STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965550	08/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Lindsay's Alternative Care, Inc	6463 Nw 43rd Drive Coral Springs, FL 33067	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses

Specific Tag Findings:

0000-Initial Comments
An unannounced abbreviated Relicensure survey was conducted on [redacted] at Lindsay's Alternative Care. The facility had a deficiency found at the time of the visit.

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on record review and interview, it was determined that the facility failed to ensure that 1 of 3 sampled employees have a current, eligible Level 2 Background Screening result (Employee #2).

The findings include:

Review of the personnel records, on [redacted] revealed an application and hire date for employee #2 as [redacted]. The application did not include previous work history. Employee #2 was present during the survey and confirmed she provides direct care to the residents. The Level 2 Background Screening results was dated [redacted].

During an interview at 10:20 AM with Employee #2, she stated she was in school and worked other jobs. She stated that none of the jobs required her to have a level 2 background screening. During a telephone interview at 10:30 AM with the Administrator, she stated she did not know her employment history from 2010 until she was hired at the facility in [redacted] 2014.

Unclassified

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Lindsay's Alternative Care, Inc
6463 NW 43rd Drive
Coral Springs, FL 33067

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a state relicensure survey that was conducted on 2014 by a representative of this office.

Attached 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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