Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964219	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMANUEL RESIDENCE ACLF	343 W 44TH STREET HIALEAH, FL 33012

(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 Complaint (2012007451) Investigation Survey was completed at Emanuel Residence ACLF with Limited Nursing Services (LNS) and Limited Mental Health (LMH) components on . Complaint allegations: Facility failure to follow a posted menu. Facility failure to prevent . Facility failure to provide adequate staffing and adequate supervision to meet the needs. There were deficiencies identified at the time of survey.	A 000		
A 074	58A-5.019(3)(b) Staffing Standards - Personnel File (BGS) (3) BACKGROUND SCREENING. (b) The results of employee screening conducted by the agency shall be maintained in the employee ' s personnel file. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview the assisted living facility failed to ensure that a live in staff member had evidence of a completed level 2 background screening at the facility. Findings include: Arrived at the facility on at 9:40 a.m. found staff #1 present caring for six residents. Record review found that the facility only had a receipt that staff #1 had her fingerprints scanned on , 2012. The facility did not have a completed level 2 background screening for staff	A 074		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964219	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMANUEL RESIDENCE ACLF	343 W 44TH STREET HIALEAH, FL 33012

(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 074	Continued From page 1 #1. The Agency's background screening website was check and found that staff #1's background screening was completed on . Interview with the facility's administrator on at 3:19 p.m. confirmed that the facility only has staff #1's receipt for a background screening.	A 074		
A 083 SS=D	58A-5.0191(4) FAC Training - First Aid and . (4) FIRST AID AND ( ). 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 course offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Association, or National Safety Council; or a provider approved by the Department of Health, shall satisfy this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under Part III of Chapter 401, F.S., shall be considered as having met the training requirements for both First Aid and . This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview the assisted living facility failed to ensure that at least one staff member is trained with First Aid and at all times. Findings include:	A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964219	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMANUEL RESIDENCE ACLF	343 W 44TH STREET HIALEAH, FL 33012

(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 083	Continued From page 2 Arrived at the facility on at 9:40 a.m. found staff #1 present caring for six residents. Record review found that staff #1 did not have any documentation at the facility of having First Aid and training. Interview with the facility's administrator on at 3:19 p.m. confirmed that the facility did not have proof of staff #1's First Aid and training. Class III	A 083		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Emanuel Residence Aclf
343 W 44th Street
Hialeah, FL 33012

Re: CCR #2012007451

Dear Administrator:

This letter reports the findings of a state complaint survey that was conducted on , 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) 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 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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

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