

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER EMANUEL RESIDENCE ACLF			STREET ADDRESS, CITY, STATE, ZIP CODE 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 (2012005826) 2nd Flook Up Survey was completed at Emanuel Residence ACLF with Limited Nursing Services (LNS) and Limited Mental Health (LMH) components on - A-L243 still UNCORRECTED		{A 000}		
{AL243} SS=D	58A-5.0191(8) FAC LMH - Training (8) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to Section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility 's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Staff in " direct contact " means direct care staff and staff whose duties take them into resident living areas and require them to interact with mental health residents on a daily basis. The term does not include maintenance, food service or administrative staff, if such staff have only incidental contact with mental health residents. c. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to Section 429.52(4), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator or through distance learning, biennially thereafter in subjects dealing with one or more of the		{AL243}		

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0090

ZBC013

If continuation sheet 1 of 3

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{AL243}	Continued From page 1 following topics: a. Mental health diagnoses; and b. Mental health treatment such as mental health needs, services, behaviors and appropriate interventions; resident progress in achieving treatment goals; how to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to Section 429.52(4), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on record review and interview facility failed to have employee #1's 3 hour of mental health updates in her file. Findings includes: 1. Record review revealed that employee #1 did		{AL243}		

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{AL243}	Continued From page 2 not have her in service training for 3 hours update for mental health. 2. Interviewed administrator on 11-11-12 @ 11:00 am, she stated that employee #1 did not have the in service 3 hours update for mental health in her file. Class III UN-CORRECTED	{AL243}			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11964219	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
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Name of Facility EMANUEL RESIDENCE ACLF	Street Address, City, State, Zip Code 343 W 44TH STREET HIALEAH, FL 33012
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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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0025</u>	Correction Completed	ID Prefix <u>A0160</u>	Correction Completed	ID Prefix <u>A0161</u>	Correction Completed
Reg. # <u>58A-5.0182(1) FAC</u>		Reg. # <u>58A-5.024(1) FAC</u>		Reg. # <u>58A-5.024(2) FAC</u>	
LSC _____		LSC _____		LSC _____	
ID Prefix <u>A0162</u>	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # <u>58A-5.024(3) FAC</u>		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: <u>Kusiala</u>	Date: <u>11/27/2013</u>
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: _____

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

, 2012

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

CCR#2012005826 2nd f/u

Dear Administrator:

This letter reports the findings of a 2nd revisit survey to a complaint conducted on , 2012by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), 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 , 2012.**

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
Field Office Manager

AMD:sy
Enclosure

BBT7

