

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105720	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Mayflower Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 Mayflower Court Winter Park, FL 32792	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50875</p> <p>Based on observation, interview, and record review, the facility failed to conduct medication self-administration assessment to ensure safety for 1 of 1 residents reviewed for self-administration of medications, of a total sample of 28 residents, (#42).</p> <p>Findings:</p> <p>Resident #42 was admitted to the facility on [DATE] with diagnoses which included encounter for surgical aftercare following surgery on the digestive system, Parkinson's Disease, anemia, major depressive disorder, generalized anxiety disorder, presence of left artificial hip joint and dementia.</p> <p>Review of the Minimum Data Set annual assessment with assessment reference date of 12/11/24 revealed resident # 42 had a Brief Interview for Mental Status score of 15 out of 15 which indicated she was cognitively intact.</p> <p>On 2/17/25 at 12:58 PM, resident #42 was observed in her wheelchair watching television with her bedside tray table directly in front of her. Towards the right side of the tray table a small red pill was observed on a white tissue that had times written on it. When asked about the times written on the tissue, she explained that it was written down so that she could be reminded of when to take her eye vitamin. Resident #42 mentioned her daughter bought the vitamins for her because the eye doctor told her it was okay to take them and that they were very expensive. She stated the nurses knew she had been taking the medication on her own twice daily.</p> <p>A review of resident #42's medical record indicated no physician orders for eye vitamins or self administration of medication, no care plan for self-administration of medication and no assessments completed for resident #42 regarding self-administration of medications.</p> <p>On 2/17/25 at 2:07 PM, the assigned nurse Registered Nurse (RN) A observed and verified the red pill on a piece of tissue on resident #42's tray table in her room. With the resident's permission, RN A then retrieved the bottle of pills from an uncovered white plastic container on the resident's tray table and confirmed the pill bottle was labeled PreserVision AREDS 2. Resident #42 explained she had been taking it a long time and it was very expensive. RN A told the resident she was not allowed to have the medication at the bedside and assured her that the facility had medications in stock which could be provided.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/18/25 at approximately 10:00 AM, resident #42 stated she was not aware she could not take her own medication. She explained she did not know of any assessments which should be completed by nurses prior to her self-administering medication. She said that the nurse took the medication from her, and they would administer it.</p> <p>On 2/19/25 at 10:06 AM, assigned Certified Nursing Assistant (CNA) B said she had seen the medication on the resident's tray table previously and confirmed the resident had marked the times on the tissue to remind herself when to take it. CNA B stated she thought the residents were allowed to have over the counter medications at their bedside but now understood why that might not be okay.</p> <p>On 2/19/25 at 11:46 AM, the Assistant Director of Nursing (ADON), acknowledged she did not really know what happened in regards to resident #42's medication at her bedside. She explained if a resident requested to use their own medications and self-administer, they would first have to be assessed for self-administration of medications by nursing. The ADON said that a physician order for the PreserVision was now in the computer and the resident wanted to receive her own medication but preferred the nurses to administer it.</p> <p>On 2/19/25 at 12:14 PM, assigned Licensed Practical Nurse (LPN) C said she was not sure if residents could have medications at the bedside and explained, if residents wanted to administer their own medications, the supervisor would handle it. LPN C explained she was not aware resident #42 was taking her own eye vitamins and had not seen any medication on the resident's tray table.</p> <p>On 2/19/25 at 12:29 PM, the Director of Nursing (DON) said he was made aware of the medication on resident #42's tray table on Monday. He continued that, sometimes residents have a way of bringing stuff in the facility which in this case, was unfortunately missed. The DON went on to explain that the Interdisciplinary Team ultimately decided if it was appropriate for residents to take their own medications based on the assessment for self-administration of medications and the management of a lock box provided.</p> <p>Review of the undated facility policy regarding Self-Administration of Medications revealed Residents may self-administer their own medications only if the Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision -making capacity to do so safely.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50875</p> <p>Based on interview, and record review, the facility failed to ensure nurses followed physician orders regarding administration of blood pressure medication per parameters set by the physician, for 1 of 5 residents reviewed for unnecessary medications, of a total sample of 28 residents, (#44).</p> <p>Findings:</p> <p>A review of the medical record revealed resident #44 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of pancreas, benign neoplasm of colon, anxiety disorders, chronic pain, major depressive disorder and essential (Primary) Hypertension.</p> <p>The medical record revealed resident #44 had an active physician order for Clonidine HCL tablet 0.1 milligrams (mg) tablet that directed staff to give 1 tablet by mouth two times a day for hypertension. The order included a parameter to hold the medication if the resident's systolic blood pressure (SBP) was less than 170 millimeters of mercury (mm Hg) or diastolic blood pressure (DBP) was less than 90 mm HG.</p> <p>Clonidine is prescribed to treat high blood pressure (hypertension) by decreasing the levels of certain chemicals in your blood. This allows your blood vessels to relax and your heart to beat more slowly and easily, (retrieved on 2/23/25 from www.drugs.com/clonidine.html).</p> <p>Review of resident #44's Medication Administration Record (MAR) for January 2025 and February 2025 revealed Clonidine HCL 0.1 mg was scheduled twice a day at 10:00 AM and 9:00 PM. The document showed the medication was either administered (indicated by a check mark) or not administered (indicated by the number 4-Vitals outside of parameters; 5-Hold/see progress notes; 9-Other/see progress notes).</p> <p>Review of the January 2025 MAR revealed Clonidine HCL 0.1 mg was administered once at 10:00 AM on 1/27/25 for a blood pressure of 153/70, under the parameters of the physician order. The MAR also revealed the medication was checked as administered several times at 9:00 PM when it should have been held according to the physician order. On 1/06/25 when the resident's blood pressure was 157/65; on 1/07/25 when the resident's blood pressure was 129/57; on 1/11/25 when the resident's blood pressure was 141/67 and on 1/17/25 when the resident's blood pressure was 123/63.</p> <p>For the month of February 2025, resident #44's MAR indicated on 2/15/25 at 10:00 AM Clonidine HCL 0.1 mg was checked as administered even though the documented blood pressure was 149/67, less than the parameters set by the physician order. On 2/08/25 at 9:00 PM the medication was also checked as administered for a documented blood pressure of 112/65 and again on 2/18/25 at 9:00 PM for a blood pressure of 104/59.</p> <p>On 2/20/25 at 10:43 AM, the Director of Nursing (DON) verified the administration of Clonidine HCL 0.1 mg for resident #44 and confirmed the check marks on the MAR for January and February of 2025 indicated the medication was given by the nurse. He acknowledged the medication should have been held instead of given per the parameters set in the physician order.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's undated Policy on Administering Medications indicated, Medications shall be administered from a unit dose system in a safe and timely manner, and as prescribed.</p>