STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966891	**02/13/2019**
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

A re-licensure survey was conducted on at Faith House Assisted Living, Chulouta LIC#10995 had deficiencies at the time of the visit.

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on review and interview, the facility failed to maintain accurate Medication Observation Records (MORs) for 1 of 2 sampled residents (#6).

Findings:

1. During a Medication Pass Observation and a review of the MORs for Resident#6 at 1:00 pm on it revealed Resident #6 was prescribed the medication Floraster 250 mg 1 capsule by 2x daily at 8am and 6pm. In further review of the MORs, there were no staff signatures for the following dates for the 6pm administration of the medication on , , , , , , , , , , , and . There was no evidence that the resident received the medication at 6pm on those dates.

2. In an interview on at 1:30 pm with the Administrator, she confirmed the finding.

Class III