

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11964219	(X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER Emanuel Residence Acif	STREET ADDRESS, CITY, STATE, ZIP CODE 343 W 44th Street Hialeah, FL 33012	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Specific Tag Findings:

0000-Initial Comments

A Monitoring visit was conducted on August 21, 2014. Emanuel Residence had uncorrected deficiencies at time of survey cited under the complaint investigation (2014006425) on 07/10/2014.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 2, 2014

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

Dear Administrator:

This letter reports findings of a monitoring survey that was conducted on August 21, 2014 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the 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,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure

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