STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953669	08/26/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Mayflower Assisted Living Facility	1620 Mayflower Court Winter Park, FL 32792	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G

Specific Tag Findings:
0000-Initial Comments
Complaint Investigation #2014005731 was conducted on and The Mayflower Assisted Living Facility had a deficiency found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on record review and interview, the facility failed to ensure they provided adequate supervision and knowledge of the whereabouts to prevent elopement for 1 of 3 sampled residents who was and actively exit seeking (#1).

Findings:

The agency received information that resident #1 had eloped from the facility on

Resident record review revealed an Assisted Living Facility Health Assessment Form (1823) dated that indicated diagnoses of memory loss, aneurysm and spinal

Review of facility notes revealed resident #1 was noted to be exit seeking on:
- the resident left the facility grounds at 11:30 AM ran to the highway with staff in pursuit. The resident was verbally and physically to staff. He ran into the local bank and refused to leave, the police were called and he was escorted back to the facility.

11:30 (AM or PM not noted) - the resident was agitated and wanted to elope. The physician was called and , an medication was increased to 0.5 milligrams (mg.) three times a day. The resident cut off his Wander guard, a bracelet that activated the alarm when resident exited facility.

- resident made several attempts to elope, redirected back to staff.

- attempted to elope x 3 and was redirected.

at 6 PM - found by staff outside facility, redirected to his

at 6:30 PM - attempted to elope.

Review of the adverse incident report dated at 1:30 PM revealed resident #1 left the lunch table, in the dining where he was last seen. Staff B received a phone call from

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the security guard that she had resident #1 downstairs, where he had been dropped off by another resident's private sitter, who had found him behind a bank on the sidewalk. The resident was unharmed and did not know why he left. He had ankle identification on, a wallet with an identification card located in the back pocket, and a Wander guard to the right wrist which did not activate.

The resident had with short term memory loss and impulsivity. He liked to ambulate and did not understand why he needed to be accompanied by someone, especially outside. The Wander guard was on and functional but under a sweater and the alarm did not go off.

at 5 PM - resident wandering and exit seeking.

at 6 PM - resident exit seeking numerous times. Constantly trying to leave the building. Medicated as ordered to no avail. All staff and this nurse doing one on one and private duty all day.

at 2 PM - resident exit seeking numerous times. Got aggressive with staff when they tried to redirect him. Not re-directable and tried to hit.

Review of the facility's Elopement policy defined elopement as the act of a resident of the facility leaving the campus without the knowledge of the staff.

In an interview with the administrator on at approximately 1:30 PM, she stated the resident left the facility on and an adverse incident report was completed. The facility determined the elopement was not an adverse incident, because staff was following the resident when he initially left the facility on The resident had a private sitter or family member with him, since that time, from approximately 1 PM to 5 PM daily. The resident did not have a sitter with him on when he left the facility.

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Mayflower Assisted Living Facility
1620 Mayflower Court
Winter Park, FL 32792

RE: CCR #2014005731

Dear Administrator:

This letter reports the findings of a 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 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. The agency has approved another timeframe and 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 Lorraine Henry at

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

Received 10-14-2014
Jean Marie Cameron

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

OCT 16 2014

Anne Marie Cameron, Administrator
Mayflower Assisted Living Facility
1620 Mayflower Court
Winter Park, FL 32792

Dear Cameron:

This letter reports the findings of a complaint inspection survey (CCR#2014005731) conducted on and , by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

1) A 0025 - Resident Care and Supervision Class II
Your Assisted Living facility failed to provide the adequate supervision and knowledge of the whereabouts of the resident to prevent elopement of a resident who was actively exit seeking.

Your facility must comply with the following;

1). Retrain all employees on your facility's elopement policy.

2). Make sure that your staff are aware that once the facility becomes aware that a resident has left the facility without permission before and is exit seeking the facility is aware the resident is an elopement risk.

3). Train staff to report a resident who is actively exit seeking to their supervisor immediately.

4). Make sure that the residents who are considered elopement risk have all the required information in a binder and identification on there person at all times.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Lorraine Henry, ALF Supervisor Area 7 Orlando, at (407) 420-2534.

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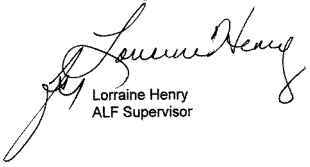
Mayflower Assisted Living Facility

Sincerely,



Lorraine Henry
ALF Supervisor

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