

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967485	(X3) DATE SURVEY COMPLETED 10/06/2014
NAME OF PROVIDER OR SUPPLIER Two Sisters Love & Care, Inc	STREET ADDRESS, CITY, STATE, ZIP CODE 54-56 Nw 45th Avenue Miami, FL 33126	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D

Specific Tag Findings:

0000-Initial Comments

An Abbreviated Biennial survey was conducted on _____, 2014. Two Sisters Love and Care, Inc had the following deficiency found at the time of the survey:

0093-Food Service - Dietary Standards 58A-5.020(2) FAC

Based on observation, record review and interview the facility failed to note meal substitution before or when the meal is served.

Findings included:

Lunch observation on _____ at 12:00 p.m. found residents were served black beans, white rice, ground beef, diced tomatoes, pudding, and juice.

Review of the menu posted on wall near dining area had the following lunch listed to be served for lunch: spaghetti and meatballs, tomatoes, dinner roll, mixed salad, dressing, fruit cup and juice. The substitutions were not documented at all on the menu or anywhere else.

Interview with the administrator stated, " they usually write it but must have forgotten."

Class III



RICK SCOTT
GOVERNOR
ELIZABETH DUDEK
SECRETARY

January 14, 2014

Administrator
Two Sisters Love & Care, Inc
54-56 Nw 45th Avenue
Miami, FL 33126

Dear Administrator:

This letter reports the findings of an Abbreviated Biennial survey that was conducted on
January 14, 2014 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after 30 days to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90

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



Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida