

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11967448(Y2) Multiple Construction
A. Building
B. Wing(Y3) Date of Revisit
7/29/2015

Name of Facility

CHANNEL NURSING CARE ALF, CORP

Street Address, City, State, Zip Code

14111 SW 43 STREET
MIAMI, FL 33175

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
	Correction Completed		Correction Completed		Correction Completed
ID Prefix A0007		ID Prefix		ID Prefix	
Reg. # 429.26(11) FS: 58A-5.0181		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By
State Agency
Reviewed By
CMS ROReviewed By

Reviewed ByDate:
08/10/15
Date:Signature of Surveyor:

Signature of Surveyor:Date:

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

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 08/10/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967448	(X3) DATE SURVEY COMPLETED R 07/29/2015
NAME OF PROVIDER OR SUPPLIER CHANEL NURSING CARE ALF, CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 14111 SW 43 STREET MIAMI, FL 33175	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

A Complaint Revisit Survey was conducted on 29, 2015. Chanel Nursing Care ALF, Corp had the following deficiency found at time of the survey.

0077 Staffing Standards - Administrators

Based on observations, record review and interview the facility failed ensure administrator who supervise a maximum of three assisted living facilities appoint in writing a separate manager for each facility.

Findings included:

Observation made on of Letter of Delegation has the administrator listed.

Record review of a staff files contained no manager listed for the facility. A Internet search in the Florida Facility Finder found the administrator is listed for three licensed facilities.

Interview on / at 9:58 AM with the Administrator stated, "I have three facilities and I do not have a manager for any of them."

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Chanel Nursing Care Alf, Corp
14111 Sw 43 Street
Miami, FL 33175

Dear Administrator:

This letter reports the findings of a Complaint Survey conducted on , 2015 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than , 2015.

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,

A handwritten signature in black ink, appearing to read "Arlene Mayo-Davis".

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure

BBT7

