RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Mullins & Mullins Enterprises LLC
2310 Whitewood Avenue
Spring Hill, FL 34609

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2014 by representative(s) of this office.

Enclosed 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. 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 this office at (386) 462-6201.

Sincerely,

Kristen J. Mennella
Field Office Manager

KJM/amw

Enclosure

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967779	07/02/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Mullins & Mullins Enterprises Llc	**2310 Whitewood Avenue Spring Hill, FL 34609**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0026 - 58a-5.0182(2) Fac - Resident Care - Social & Leisure Activities S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= D

Specific Tag Findings:

0000-Initial Comments

On , an unannounced Biennial Survey was conducted at Mullins and Mullins Enterprises LLC (Rainbow Gardens) Assisted Living Facility. Deficient practice was identified at the time of the survey.

0026-Resident Care - Social & Leisure Activities 58A-5.0182(2) FAC
Based on observations, interviews and record reviews, the facility failed to provide ongoing scheduled activities for at least 12 hours per week, 6 days a week for 6 of 6 residents living in the facility (Residents #1, #2, #3, #4, #5, #6).

The findings include:

1. On , at approximately 9:15 a.m., observations revealed there were residents #1 through #6 in the facility, not engaged in activities. Continued observations throughout the day through 6:30 p.m., revealed no scheduled activities were provided for residents #1 through #6.

2. On , observations from 9:15 a.m. throughout the day through 6:30 p.m., revealed that Resident #2 layed in her bed during the entire time frame, except for being at the dinner table for lunch at 12:30 p.m. and for dinner at 5:30 p.m. No activities were offered for Resident #2.

3. On , observations from 9:15 a.m. throughout the day through 6:30 p.m., revealed that Resident #1 carried a stack of Uno cards while walking throughout the facility. No activities were offered for Resident #1.

4. On , at 9:38 a.m., interview was conducted with Resident #4. She stated she does not do activities, because the staff does not offer activities. She stated the facility offered activities in the past. She stated she would like to play dominos at the facility.

5. On , at 10:15 a.m., interview was conducted with Resident #3. She stated she does not engage in activities too much. Resident #3 stated "I don't do anything, I stay in my ..' in living ....'

6. On , at 11:20 a.m., interview was conducted with Resident #5. She stated the facility has no planned activities, she goes walking, but this is something she does on her own. She stated the facility does not offer activities for her and the other residents. The only activity Resident #5 mentioned is when the facility staff take her to church on Sundays.

7. On , at 1:02 p.m., interview was conducted with Resident #4's family member. He stated he visits Resident #4 every day, four times per day. He stated he can not say much about the activities the facility provides. He stated the facility used to play games, but he has not seen them play games anymore.

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8. On , at 1:15 p.m., interview was conducted with Resident #6. She stated the facility doesn't have too many planned activities. She stated the residents do pretty much what they want.

9. On , at 2:25 p.m., interview was conducted with Staff A. She stated other than reading the newspaper, the facility has an activity at least once per week.

10. On , at 4:23 p.m., interview was conducted with facility owner. She stated there was no activities scheduled for 2014. She stated she forgot to make an activities schedule.

11. Review of activity records, confirmed there were no scheduled activities for the month of 2014.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and interview, the facility failed ensure 1 of 6 residents in the facility was treated with diginty during a medication observation (Resident #4).

The findings include:

1. On at 10: 27 a.m. Staff A was observed with gloves on and preparing Resident #4's medication in a small cup. Resident #4 was unable to get the medication out of the cup, so Staff A poured the pills in her own left hand. Continued observation revealed Staff A used the finger on her right hand to pick the pills out of her left hand, one at a time, and then give the pills to Resident #4. at 10:35 p.m. Staff A had two pills in the palm of her left hand. Staff A reached in a small trash can with her right hand to retrieve a label. Staff A then proceed to use the finger on her right hand to pick up the medication out of her left hand. Staff A gave that same medication to Resident #4. Resindent #4 raised her hand to her mouth to take the pills Staff A gave to her, then the surveyor interveined.

2. On at 10:37 a.m. Resident #1 was interviewed. She stated she was not aware Staff A reached in the trash can while providing her medications. Resident #1 stated she did not want to take the last two pills Staff A had for her and requested that Staff A dispense two new pills for her.

