

|                                                                   |                                                                                       |                                                           |
|-------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------|
| STATEMENT OF DEFICIENCIES                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11964219</b>           | (X3) DATE SURVEY COMPLETED<br><br><b>R<br/>08/29/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMANUEL RESIDENCE ACLF</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>343 W 44 STREET<br/>HIALEAH, FL 33012</b> |                                                           |

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

**0000 - Initial Comments**

A standard biennial revisit survey was conducted on . Emanuel Residence ACLF with the Limited Mental Health component, license #8954, had the following deficiencies identified at the time of the survey:

**0054 - Medication - Records - 58A-5.0185(5) FAC**

Based on record review and interview, the facility failed to maintain an accurate daily medication observation record (MOR) for two out of seven sampled residents (#2 and #5) who received assistance with self-administration of medications.

Findings included:

Record review showed that Resident #2's had a physician order for . 25 mg. At 8:00 A.M, the medication observation record (MOR) was not initialed. Furthermore Resident #5's physician ordered . 0. 4 capsule one by mouth daily at bed time 9:00 P.M., the pill was in the medication . packet card, but the MOR's was initialed by staff.

During an interview on . at 12:44 P.M. Staff B stated "I made a mistake in signing in the medication this morning." At 12:50 P.M. Staff B stated "I gave the medication to her." She acknowledged that MOR's was not initialed.

Uncorrected  
Class III

**0079 - Staffing Standards - Levels - 58A-5.019(3) FAC**

Based on observation, record review, and interview, the facility failed to maintain a written work schedule that reflected its 24-hour staffing pattern.

Findings included:

On . at 12:06 P.M. observed Staff B alone caring for a census of six residents. At 1:16 P.M., observed Staff C arrive at the facility.

Record review found the staffing pattern for the facility documented that staff B was scheduled to work from 7 AM to 7 PM and Staff C from 9:00 A.M. to 6:00 P.M. on Tuesday .

**AGENCY FOR HEALTH CARE  
ADMINISTRATION**

PRINTED: 10/19/2017  
FORM APPROVED

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------|
| STATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11964219</b>           | (X3) DATE SURVEY COMPLETED<br><br><b>R<br/>08/29/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMANUEL RESIDENCE ACLF</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>343 W 44 STREET<br/>HIALEAH, FL 33012</b> |                                                           |
| SUMMARY STATEMENT OF DEFICIENCIES<br>(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                           |
| <p>During an interview on _____ at 12:16 P.M. Staff B stated that Staff C went to the other ALF that the administrator had.</p> <p>Class III</p> <p><b>0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC</b></p> <p>Based on observations and interview, the facility failed to ensure that residents lived a decent living environment. The facility failed to provide privacy to residents who use portable bedside commodes for a samples of seven residents.</p> <p>Findings included:</p> <p>Observations on _____ at 3:30 P.M. found black and yellow substances around the air conditioner vent located in the dining _____. Further observed that the kitchen had a cracked ceiling and the _____ had holes and areas that needed to be painted. In _____ # _____, observed a red sheet hanging in the glass window.</p> <p>During an interview on _____ at 12:20 P.M, Staff B stated Resident # 7 liked to cover the window with dark linen to block the light.</p> <p>Uncorrected<br/>Class III</p> |                                                                                       |                                                           |