AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942969	**01/04/2017**
NAME OF PROVIDER OR SUPPLIER **HOUSE THAT FAITH BUILT (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **1105 MELBA COURT** **LARGO, FL 33770**	

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

0000 - Initial Comments

Assisted Living Facility

A biennial state licensure survey with limited mental health (LMH) was conducted at House That Faith Built Assisted Living Facility on 1/04/17. House That Faith Built, Assisted Living Facility, had deficient practice identified at the time of the visit.

(License # 5976)

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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, that facility failed to ensure that Clearinghouse Employee Roster was updated to reflect the current employees.

Findings included:

Review of facility's current staff list and the Clearinghouse Employee Roster during the survey revealed that none of the facility's three employees were listed on the roster.
During interview with the administrator, conducted on / at 2:34 p.m., the administrator confirmed that none of the current employees are listed on the Clearinghouse Employee Roster. The administrator stated she was unware that this was a requirement.

Unclassed

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
House That Faith Built (The)
1105 Melba Court
Largo, FL 33770

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on , 2017, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of the identified deficiency. Submit summary and documents to the Field Office no later than , 2017.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiency identified on your survey, which may include a desk review or onsite revisit.

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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

FOR Patricia Reid Caufman
Field Office Manager

PRC/kpr
Enclosure: State Form 5000-3547

XG90

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