

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11965079	(X3) DATE SURVEY COMPLETED 02/11/2015
NAME OF PROVIDER OR SUPPLIER Lindsay's Alternative Care, Inc	STREET ADDRESS, CITY, STATE, ZIP CODE 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 _____ 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 _____ care.

The findings include:

During an interview conducted with the representative of Resident #4 on _____ 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 _____ bag, since she cannot do it herself.

On _____, a record review of Resident #4's record revealed an admission date of _____ and an AHCA 1823 form dated _____ with the following diagnosis:

A-Fib, _____ On page 1 under nursing/treatment service requirements: Medication management. The assessment was lacking any documentation of the _____ bag or care needs for the bag. The record was also lacking a physician's order for the _____ bag and care of it.

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, and an assessment of the _____ 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:

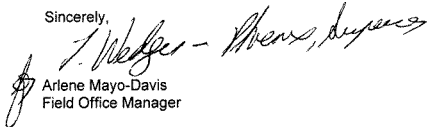
This letter reports the findings of a state relicensure survey that was conducted on 2015 by a representative of this office.

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

