 AM-3 PM.

Class III
Uncorrected

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interview, the facility failed to complete and submit one day and fifteen day adverse incident report for one out of four (Resident #1) sampled residents.

Findings Include:

Review of Resident #1 record review showed that she was admitted at the facility on . Health Assessment dated indicated that the resident was diagnosed with and memory . The resident requires supervision with bathing and independent with the rest of the activities of daily living.

The progress notes document that Resident #1 went for a walk and did not return on . The facility called the police. The resident was and still was in jail on . The hospital contacted the facility letting them know that Resident #1 was there on .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER **OSMANI M ALF LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **26423 SW 122 PLACE** **HOMESTEAD, FL 33032**	

SUMMARY STATEMENT OF DEFICIENCIES
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Interview conducted on at 10:20 AM, Staff B stated that she did not submit one day and fifteen day adverse incident report for Resident #1.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a Standard Biennial revisit survey conducted on , 2016by 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

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