STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967789	R
NAME OF PROVIDER OR SUPPLIER **TWO SISTERS ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1675 SW 25 AVENUE** **MIAMI, FL 33145**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

A Monitoring Survey Revisit to check on the residents was conducted on . Two Sisters ALF Inc. with a Limited Nursing Services component, License #11776 had the following deficiencies found at the time of the survey:

0160 Records - Facility

Based on record review and interview the facility failed to have a satisfactory fire inspection.

Findings Included:

Record review showed the facility's fire inspection available for review (dated) stated must install fire sprinkler system and repair emergency lights.

On at 10:38 a.m. the facility's Administrator, stated the sprinkler system was already installed but the fire department did not do the reinspection, yet.

Uncorrected Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on observation record review and interview the facility failed complete a one day adverse incident report to the agency.

Findings as follow:

On at 8:40 a.m. it was observed Resident #1 had a in the right side of forehead and around right eye. Accompanying the resident in a hospice nurse.
The hospice nurse stated on at 8:40 a.m., "I was taking care of resident since Monday from 8:00 a.m. to 8:00 p.m." He stated resident has agitation periods and tries to wake up from bed. The nurse added the resident had on the forehead and had improved a lot since . The resident is non ambulatory.
Staff #2, caretaker, stated, "I was working on when Resident #1 from the recliner." Staff #2 reported the night before the , resident was restless and wanted to get up from the bed. Staff stated the rescue was call and after evaluation, determined resident was ok.
Record review showed the facility wrote an internal incident report. Record review showed Resident #1 had another in previous month.

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On at 10:00 a.m. The facility's Administrator stated the facility did not send a one day incident report to AHCA.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967789 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO SISTERS ALF INC	1675 SW 25 AVENUE MIAMI, FL 33145

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 A0152 Reg. # 58A-5.023(3) 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
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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) JG	DATE 9/15/14	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 6/27/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Two Sisters Alf Inc
1675 Sw 25 Avenue
Miami, FL 33145

Dear Administrator:

This letter reports the findings of a Monitoring Licensure revisit survey conducted on , 2016by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

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