STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964501	R 12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE ALF, INC.	**315 WAINAI DRIVE** **MERRITT ISLAND, FL 32952**

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

0000 - Initial Comments

A second revisit to the re-licensure survey was conducted on . Our House ALF, Inc. Assisted Living Facility, license#9061 had a deficiency at the time of the visit.

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

DEFICIENCY REMAINED UNCORRECTED

Based on personnel record review and interview the facility failed ensure 1 of 2 sampled staff (B) had documentation freedom from communicable signed by a health care provider.

Findings:

Personnel record review for staff B hired revealed there was no documentation from a health care provider confirming she was free from communicable .

Staff A said on at 12:30 PM, Staff B did not have her freedom from communicable statement completed by her health care provider.

Class III