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
	AL11965550	A. BUILDING: _____ B. WING _____	01/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSAY'S ALTERNATIVE CARE, INC	6463 NW 43RD COURT CORAL SPRINGS, FL 33067

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A 000	Initial Comments An unannounced Complaint survey, complaint numbers 2021016297, 2021016870, and 2022000018, was conducted on and at Lindsay's Alternative Care, Inc. The facility had deficiencies at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide appropriate supervision to a resident that was diagnosised with and that required supervision to prevent an elopement, for 1 of 6 sampled residents's records reviewed (Resident #1). As evidence of Resident #1 exiting the facility through the main door unsupervised and leaving the premise of the facility; resident was found at a park (nearby the facility) by a passerby. The Findings Included: Review of the facility's undated Policy &	A 025		

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A 025	Continued From page 2 Procedures titled, Missing Residents Protocol showed the following. Purpose: To promote an effective method to locate a missing resident in a timely and efficient manner. Procedures: 1. Nursing Supervisor shall alert ALL staff that a resident is missing. 2. All staff shall participate in conducting a room-to-room search, the vicinities, surrounding areas, parking lots, garden, park, businesses located around the immediate facility. 3. Nursing Supervisor shall instruct Security Guard/Receptionist to notify the following persions via phone and or beeper *911* - Administrator , Director of Nursing. 4. Nursing Supervisor shall contact the police, giving as musth information as possible- date of birth, gender and race, clothing and footwear wearing if known, ⌣ and ⌣ , last time seen by staff. Give special attention to any medical conditions: . . . . . Photograp/picture of resident if available 5. Nursing Supervisor shall instruct the Licensed Nurse to notify the resident's attending physician of the resident's disappearance. 6. Resident's family/legal representative or significant other of the resident's disappearance. 7. Nursing Supervisor shall intstruct Licensed Nurse to complete an internal Incident report to include as much information as possible: clothing and footwear the resident was last seen wearing, whether or not the resident had money or other personal belongings with her/him , last time the resident was seen by the staff, last meal eaten, mental status. 8. Nursing Supervisor shall instruct resident's assigned CNA and any other individuals directly involved with resident at the time of occurrence to	A 025		

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A 025	Continued From page 3 provide written statement indicating ; when and where the last time by the CNA or other personnel present, the last time care was provided to the resident. 9. Licensed Nurse shall document the resident's disappearance in the Nurse's Progress Notes. Review of facility progress notes dated . . . . . (3PM) and signed by the Assistant Administrator (AA) document the following. Resident had lunch and informed staff she was going to bed to nap. Resident last seen approximately 12:45 PM in bed. Resident noted not in bed approximately 1:30 PM. Facility searched and and resident not found. Perimeter searched , resident still not found. Search widened to ccommunity. Staff encoutered Coral Spring Police Department Officer and informed him. Officer stated that resident was found and transfported to hospital. Call placed to family, no answer. Staff proceeded to hospital. Staff informed by hospital that resident is stable and being kept for observation. Alarm device replaced as precaution. Review of a Local Law Enforcement Agency report dated . . . . . revealed Resident #1 was seen walking in the area of the park on . . . . . by a passerby who observed Resident #1 appearing to be lost and in need of medical assistance and contacted Law Enforcement. Law Enforcement arrived approximately 12:39 PM on . . . . . The responding officer stated he made contact with Resident #1 who identified herself, but was unable to say where she was, where she lived, or how she ended up at the location. Resident noted to be weak. Resident was transported to a medical center for treatment by Emergency Medical Services. Family was notified by the	A 025		

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A 025	Continued From page 4 hospital. Further review of the Local Law Enforcement Agency report revealed the following additional information. The responding office further stated in the report that on at 2:45 PM, he was flagged down while patrolling the area by a male (AA) who identified himself as the manager of the facility who stated he was not at the facility at the time of the elopement but was informed by staff that she was sleeping in her bed but wasn't there when they went to awaken her for her walk. Review of Resident #1's Health Assessment form dated revealed the resident suffers from and behavioral status noted as . Resident noted as an elopement risk. Further review of the form revealed the following nursing/treatment/ service requirements; needs supervision and assistance with ADLs (Activities of Daily Living). needs assistive device and supervision to walk. In an interview with Staff A (Caregiver) on at 10:17 AM who works the 7:00 AM -7:00 PM shift and was on duty the day elopement the resident, she stated the resident went through the door unexpectedly." She stated Resident #1 had finished her lunch and went to wash her in her room. Staff A also stated in the interview that when she checked on her, she was in her bed, which she Staff A stated she would usually do after eating lunch. Staff A stated she "packing (doing) laundry and going and forth," and went to the room. That is when she noticed Resident #1 wasn't in her bed so she begin to look for her because she will hide in her closet. She stated she looked throughout the house as the Resident will sometime go to the	A 025		

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A 025	Continued From page 5 other side of the house. When she was unable to locate the Resident inside the house, she called the Assistant Administrator (AA). Staff A further stated in the interview that Resident #1 had and sometimes she would try to go to other people bedroom, or the laundry room, but had never attempted to leave before. She stated the Resident went through the front door and that the alarm on the door wasn't working that day and had been down about days, and that she wasn't sure if someone turned it off or it needed batteries. Observation of the front door from Resident #1's bedroom by this Surveyor on revealed a L-shaped wall that separates the dining room (by the Resident's room), and the den area from the view of anyone in the kitchen and den area. As such, a person could leave the room and got through the front door without being noticed. Staff A stated she was in the washroom area adjacent to the kitchen and the TV/den area where four other residents where at the time. As such, her view would have been obstructed and she would not have seen the Resident leave through the front door. Staff A further stated that she checked with the other residents (4) and no one knew where Resident #1 was, exact time unknown. She further that the Staff B who usually works with her was off the day of the elopement, and that the employee (Staff C) who goes to all the facilities was there that day. In an interview with Staff B (Caregiver) on at 10:46 AM who works the 7:00 AM -7:00 PM shift, she stated she was not there the day of the elopement as it was her day off. She	A 025		

