

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 04/01/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966891	(X3) DATE SURVEY COMPLETED 03/18/2015
NAME OF PROVIDER OR SUPPLIER FAITH HOUSE ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 335 FOSTER COVE CHULUOTA, FL 32766	

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

0000 - Initial Comments

Conducted Abbreviated re-licensure survey on 3/18/15. Faith House Assisted Living Facility had no deficiencies found at the time of the visit.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 1, 2015

Administrator
Faith House Assisted Living Facility
335 Foster Cove
Chuluota, FL 32768

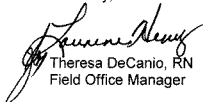
Dear Administrator:

This letter reports findings of a state licensure survey that was conducted on March 18, 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

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 Lorraine Henry at (407) 420-2502.

Sincerely,



Theresa DeCanio, RN
Field Office Manager

TDC:clr
Enclosure

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