

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964997	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/10/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MAYFLOWER, THE

**19880 N US HWY 441
HIGH SPRINGS, FL 32655**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced change of ownership survey, complaint number 2021008157, emergency power plan monitoring, and a COVID-19 focused infection control survey were conducted on August 9 - 10, 2021, at Mayflower Assisted Living. No deficiencies were identified.	A 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE