STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968557	**05/24/2017**
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 limited nursing services (LNS) monitoring visit was conducted on at Faith Home Care Assisted Living Facility. The Faith Home Care Assisted Living Facility had deficiencies at the time of the visit.

(License # 12447)

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on interview and record review, the facility failed to complete the screening for the year 2017 for one of two sampled staff (Staff A- Hired). There was no statement attesting to the freedom from communicable from a health care provider and/or freedom from signs and symptoms of ( ) and /or an annual update of freedom from available for inspection.

Findings included:

On , an employee record review was conducted on Staff A personal file. Staff A screening for 2017 was not found in the employee personal records. In an interview conducted at 2:00p.m., the administrator acknowledged the omission of an annual updated statement attesting to the freedom from communicable from a health care provider and/or freedom from signs and symptoms of ( ) available for inspection.

Class III