STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964997	C 12/20/2018
NAME OF PROVIDER OR SUPPLIER **MAYFLOWER, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **19880 N US HWY 441** **HIGH SPRINGS, FL 32655**	

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

0000 - Initial Comments

On [redacted], an unannounced complaint investigation survey (CCR #2018017915) was conducted at The Mayflower Assisted Living Facility (License #9545), High Springs, FL. Deficient practice was identified at the time of the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation and interview, the facility failed to ensure 6 of 6 observed residents (Residents #3, #4, #6, #7, #8, and #9) were treated with due recognition of personal dignity, individuality and the need for privacy.

Findings:

On [redacted] at 12:00 PM, during observation of assistance with self-administration of medications, six bags of medications belonging to Residents #3, #4, #6, #7, #8, and #9 were left exposed and to others on a table unattended by Staff A and the Medication Observation Record Book was left open exposing Protected Health Information (PHI) to other persons in and around close proximity of the dining room. In addition, during assistance with self-administration of medications, Staff A was observed reading the medication labels aloud and announcing the diagnoses of the residents in front of other residents sitting nearby. Staff A was not observed to take into consideration or make accommodations to ensure the privacy of the residents (Photographic evidence obtained).

On at 4:10 PM, during the second observation of assistance with self-administration of medication, Staff A left the drawers of the file cabinet in the office, where all the resident medications were stored, wide open. (Photographic evidence obtained).

On at 4:50 PM, an interview was conducted with Staff A. She confirmed the need to protect resident rights to privacy. She further stated that in the future she planned to assist residents with their medications in the office in a private setting.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation and interview, the facility failed to ensure unlicensed Staff A assisted 6 of 6 residents (Residents #3, #4, #6, #7. #8, and #9) with self administration of medication as described in

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964997	C 12/20/2018
NAME OF PROVIDER OR SUPPLIER **MAYFLOWER, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **19880 N US HWY 441** **HIGH SPRINGS, FL 32655**	

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

Section 429.256 of Florida Statutes (F.S).

Findings:

On at 12:00 PM, Staff A/Administrator was observed assisting with self-administration of medications. Staff A was observed picking up multiple plastic bags full of medications from the file cabinet in the office along with the Medication Observation Record (MOR) binder. The Administrator then walked into the dining room and placed the multiple bags of medications belonging to Residents #3, #4, #6, #7. #8, #9 on the table where over 10 residents were seated eating or waiting to eat their lunch. Staff A was observed grabbing up the plastic bag of medications one by one, for the residents, who were being assisted with medications while sitting at the dining room table eating lunch, with other residents sitting nearby. While assisting each resident, Staff A, left the remaining bags of medications for the other residents on the table unattended along with the MOR binder. This same process was observed for all six residents receiving medications on at 12 noon (Residents #3, #4, #6, #7, #8, #9). Between assisting each of the six residents, Staff A was not observed sanitizing or washing her . . . (Photographic evidence obtained).

On at 12:29 PM, an interview was conducted with Staff A. She stated, in reference to the observations made during assistance with self-administration of the medications, that she was distracted and could not focus as she had other things on her mind. She confirmed she should not have left the medications out in the open and should have sanitized her between residents.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964997	C 12/20/2018
NAME OF PROVIDER OR SUPPLIER **MAYFLOWER, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **19880 N US HWY 441** **HIGH SPRINGS, FL 32655**	

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

0000 - Initial Comments

On [redacted], an unannounced complaint investigation survey (CCR #2018017915) was conducted at The Mayflower Assisted Living Facility (License #9545), High Springs, FL. Deficient practice was identified at the time of the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation and interview, the facility failed to ensure 6 of 6 observed residents (Residents #3, #4, #6, #7, #8, and #9) were treated with due recognition of personal dignity, individuality and the need for privacy.

Findings:

On [redacted] at 12:00 PM, during observation of assistance with self-administration of medications, six bags of medications belonging to Residents #3, #4, #6, #7, #8, and #9 were left exposed and to others on a table unattended by Staff A and the Medication Observation Record Book was left open exposing Protected Health Information (PHI) to other persons in and around close proximity of the dining room. In addition, during assistance with self-administration of medications, Staff A was observed reading the medication labels aloud and announcing the diagnoses of the residents in front of other residents sitting nearby. Staff A was not observed to take into consideration or make accommodations to ensure the privacy of the residents (Photographic evidence obtained).

On at 4:10 PM, during the second observation of assistance with self-administration of medication, Staff A left the drawers of the file cabinet in the office, where all the resident medications were stored, wide open. (Photographic evidence obtained).

On at 4:50 PM, an interview was conducted with Staff A. She confirmed the need to protect resident rights to privacy. She further stated that in the future she planned to assist residents with their medications in the office in a private setting.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation and interview, the facility failed to ensure unlicensed Staff A assisted 6 of 6 residents (Residents #3, #4, #6, #7. #8, and #9) with self administration of medication as described in

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964997	C **12/20/2018**
NAME OF PROVIDER OR SUPPLIER **MAYFLOWER, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **19880 N US HWY 441** **HIGH SPRINGS, FL 32655**	

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

Section 429.256 of Florida Statutes (F.S).

Findings:

On at 12:00 PM, Staff A/Administrator was observed assisting with self-administration of medications. Staff A was observed picking up multiple plastic bags full of medications from the file cabinet in the office along with the Medication Observation Record (MOR) binder. The Administrator then walked into the dining room and placed the multiple bags of medications belonging to Residents #3, #4, #6, #7. #8, #9 on the table where over 10 residents were seated eating or waiting to eat their lunch. Staff A was observed grabbing up the plastic bag of medications one by one, for the residents, who were being assisted with medications while sitting at the dining room table eating lunch, with other residents sitting nearby. While assisting each resident, Staff A, left the remaining bags of medications for the other residents on the table unattended along with the MOR binder. This same process was observed for all six residents receiving medications on at 12 noon (Residents #3, #4, #6, #7, #8, #9). Between assisting each of the six residents, Staff A was not observed sanitizing or washing her . . . (Photographic evidence obtained).

On at 12:29 PM, an interview was conducted with Staff A. She stated, in reference to the observations made during assistance with self-administration of the medications, that she was distracted and could not focus as she had other things on her mind. She confirmed she should not have left the medications out in the open and should have sanitized her between residents.

Class III