State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
AL11968557

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
12/28/2015

Name of Facility
FAITH HOME CARE ALF INC

Street Address, City, State, Zip Code
114 EUCLID AVE
SEFFNER, FL 33584

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0052 Reg. # 58A-5.0185 (3) LSC		ID Prefix A0053 Reg. # 58A-5.0185(4) FAC LSC		ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	
ID Prefix A0083 Reg. # 58A-5.0191(4) FAC LSC		ID Prefix A0084 Reg. # 58A-5.0191(5) FAC LSC		ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	
ID Prefix A0161 Reg. # 429.275(2) FS; 58A-5.024(2 LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency — Reviewed By: [signature] Date: 1/1/16 — Signature of Surveyor: — Date:

Reviewed By CMS RO — Reviewed By — Date: — Signature of Surveyor: — 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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968557	R
NAME OF PROVIDER OR SUPPLIER FAITH HOME CARE ALF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 114 EUCLID AVE SEFFNER, FL 33584	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

A revisit to / / biennial survey with limited nursing services (LNS) was conducted at Faith Home Care ALF on / /. Faith Home Care ALF had a deficiency at the time of the visit.

0054 Medication - Records

Based on observation, interview, and record review, the facility failed to maintain an accurate medication observation record (MOR) for each resident who receives assistance with self-administration of medications for 1(Resident #1) of 1 record reviewed.

Findings included:

During a medication observation conducted on / at approximately 9:30 AM, the administrator was explaining medications to be taken to Resident #1 and stated that she has an for her take. A review of the MOR showed no documentation for an .

The administrator was interviewed at 9:33 AM on / and stated that the resident had been taking the since Friday (/). The medication package for the was then reviewed and showed the following: /TMP DS Tab #14- Take one tablet by mouth 2 times daily for 7 days.

The administrator was interviewed at 9:40 AM on and stated that Resident #1 has been taking the since and that she did not add the to the MOR. Additionally, the administrator stated that she did not initial the MOR for medications that were utilized earlier which included the following: 1) 2% Cream- Apply to the affected area(s) of foot once a day. 2) Prop 50 MCG SPR- Instill 1 spray in each nostril two times a day.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Faith Home Care ALF Inc
114 Euclid Ave
Seffner, FL 33584

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2015 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 (727) 552-2000.

Sincerely,

for Reid Caufman
Field Office Manager

PRC/clt
Enclosure: (State Form 5000-3547)

BBT7

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