

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11964219	(X3) DATE SURVEY COMPLETED 10/16/2014
NAME OF PROVIDER OR SUPPLIER Emanuel Residence Acf	STREET ADDRESS, CITY, STATE, ZIP CODE 343 W 44 Street Hialeah, FL 33012	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Specific Tag Findings:

0000-Initial Comments

A Complaint Investigation Survey (CCR # 2014010281) was conducted on October 16, 2014. Emanuel Residence A.C.L.F had no deficiencies at time of survey.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

November 6, 2014

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

RE: CCR #201410281

Dear Administrator:

This letter reports the findings of a complaint survey completed on October 16, 2014 by representative(s) of this office.

Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, indicating no deficiencies were identified during this 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 contact 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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