

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 09/14/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968674	(X3) DATE SURVEY COMPLETED 09/07/2016
NAME OF PROVIDER OR SUPPLIER AMELIA'S HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7175 53RD ST PINELLAS PARK, FL 33781	

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

0000 Initial Comments

Assisted Living Facility

On , a re-licensure Biennial survey with limited mental health (LMH) was conducted at Amelia's House. Amelia's House Assisted Living Facility had deficient practice identified during the survey.

(License # 12566)

0093 Food Service - Dietary Standards

Based on record review and interview, the facility failed to have the facility menus reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian to ensure the meals meet the nutritional standards.

Findings included:

During record review on , it was revealed the facility menus were reviewed, signed and dated by their licensed dietitian and expired . The manager stated she was not aware but would have the dietitian prepare new menus.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 1, 2016

Administrator
Amelia's House
PO Box 205
Pinellas Park, FL 33780

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with limited mental health (LMH) that was conducted on January 1, 2016, 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 January 15, 2016.** 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.

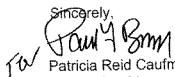
The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. 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.

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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,

Patricia Reid Kaufman
Field Office Manager

PRC/kpr

Enclosures: State Forms 5000-3547

XG90