Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911097	A. BUILDING: _____ B. WING _____	C 06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD RETIREMENT CENTER	460 NEWELL HILL ROAD LEESBURG, FL 34748

(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 A complaint investigation (complaint number 2026009567) was conducted at Mayfield Retirement Center on June 8, 2026. Deficiencies were identified during the time of the visit.	A 000		
A 165	429.23(1-4 & 6-10) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. Death; 2. Brain or spinal damage; 3. Permanent disfigurement; 4. Fracture or dislocation of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or	A 165		

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A 165	Continued From page 1 its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) Abuse, neglect, or exploitation must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of	A 165		

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A 165	Continued From page 2 s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit an adverse incident report to the Agency for Healthcare Administration within timeframe's for 1 of 1 residents sampled (Resident #1). Findings Include: Review of Resident #1's record revealed an admission date of 08/12/25. Health Assessment dated 11/21/25 reads resident has a diagnosis of Parkinson's and is alert and oriented x's 1 with confusion. During an interview on 06/08/2026 at 10:57 AM, the Assistant Administrator stated, "I am familiar with the incident that happened with [Staff A' name] and [Resident #1's name]. I came into work the next day on 06/3/26 and I saw [Resident #1's name] sitting in the chair at the end in the	A 165		

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A 165	Continued From page 3 living room. I noticed a blister of red blood on her arm. I asked her what happened and [Resident #1's name] said "You know I got attacked, stop acting crazy [Assistant Administrator's nick name]." So I waited for [Staff B's name] and [Staff A's name] to walk up and asked them what happened. [Staff A's name] said "[Resident #1's name] grabbed her hair and she slapped her [Resident #1] on the arm"." During an interview on 06/08/2026 at 9:36 AM, the Administrator stated, "I was told about the abuse incident and what happened between [Resident #1's name] and [Staff A's name]. When I first came, I did ask the owners if an Adverse incident had been done and the owners said that the former admin [Administrator] had taken care of everything. I have access to the incident reporting site, but I can't see any of the previous adverse incidents that have been reported. I know I didn't file an adverse incident report for this incident. Review of the facility's policy titled "Abuse, Neglect, and Exploitation" dated 4/7/26 reads, "1. All employees must be background screened prior to working with residents. 3. All employees will attend a 1-hour training course in abuse, neglect, and exploitation within 30 days of hire. 4. All employees are mandatory reporters and must report any observed incidents of abuse, neglect, and/or exploitation to the administrator immediately. Administrator will report the allegation of abuse, neglect, and/or exploitation to the Department of Children and families (DCF), adult protection services (APS), by calling 1-800-962-2873 or report it online ....." Class III	A 165		