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A 025	Continued From page 6 stated they take care of the residents and give them food and make sure they are clean and check on them "not 1 time, 2 time, but every time you turn around to make sure they are okay." Staff B stated that the procedure for locating a missing resident is to search the house and if they don't see the person, they check around the house. If they do not see them, they contact the AA. She further stated Resident #1 had never attempted to leave before and that there is always 2 people on her shift. In an interview with Staff C (Caregiver) on at 2:40 PM, he stated he was at the facility at the time of the elopement. He stated the Resident had finished her lunch and went to her room to lie down. He stated Staff A had gone into Resident #1's room to put down some laundry, and he was in the kitchen. He stated Staff A took some more laundry in resident's room, then came out and told him she didn't see the resident in her room. He stated he responded: "What do you mean she isn't in her room?" He stated he went looking for her outside, and that he asked some neighbors if they had seen her, but they said they hadn't. He stated Staff A called the Assistant Administrator, who later shared with him that he talked with a police officer he told him he took Resident to the hospital. He further stated there was nothing out of the ordinary and that it was a normal day. "That's what so shocking about it. It really shook me." During an interview with Resident #1's Representative on at 11:05 AM, the family member stated no one from the facility called her to inform her that the resident had left the facility. She stated she received several calls, but they all showed up as Spam, so she didn't answer. She stated learned later the Police	A 025		

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A 025	Continued From page 7 Department was attempting to reach her, but she missed their calls. She stated she was advised of the elopement by her brother who had spoken with the police. Relative to the elopement she stated Resident #1 did not leave the community (in which the facility is located) and was found a few blocks away. She stated a neighbor saw her walking around and called the police. She also stated the alarm at the front door wasn't working so no one knew she had left. She also stated the alarm at the front door wasn't working when she came to the facility later that evening. She stated that she moved her mother that day as she was concerned because there are lakes and canals in the area. She further stated her Resident #1 was taken to the hospital by the Police as a precaution because he wasn't sure if she had or herself. She stated she was kept for observations, they ran a few tests, she is fine and was just a little On between 1:23 PM and 1:25 PM, this Surveyor walked to the park where the resident was alleged to have walked. The park is located directly behind the facility approximately 100 yards across a four-lane street and can be seen from the facility's patio. However, it is accessed by using the streets that lead to it. This Surveyor retraced the stated route the Resident took to the park where she was alleged to have gone. Observation revealed Resident #1 would have had to exit the front door, walk down the driveway, walk down the street pass 4 houses, make a right turn, and walk approximately 50-55 to the next street. She would then have to cross a four-lane residential road (two in each direction), access the sidewalk, and walk to the area of the park where she was said to have	A 025		

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A 025	Continued From page 8 been found. The route was approximately 150 -200 yards and took this Surveyor 2 minutes, 35 seconds to walk it. Additional observations made by this Surveyor revealed a lake at the end of the street behind a few homes where the facility is located. Observation also revealed a lake with open access from the park, which can be accessed from the backyard of the facility. In the interview with the Assistant Administrator (AA) on ..... at 2:12 PM, he stated he encountered the Police Officer at the School that is adjacent to the park where Resident #1 was said to have been locatedon . He stated he stopped and informed the Officer that he had a missing Resident. He stated the Officer said "Stop, I saw her (pointing down the street) in the area down there." The AA stated he did not say she was in the park, just in the area of the park. Observation by this Surveyor revealed the Park grounds begin immediately after the school property ends. In an interview with the AA on at 12:09 PM, he stated he changed the alarm devices on the doors, retrained staff to check on residents with more frequency (instead of every hour). Observations of the door revealed a new device which was similar to the prior device installed on the main entrance door. He stated that he is exploring getting a security system with (company name) with cameras that monitors the interior (except bedrooms), exterior and provides a warning and visual when someone uses the doors. However, this had not been completed/implemented as of the day of the survey. The AA was also unable to verify that the new steps implemented by the facility to prevent	A 025		

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A 025	Continued From page 9 future elopement had been reassessed and audited to ensure compliance for resident safety and ensure adequate supervision. He further stated they try not to admit residents who are elopement risk, but unfortunately the only time you know is when the do it. Class III	A 025		
A 165	429.23(&) 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. ; 2. or , damage; 3. Permanent ; 4. or 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	A 165		

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A 165	Continued From page 10 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 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) ..., neglect, or ..., ... 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,	A 165		

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A 165	Continued From page 11 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 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 following the Elopement of one (1) of six (6) residents reviewed/or observed (Resident 1). The Findings Include: On and a Complaint Survey was conducted at the facility. During the Survey a review of facility records and documents was performed. The review did not reveal an Adverse Incident Report (AIR) for the elopement of Resident #1 that occurred on .	A 165		

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A 165	Continued From page 12 In an interview with the Assistant Administrator (AA) on at 12:13 PM he stated he did not submit an Adverse Incident Report as he didn't consider it an adverse incident because Resident #1 didn't get hurt. This Surveyor informed the AA and Facility Manager of the requirements for submitting an AIR and provided the regulation related to it. They responded that they would submit a report should any similar incident(s) occur going forward. On this Surveyor met with the Assistant Administrator (AA) to conduct the Exit Interview. He was informed of the finding: failure to submit an Adverse Incident Report (AIR). He was also informed that he would receive a report from of our office of the findings. He stated he understood. Class	A 165		