

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/01/2022
NAME OF PROVIDER OR SUPPLIER TWO SISTERS ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1675 SW 25 AVENUE MIAMI, FL 33145		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure survey was conducted at Two Sisters ALF Inc. on 03/01/2022. Deficiencies were identified at the time of the survey.	A 000			
A 004 SS=D	59A-36.004 FAC Licensure - Requirements 59A-36.004 License Requirements. (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in Rule 59A-36.005, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in Rule 59A-36.005, F.A.C. (4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership	A 004			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/01/2022
NAME OF PROVIDER OR SUPPLIER TWO SISTERS ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1675 SW 25 AVENUE MIAMI, FL 33145		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 004	Continued From page 1 separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Chapters 408, Part II, 429, Part I, F.S. and rule Chapter 59A-35, F.A.C., and this rule chapter. (5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Chapter 408, part II, and Section 429.14, F.S., and rule Chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that the sanitation inspection was done annually. Findings included: A review of records revealed that the last sanitation inspection had been done on On _____ at 11:57 AM the Administrator stated, "They have not come yet. I sent them an email and I spoke to a lady." Class III	A 004			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/01/2022
NAME OF PROVIDER OR SUPPLIER TWO SISTERS ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1675 SW 25 AVENUE MIAMI, FL 33145			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 031 SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, _____, and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the _____ resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and	A 031			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/01/2022
NAME OF PROVIDER OR SUPPLIER TWO SISTERS ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1675 SW 25 AVENUE MIAMI, FL 33145		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 031	Continued From page 3 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide updated documentation from third party (Hospice) services which were provided to one out of nine (Resident # 3) sampled residents. Findings included: A review of Resident # 3's records revealed that she was receiving hospice services since	A 031			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/01/2022
NAME OF PROVIDER OR SUPPLIER TWO SISTERS ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1675 SW 25 AVENUE MIAMI, FL 33145		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 4 Further review revealed the physician orders had no diagnosis, no initial certification and no plan of care. On at 11:52 AM the Administrator stated, " hospice is always the same." Class III		A 031		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012,		A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/01/2022
NAME OF PROVIDER OR SUPPLIER TWO SISTERS ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1675 SW 25 AVENUE MIAMI, FL 33145		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 5 F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , (), CF-ES 1006, , which is hereby incorporated by reference and available for review at:	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/01/2022
NAME OF PROVIDER OR SUPPLIER TWO SISTERS ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1675 SW 25 AVENUE MIAMI, FL 33145			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 6 http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/01/2022
NAME OF PROVIDER OR SUPPLIER TWO SISTERS ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1675 SW 25 AVENUE MIAMI, FL 33145		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 7 resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have accurate health assessments for three out of nine sample residents (# 2, # 3 and # 9). Findings included: A review of Resident # 2's hospice record revealed that /she had a _____ on the right _____ and was receiving _____ care daily. A review of her health assessment completed on _____ revealed that it did not mention that the resident had a _____ on the right _____. On _____ at 11:55 AM the Administrator stated, "You are right, Resident # 2 needs a new health assessment." A review of Resident # 3's record revealed that she was receiving hospice services since _____. Her health assessment had been completed on _____ and at the time the resident was not on hospice and required assistance with activities of daily living. On _____ at 11:58 AM the Administrator	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/01/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTERS ALF INC

**1675 SW 25 AVENUE
MIAMI, FL 33145**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 8 stated, "Resident # 3 is now total, she needs a new health assessment." A review of Resident# 9's record revealed that the health assessment done at Hospital on had the physical or sensory limitations and the nursing/treatment/..... requirements left blank; also had her identified as elopement risk. On at 12:19 PM the Administrator stated, "Resident # 9 needs a new health assessment. She has never tried to leave the facility; she is not at elopement risk." Class III	A 162		