RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Mayflower, The
725 Nw Santa , Blvd
High Springs, FL 32655

RE: CCR #

Dear Administrator:

This letter reports the findings of a state licensure survey 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 Jasmine Hayes at (386) 462-6201.

Sincerely,

Kristie J. Mennella
Field Office Manager

KJM/jjh
Enclosure
XG90

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964997	**05/26/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
MAYFLOWER, THE	**725 NW SANTA BLVD HIGH SPRINGS, FL 32655**	

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

0000 - Initial Comments

A biennial survey was conducted at The Mayflower, an assisted living facility, on and Deficient practice was identified at the time of the survey.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on observation interview and record review, the facility failed to obtain omitted documentation for a health assessment for 1 of 2 resident records reviewed (Resident #3).

The findings include:

A review of Resident #3 ' s health assessment (AHCA Form 1823) revealed Resident #3 ' s health assessment, dated , did not list the residents, medical history or medical diagnosis, physical or sensory limitations, or behavioral status and did it did not list and nursing treatment or services required for Resident #3. The comments for the aforementioned sections directed the reader to see an attachment. There were no attachments to the AHCA 1823. Further review revealed the health assessment did not state the level of assistance the resident requires with medication.
An interview was conducted with the Administrator on at 7:41 a.m. The Administrator confirmed the health assessment dated was the current health assessment for Resident #3. She stated she did not see an attachment to Resident #3 ' s health assessment and does not know where the attachment could be. She stated Resident #3 would have a new health assessment completed.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185(3) FAC

Based on observation interview and record review, the facility failed to ensure medication was prepared in the presence of the resident for 1 of 4reisdents observed (Resident #3), failed to ensure 1 of4 residents received the correct dosage of medication (Resident #7) and failed to ensure unlicensed staff did not assist residents with the self administration of medications which require judgement (Resident #3).

The findings include:

1. On at 12:15 p.m. Staff A was observed in kitchen with a bag of medications for Resident #3 and a small cup with 10 pills in it. When Resident #3 entered the dining Staff A called Resident #3 to her then handed him a small cup with 10 pills in it. Resident #3 swallowed the medications.

On at approximately 12:20 p.m. an interview was conducted with Staff A. She confirmed she prepared Resident #3 ' s medication in the cup prior to the resident entering the dining
2. On at 4:35 p.m. Staff B was observed assisting Resident #7 with the self-administration of

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0052 Continued From page 1

medications. Staff B provided Resident #7 with a 100mg capsule of . Resident #7 took the medication and swallowed it.
A review of the label confirmed Resident #7 received 100 mg of . The label stated the medication should be given twice daily (photographic evidence obtained).
A review of Resident #7 ' s medication observation record revealed Resident #7 should have receive 50 mg of by mouth, twice daily. A review of medications orders for Resident #7 physician orders revealed the order was for 50 mg of twice per day.
On at approximately an interview was conducted with the Administrator. She confirmed Resident #7received incorrect dosages of . She stated the bottle for 100 mg of was from an older order and that the new bottle (with 50 mgs capsules) had not been placed in with the resident ' s current medication.
3. On at approximately 9:30 a.m. observations of Resident #3 ' s medications revealed the resident has a bottle of 5 MG. The instruction on the bottle stated, " Take 1 to 2 tablets by mouth every 6 hours as needed for breakthrough pain.
A review of Resident #3 ' s MOR confirmed the resident is assisted with by the facility ' s staff.
On at approximately 9:30 an interview was conducted with the administrator. She confirmed there are no licensed nurses in the facility to administer or assist residents with medication. She confirmed unlicensed staff assisted Resident #3 with
Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, interview and record review, the facility failed to ensure the medication observation record (MOR) was accurately transcribed for 1 of 4 residents whose MORs were reviewed (Resident #3).
On 11: 54 an interview was conducted with Resident 3. Resident #3 stated he receives assistance with the self-administration of medication, with the exception of his
On at 11:56 a.m. a vial two vials of was observed in Resident #3 ' s
A review of Resident #3 ' s MOR revealed there was no information regarding resident #3 ' s included on the MOR.
A review of Resident #3 ' s Active Prescription List, dated (medication orders) listed on page 2 the 5th entry is Aspart, Human 100 units/ml Inject 5 units before meals for (Discard vials 28 days after opening.). Give before breakfast, lunch, and dinner. The 6th entry on page 2 showed, Gargine, Human 100u/ml, inject 35 units every evening for (Do not mix with other Discard vials 28 days after opening)"
Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on observation interview and record review, the facility failed to ensure a person holding a currently valid health First Aid card remained on the premises at all times for 13 of 14 residents in the facility (Staff B).

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SUMMARY STATEMENT OF DEFICIENCIES
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The findings include:
On at approximately 2:00 p.m. the administrator was observed telling Resident #6 she was going to the bank and asked a resident is he would like to go with her. The resident agreed. The administrator and Resident #6 were observed leaving the facility. Staff B was observed to be the only staff member on the property and was left in charge of the residents.
A review of Staff B ' s personnel records revealed Staff B did not have a currently valid first aid card.
On p.m. an interview was conducted with the administrator. The Administrator confirmed she left property and left Staff B in charge. She further stated she will have Staff B complete the training before the next day.
Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation interview and record review, the facility failed to maintain a signed copy of a contract for 1 of 2 resident records reviewed (Resident #7).

The findings include:

A review of Resident #7 ' s record revealed a copy of a residency agreement for Resident #7. The contract was not signed by Resident #7 or his representative.
On at 6:08 p.m. the administrator was interviewed regarding the missing documentation. The administrator stated the page was lost. She added she would have Resident#7 representative sign the contract by

Class III