STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967701	11/04/2015
NAME OF PROVIDER OR SUPPLIER **TWO SISTERS ETERNITY CARE, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8610 S W 97 RD** **MIAMI, FL 33173**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on / . Two Sisters Eternity Care with Limited Nursing Service component had the following deficiencies found at the time of the survey:

0085 Training - Nutrition & Food Service

Based on record review and interview the facility failed to ensure four of four (Staff A, B, C, and D) sampled staff member had a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility.

Findings included:

On / at 11:16 AM record review found the facility did not have evidence that Staff A, B, C, and D received a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility annually.

On / at 1:00 PM the Administrator acknowledged the findings that staff did not have the training.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Two Sisters Eternity Care, Llc
8610 S W 97 Rd
Miami, FL 33173

Dear Administrator:

This letter reports the findings of a standard biennial licensure survey that was conducted on , 2015 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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

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