STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965079	02/11/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Lindsay's Alternative Care, Inc	5783 Nw 48th 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 - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D

Specific Tag Findings:

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

0010-Admissions - Continued Residency 429.26(1&9) FS; 58A-5.0181(4) FAC
Based on interview and record review, the facility failed to ensure that a resident's continued residency is appropriate and that their Health Assessment Form (AHCA 1823) was accurate , reflective of their current care needs and services for 1 out of 2 residents (Resident # 4). As evidenced of the facility failing to have a nurse on staff or under contract to provide assistance to perform routine [redacted] care.

The findings include:

During an interview conducted with the representative of Resident #4 on [redacted] at 1 PM, they were asked if they were aware that unlicensed staff assists with self- administration of medications, they stated they were, but that they were unsure who assists Resident #4 with her [redacted] bag, since she cannot do it herself.

On [redacted] a record review of Resident # 4's record revealed an admission date of [redacted] and an AHCA 1823 form dated [redacted] with the following diagnosis: [redacted] A-Fib, [redacted] On page 1 under nursing /treatmer [redacted] service requirements: Medication management. The assessment was lacking any documentation of the [redacted] bag or care needs for the bag. The record was also lacking a physicians order for the [redacted] bag and care of it.

A review of Resident # 4's file revealed a physician note dated [redacted] where he conducted a physical examination , and includes the [redacted] bag to the abdomen, and an assessment of the [redacted] status.

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A review of Resident # 4's file revealed a physician note dated where he conducted a physical examination , and includes the bag to the abdomen in place , and an assessment of the status.
There was no other documentation in the record of the bag or care of the

During an interview conducted on at 1:45 PM, with the Assistant Administrator, she confirmed that Resident #4 has a bag, is not receiving home health services and is unable to change the bag herself. She could not provide a name of any nurse or any nurse ' s notes for the care of the bag for Resident #4.

During an interview with the Nurse Practitioner that completed the physician notes on and , he confirmed that Resident #4 has a bag, he saw her this morning. He stated he was unaware of who was changing the bag, or who is overseeing the care of the . He stated he does not send a nurse to change it.
In interviews conducted on with Staff A, Staff B, Staff C and Staff D, they all stated they do not change the bag.

In an interview conducted with the Assistant Administrator on at 3:25 PM, she acknowledged the findings.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Lindsay's Alternative Care, Inc
5783 NW 48th Drive
Coral Springs, FL 33067

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a state relicensure survey that was conducted on 2015 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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