| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964219 | 01/27/2015 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| Emanuel Residence Aclf | 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 (2015000746) Investigation Survey was conducted on 01/27/15. Emanuel Residence ACLF did not have deficiencies related to the complaint.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

February 10, 2015

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

**RE: CCR #2015000746**

Dear Administrator:

This letter reports the findings of a complaint survey completed on January 27, 2015 by representative(s) of this office.Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form.

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 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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