RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

December 6, 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 state licensure survey revisit conducted on November 23, 2016 by representative(s) of this office.

Attached is the provider's copy of the State Form, which indicates the previously cited deficiencies were found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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

DT9D

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968320	R **11/23/2016**
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 3rd Revisit Survey was conducted on 11/23/16. Our Family Assisted Living Facility II, license number 12214, had no deficiencies found at the time of the survey:

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968320 Y1	A. Building B. Wing Y2	11/23/2016 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 A0079	Correction	ID Prefix A0152	Correction	ID Prefix A0161	Correction
Reg. # 58A-5.019(3) FAC	Completed	Reg. # 58A-5.023(3) FAC	Completed	Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed
LSC	11/23/2016	LSC	11/23/2016	LSC	11/23/2016
ID Prefix AZ814	Correction	ID Prefix AZ816	Correction	ID Prefix	Correction
Reg. # 435.12(2)(b-d), FS	Completed	Reg. # 408.809(2)(a-c) FS	Completed	Reg. #	Completed
LSC	11/23/2016	LSC	11/23/2016	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)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE 12/6/16	TITLE HCES	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
5/12/2016	

EVENT ID: TWZD14