STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968320	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR FAMILY ASSISTED LIVING FACILITY II, INC	**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 2nd Revisit Survey was conducted on 8/10/16. Our Family Assisted Living Facility II with a standard license, number 12214, had the following deficiencies found at the time of the survey:

0079 Staffing Standards - Levels

Based on observation, record review, and interview the facility failed to maintain a written staffing pattern that reflects its 24 hour staff pattern for a given time period.

Findings included:

Observation on at 9:00 a.m. found Staff D in the facility cleaning.

The facility's staffing pattern did not have Staff D listed. The staffing pattern documented that the Administrator was scheduled to work from 9 a.m. to 6 p.m. Also, on the weekends it documented that two staff members worked 48 hours but the staffing pattern did not indicate which hours the staff members would work.

Interview on at 9:05 am Staff B stated, "We are two staff, and there are six residents in the facility."

Interview on at 9:53 am Staff A stated that Staff D started to work in the facility on .

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview the facility failed to maintain that the plumbing system was in good working order.

Findings included:

During the facility tour on at 9:08 am, observed under the kitchen cabinet a water pipe that was leaking water. The facility placed a bucket under the leaking pipe to gather the water.

Interview on at 9:45 am the Administrator stated, "there is a handing man who will come to fix it."

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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

0161 Records - Staff

Based on observation, record review, and interview the facility failed to ensure that one of four (Staff D) sampled staff members had completed employment application with references.

Findings included:

Observation on / at 9:00 am found Staff D working in the facility.

Record review on of Staff D's record found the facility did not have a completed employee application with references at the time of the survey.

Interview on at 9:53 am Staff A stated that Staff D started to work in the facility on . Staff A confirmed that Staff D did not have her employee application in file.

Class III

Z814 Background Screening Clearinghouse

Based on observation, record review, and interview the facility failed to register with the clearinghouse and maintain the employment status of one staff (D) out of four sampled staff within 10 days of employment.

Findings:

Observation on at 9:00 a.m. Staff D working in the facility.

Record review showed the background screening website did not have Staff D listed on the facility's employee roster.

Interview on at 9:53 am Staff A stated that Staff D started to work in the facility on / . Staff A confirmed that Staff D was not reflected at the facility's roster.

Unclassified

Z816 Background Screening-Compliance Attestation

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968320	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)

Based on observation, record review, and interview the facility failed to show that one out of four (D) sampled staff did not have a 90 day break in service.

Findings included:

Observation on at 9:00 a.m. found Staff D working in the facility.

Record review on showed Staff D's background screening on file was dated on (eligible, printed on). Record review of Staff D's record found the facility did not have a completed employee application with references at the time of the survey. The facility failed to show that Staff D did not have a 90 day break in service.

The background screening database showed Staff D's last employment at an assisted living facility ended on .

Interview on at 9:53 am Staff A stated that Staff D started to work in the facility on .

Unclassified

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968320 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR FAMILY ASSISTED LIVING FACILITY II, INC	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 A0077 Reg. # 429.176 FS; 58A-5.019(1) 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	ID Prefix Reg. # 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	ID Prefix Reg. # 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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) [signature]	DATE 8/25/14	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

 EVENT ID: TWZD13

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 **second** Biennial Licensure Revisit Survey conducted on 10, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

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(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

YOSF

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
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