3. On at approximately 10:40 a.m. Staff A confirmed she did not change her gloves between reaching in the trash can and continuing the medication pass for Resident #4.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, interview and record review the facility failed to assist residents with the self-administration of medication in accordance with Section 429.25(6), F.S. by not preparing the medication in the presence of the resident for 2 of 4 residents observed during a medication pass (Resident #2 and #6) and failing to read the medication label in the presence of the resident for 1 of 4 residents observed during a medication pass (Resident #2).

The findings include:

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SUMMARY STATEMENT OF DEFICIENCIES
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1. On at 10:00 a.m. Staff A was observed in Resident #4's for a medication pass. Resident #4 requested her . Staff A left Resident #4's returned with a glass of juice at 10:05 p.m. Staff A told Resident #4 she mixed the the her juice.

2. On at 2:42 p.m. Staff A was observed preparing Resident #6's medications while standing in the kitchen. At the time Resident #6 was seated in the living . Staff A dispensed one medication into a small cup, then she returned the medication to it's storage area. Staff A then walked into the living , where resident #6 was sitting. Staff A gave the pill to Resident #6.

3. at 2:59 p.m. Staff A dispensed Resident #2' medications into a small cup while standing in the Kitchen. Staff A was observed returning the medication to the locked medication storage area. Staff A then walked through the kitchen and down the hallway to Resident #2's . Staff A placed the medication in Resident #2's hand. She did not read the label in the presence of the resident nor did she inform the resident which medication she put in her hand.

4. A review of the facility's medication procedures, which is posted for staff's review, revealed the steps the staff are to follow when assisting with the self-administration of medication. The steps include: "In the presence of the resident, reading the label, opening the container and removing the prescribed amount of medication."

5. On at 10: 08 a.m. Staff A was interviewed. She stated and confirmed she mixed Resident #4's medication in the juice prior to bringing the medication to Resident #4.

6. On at approximately 5:30 p.m. The Owner was interviewed, She stated staff were taught to prepare the medication and read the label in the presence of the resident.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation and interview, the facility failed to ensure that 1 of 2 staff members (Staff A), immediately updated the medication observation record (MOR) for 5 of 6 residents receiving assistance with self-administration of medications (Residents #1, #2. #3, #5 and #6).

The findings include:

1. On , at 9:05 a.m., Staff A was observed outside the facility. collecting the newspaper in the driveway. Continued observations revealed at 9:10 a.m., Staff A was observed initialling the MOR's for Residents #1, #2, #3, #5 and #6.

2. On , at 9:10 a.m., an interview was conducted with Staff A. She stated medications were given for all residents except for Resident #4, right before she went outside to get the newspaper.

Class III

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on interviews and record reviews, the facility failed ensure the administrator was responsible for the supervision and the management of all staff and the provision of appropriate care to 4 of 6 residents in the facility

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(Resident #2, #3, #4 and #6).

The findings include:

1. An interview was conducted with Staff A on , at 2:25 p.m. Staff A stated she is the manager of the facility. Staff A stated she maintains the Medication Observation Records and supervises the facility employees. Staff A stated she is not CORE trained.

2. An interview was conducted with the facility administrator on , at 4:05 p.m. The administrator stated she visits the facility once or twice per week. She stated Staff A, Certified Nursing Assistant, supervises the employees and completes the staffing schedules. She stated she does not talk with hospice or home health agencies servicing the residents. She stated she does not know how many of the residents are being seen by home health agencies. She stated she knows one of the residents has a , but she doesn't know the resident's name. She stated she does not know if she is supposed to keep track of these things.

3. A review of Facility Manager Job Description was conducted on , at approximately 4:15 p.m. The review revealed the job description was signed by the facility administrator, dated . The job description responsibilities were observed to include work with doctors, residents, home health nurses, ensuring resident's needs are being met; order and verify medications; supervise staff; provide ongoing observation of residents; bottom checks; ensuring treatments are completed.

4. A review of resident records was conducted on , at approximately 4:30 p.m. The review revealed 4 of 6 residents are receiving services from home health agencies, to include Resident #4, who has a

Class III