

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 09/04/2018
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968320	(X3) DATE SURVEY COMPLETED R 08/14/2018
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 2nd revisit was conducted on 08/14/18. Our Family Assisted Living Facility II (license #12214) had the previously cited deficiencies corrected at the time at the survey.