

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 biennial survey was conducted at Two Sister's Home Care II, Corp on The provider had deficiencies identified at the time of the visit.	A 000		
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of or decline in mobility or function related to the use of the prescribed (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a written care plan for the use of the physical developed within 14 days of the device being	A 033		

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: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 033	Continued From page 1 prescribed, and prior to use on the resident for three out of six sampled residents that had full side bedrails (Resident #1, Resident #2, and Resident #3). Findings included: On _____ at 7:53 AM, observation showed Resident #1 lying in bed with full bed rails in upright position. Review of Resident #1's record revealed a prescription order for full side bed rails dated _____. Further review showed no documentation of a written care plan for the use of the physical _____. On _____ at 7:54 AM, observation showed Resident #2 lying in bed with full bed rails in upright position. Review of Resident #2's record revealed a prescription order for full side bed rails dated _____. Further review showed no documentation of a written care plan for the use of the physical _____. On _____ at 7:55 AM, observation showed Resident #3 lying in bed with full bed rails in upright position. Review of Resident #3's record revealed a prescription order for full side bed rails dated _____. Further review showed no documentation of a written care plan for the use of the physical _____.	A 033		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 033	Continued From page 2 On ... at 10:45 AM, the Administrator stated that the doctor would complete the care plans for the use of full bed rails for Resident #1, Resident #2, and Resident #3. Class III	A 033		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 078	Continued From page 3 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 078	Continued From page 4 does not have any signs or symptoms of communicable _____; and evidence of a negative _____ examination must be documented on an annual basis for one out of three sampled staff (Staff B). Findings included: Review of personnel records review for Staff B showed no documentation of a written statement from a health care provider documenting that she did not have any signs or symptoms of communicable _____ nor evidence of a negative _____ examination. Staff B's hire date was _____. On _____ at 1:30 PM, the Administrator stated that Staff B went to the doctor, but she had not received the documents. Class III	A 078		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 6-15 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 079	Continued From page 5 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and () and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER TWO SISTER'S HOME CARE II CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12335 NW 98 AVENUE HIALEAH GARDENS, FL 33018		
(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 079	Continued From page 6 administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least _____ must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER TWO SISTER'S HOME CARE II CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12335 NW 98 AVENUE HIALEAH GARDENS, FL 33018		
(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 079	Continued From page 7 representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 079	Continued From page 8 hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Findings included: On _____ at 7:50 AM, observation showed Staff B and Staff C working at the facility. On _____ at 8:15 AM, Staff B stated that she and Staff C were live-in personnel. Review of facility records showed no documentation of a staffing pattern. _____ at 1:35 PM, the Administrator stated that she completed the staffing schedule with the consultant, and it was posted, but probably it from the board. Class III	A 079		
A 081 SS=D	429.52(1 & 7) FS: 59A-36.011() FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER TWO SISTER'S HOME CARE II CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12335 NW 98 AVENUE HIALEAH GARDENS, FL 33018		
(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 081	Continued From page 9 who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 081	Continued From page 10 orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in _____ control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its _____ control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to _____ borne _____, may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident _____, neglect, and _____. The facility must use its _____ prevention policies and procedures when	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 081	Continued From page 11 offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one out of three sampled staff had completed the required in-service training prior to interacting with residents and before preparing and serving food (Staff C). Findings included:	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER TWO SISTER'S HOME CARE II CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 12335 NW 98 AVENUE HIALEAH GARDENS, FL 33018		
(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)	
A 081	Continued From page 12 On at 7:50 AM, observation showed Staff C working at the facility. On at 12:00 PM, observation showed Staff C cooked and served lunch to the residents. Review of personnel records for Staff C showed no documentation of having completed 2-hours of pre-service orientation, 1-hour in-service training in control and 1-hour in-service training in safe food handling practices. On at 1:30 PM, the Administrator stated that she was waiting for the consultant to go to the facility and provided the trainings to Staff C. Class III		A 081		
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 resident's health care practitioner and case manager, if applicable.		A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 13 (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form 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, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), 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. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that _____ not be taken. (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,	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 14 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: 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 a log listing the names of residents participating in this	A 162		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

AHCA Form 3020-0001
STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	---	--

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO SISTER'S HOME CARE II CORP	12335 NW 98 AVENUE HIALEAH GARDENS, FL 33018

(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 16 toileting, and transferring; and needed administration of medication. However, the health assessment indicated the resident was not bedridden. On at 7:54 AM, observation showed Resident #2 lying in bed with full bed rails in upright position. Review of Resident #2's record showed that Resident #2 began receiving hospice services on Resident #2's record revealed a prescription order for full side bed rails dated Further review showed no documentation of a signed consent for the use of full bed rails. Resident #2's health assessment completed showed medical history and diagnoses of 's without behavioral disturbance, major , and disturbance. The resident needed assistance with bathing, eating and self-care (grooming); required total care with ambulation, , toileting, and transferring; and needed administration of medication. The health assessment indicated the resident was not bedridden and the physical or sensory limitations section was left blank. On at 7:55 AM, observation showed Resident #3 lying in bed with full bed rails in upright position. Review of Resident #3's record revealed a prescription order for full side bed rails dated Further review showed no documentation of a signed consent for the use of full bed rails.	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 17 Resident #3's health assessment completed showed medical history and diagnoses of _____ (_____), _____ (_____), _____ (_____), _____ (HF), dyslipidemia, _____ (OA), hypertensive _____ without _____, and generalized _____. The resident required total care with all activities of daily living: ambulation, bathing, _____, eating, self-care (grooming), toileting, and transferring; and needed administration of medication. The health assessment indicated the resident was under hospice care and was not bedridden. On _____ at 10:45 AM, the Administrator stated that Resident #1, Resident #2, and Resident #3 were bed bounded and the doctor was completing a new health assessment for them. Class III	A 162		
A 200 SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 200	Continued From page 18 source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 200	Continued From page 19 mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 200	Continued From page 20 power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 200	Continued From page 21 monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to emergency Rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER TWO SISTER'S HOME CARE II CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 12335 NW 98 AVENUE HIALEAH GARDENS, FL 33018		
(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 200	Continued From page 22 consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than _____, have implemented the plan required under this rule. (b) The Agency shall allow an extension up to _____ to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER TWO SISTER'S HOME CARE II CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 12335 NW 98 AVENUE HIALEAH GARDENS, FL 33018		
(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)	
A 200	Continued From page 23 evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite. 2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either: a. Fully and safely evacuate its residents prior to the arrival of the event; or b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 200	Continued From page 24 ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in . . . air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of . . . and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER TWO SISTER'S HOME CARE II CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 12335 NW 98 AVENUE HIALEAH GARDENS, FL 33018		
(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 200	Continued From page 25 additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429, part I, or chapter 408, part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available"	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TWO SISTER'S HOME CARE II CORP

**12335 NW 98 AVENUE
HIALEAH GARDENS, FL 33018**

(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 200	Continued From page 26 means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to notify in writing within five (5) business days, each resident and the resident's legal representative of the submission of the plan to the local emergency management agency that the plan has been submitted for review and approval and upon final implementation of the plan for two out of six sampled residents (Resident #2 and Resident #3). Findings included: Review of Resident #2 and Resident #3's records showed no documentation of a notification notice to the residents and the residents' legal representative about the submission of the plan to the local emergency management agency nor of the implementation of the plan. On 08/16/2023 at 1:35 PM, the Administrator stated that the families had not came to sign the notification and she was thinking to send it to them by mail. Class III	A 200		