

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966891	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2012
NAME OF PROVIDER OR SUPPLIER FAITH HOUSE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 335 FOSTER COVE CHULUOTA, FL 32766		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments 6/4/12 conducted Assisted Living Facility with Limited Nursing Services monitoring visit. LNS census: 0 Faith House Assisted Living Facility had no deficiencies found at the time of the visit.	A 000			

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1