STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11964219 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EMANUEL RESIDENCE ACLF	343 W 44 STREET HIALEAH, FL 33012

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0008	Correction	ID Prefix A0052	Correction	ID Prefix A0077	Correction
Reg. # 429.26(4-6) FS; 58A-5.0181(2) FAC	Completed	Reg. # 58A-5.0185 (3)	Completed	Reg. # 429.176 FS; 58A-5.019(1) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0083	Correction	ID Prefix A0084	Correction	ID Prefix A0167	Correction
Reg. # 58A-5.0191(4) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed	Reg. # 58A-5.025 FAC	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	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
12/21/2015	

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964219	R
NAME OF PROVIDER OR SUPPLIER **EMANUEL RESIDENCE ACLF**	STREET ADDRESS, CITY, STATE, ZIP CODE **343 W 44 STREET** **HIALEAH, FL 33012**	

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

0000 Initial Comments

A Complaint Revisit survey (CCR #2015012273) was conducted on 16, 2016 at Emmanuel Residence ACLF with Limited Mental Health component. The previous deficiencies were corrected at time of the survey. There were three new deficiencies:

0080 Training - Core & Competency Test

Based on record review and inerterview, the facility failed to provide documentation that one of two sampled Employees (Employee #A, the facility's Manager) completed the required 12 hours of continuing CORE education required for Administrators and their designees.training.

Findings included:

Record review revealed that the new facility Manager started work on 01--.

A review of the Manager's employment file revealed that the Manager completed Core training on . There was no documentation that the required 12 hours of Continued Education had been completed.

On - at 3:00 PM, the Manager stated that the training would be scheduled as soon as possible.

Class III

0085 Training - Nutrition & Food Service

Based on record review and interviewed facility failed to provide documentation that one of two sampled employees (Employee #A, the facility Manager), who was responsible for preparing food for residents, had the required Nutrition and food Service training.

Findings included:

A review of the employment file for Employee #A revealed that the employee started work on . There was no documentation that the Manager completed the required training in Nutrition and food Service.

During an interviewe on - at 3:00 PM, the Manager stated that the training would be

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964219	R
NAME OF PROVIDER OR SUPPLIER **EMANUEL RESIDENCE ACLF**	STREET ADDRESS, CITY, STATE, ZIP CODE **343 W 44 STREET** **HIALEAH, FL 33012**	

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

scheduled as soon as possible.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a complaint revisit survey (CCR#2015012273) conducted on , 2016 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.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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,

Arlene Mayo-Davie, RN
Field Office Manager

AMD/sb
Enclosure

BBT7

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