STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967448	10/28/2015
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 Limited Nursing Services Monitoring Survey was conducted on , 2015. Chanel Nursing Care ALF, Corp. with Limited Nursing Services and Limited Mental Health had deficiencies identified under the component at time of survey.

0078 Staffing Standards - Staff

Based on record review and interview facility failed to document evidence of a negative examination on an annual basis for Registered Nurse contracted to provide limited nursing services.

Findings included:

Record review of Registered Nurse contracted by facility revealed that the last negative statement was dated .

Facility administrator stated on at 10:35 am that she did not know that the exam and the background screening were already expired. She also called the nurse to let her know. Class III

Z815 Background Screening: Prohibited Offenses

Based on record review and interview, the facility failed to re-screen an individual om the last Level II Background Screening conducted was between , 2009, thr , 2011 for Registered Nurse contracted by facility to provide limited nursing services by , 2015 .

Findings Include:

Record review of Registered Nurse contracted by facility revealed that the last level II background screening was conducted on / and was eligible.

Facility administrator stated on at 10:35 am that she did not know that the background screening were already expired. She also called the nurse to let her know.

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 Limited Nursing Services Monitoring Survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 o-Davis, RN
Field Office Manager

AMD:kb
Enclosure

XG90

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com