STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910826	05/29/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Dunedin Assisted Living Facility	534 Howell Street Dunedin, FL 34698	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A biennial state licensure survey with limited mental health (LMH) was conducted on [redacted].

Dunedin Assisted Living Facility had a deficiency at the time of the visit.

L243-LMH - Training 58A-5.0191(8) FAC

Based on interview and record reviews, the facility failed to ensure that 2 of 4 staff whose files were reviewed had received 3 hours of continuing education biennially in subjects dealing with mental health as stated below.

The facility was unable to provide evidence that Staff A, B, C, and D, who have been employed for more than 6 months have received 3 hours of continuing education biennially.

Interview with the Administrator and Assistant Administrator on [redacted] at 2:00 P.M. revealed that they were not aware of this requirement. The Administrator stated that he deals with Mental Health organizations on an almost daily basis and that he will get the training in order to provide it to his entire staff.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Dunedin Assisted Living Facility
534 Howell Street
Dunedin, FL 34698

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on , 2014, 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. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency 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,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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