AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932390	**06/26/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
FARMER'S RETIREMENT HOME	**2135 40TH AVENUE N. SAINT PETERSBURG, FL 33714**	

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

0000 - Initial Comments

Assisted Living Facility

An Change in Ownership with Limited Mental Health Monitoring Survey was conducted on .

Farmer's Retirement Home, had deficiencies found at the time of visit.

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, interviews, and record review, the facility failed to ensure that the menu was nutritionally adequate; failed to ensure that menus were reviewed annually and documented in the facility files.

Findings Include:

During a tour of the facility on . 9:45 A.M. Surveyor observed menus posted with a current date of . in common areas of the facility at this time.

During an interview with the facility Administrator on . 12:45 P.M., the Administrator confirms the menus have not been reviewed by an licensed dietitian since 2012. The Administrator reviewed menus with surveyor and confirmed findings. The Administrator confirms current menus dated . have not been updated since 2012. The Administrator states she plan to get menus updated as soon as possible. However, confirms the facility is currently using menus dated . for meal for all residents at the facility as of . No further documentation was provided at this time.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Farmer's Retirement Home
2135 40th Avenue N.
Saint Petersburg, FL 33714

Dear Administrator:

This letter reports the findings of a change of ownership with limited mental health (LMH) monitoring visit that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please forward documentation of correction to the Field Office.** Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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,

Paul M Brown

for Patricia Reid Caufman
Field Office Manager

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

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