STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965079	**02/24/2017**
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced licensure complaint survey, CCR# 2016013508, was conducted on , and at Lindsay's Alternative Care, Inc. (License # 9506). The facility had deficiencies at the time of the investigation.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interview and record review, it was determined that the facility failed to ensure residents' reside in a safe living environment free from and neglect. This was evidence by the facility's lack of following their policy and procedure that address Incidents. It was determined that the facility failed to ensure that a resident's (Resident # 1) Power of Attorney immediately notified after an incident.

The Findings Included:

A review of Resident # 1's file revealed an admission date of . Resident # 1's Agency for Health Care (AHCA) 1823 assessment is dated for with a diagnosis of , , unsteady gait, , atony of , history of , chronic , frequent and . Resident # 1 was admitted to hospice (third party) on and has a . Resident # 1 requires assistance of one person for activity of daily living. Resident # 1's son is his power of attorney (POA).

On at 11 am, an interview with the Assisted Living Manager (ALF) revealed Resident # 1 had an incident that occurred in 2016. The ALF Manager stated the facility did not complete an incident report for Resident # 1 and he does not recall the date that the incident occurred. The ALF Manager stated on the day of the incident; Resident # 1 was being cared for by the hospice nurse in the ALF. He stated the hospice nurse put Resident # 1 at the breakfast table and thought she locked his wheelchair. The ALF Manager stated the hospice nurse walked away and assumed that Resident # 1 pushed back from the dining table and she saw that Resident # 1's wheelchair was tilt and against a wall where she discovered that Resident # 1 probably hit his head. The ALF Manager stated an ALF staff member was present in the facility at the time but did not witness the incident either. The ALF Manager stated that hospice nurse assessed Resident # 1 to be in stable condition. The ALF Manager stated they never contacted Resident # 1's POA immediately after the incident and they never documented the incident. He stated the hospice nurse contacted Resident # 1's son approximately 2 hours after the incident occurred. The ALF Manager stated Resident # 1's POA requested Resident # 1 to be sent to the hospital emergency . The ALF Manager stated the x-rays came back negative.

A review of Resident # 1's hospital records revealed on at 1:18pm, the patient was brought in

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by fire rescue after hitting the back of his head against the wall while tipping over in the wheelchair: Patient is and unable to give coherent history.

A review of the facility's records revealed that the facility has a policy and procedure on Incident Reporting (copy obtained). The policy states that an incident report shall be completed on any happening, which is not consistent with routine operation of the facility or routine of care of a , resident.

The facility's Incident Policy and Procedure states that the facility must offer the services of an emergency , if they desire medical evaluation of a possible injury. On at 12:30 PM the ALF Manager stated Resident # 1 had on the back of his head but they did not send him to the emergency Resident # 1's POA requested it.

Further review of Resident # 1's notes dated for revealed Resident # 1 injured his right finger . Resident # 1 had x-rays done on and no were reported. On at 12:07 PM, the ALF Manager stated they informed Resident #1's POA of the injured finger but he has no documentation of contact with Resident # 1's POA for the injured right ring finger. He stated the facility never completed an incident report.

On at 3 PM, the ALF Manager acknowledged the finding of not following their Incident Policy and Procedure on file for residents and staff, failure to perform immediate notification to Resident # 1's POA of his changes in condition resulting from the incident and injuries and failing to provide immediate medical attention due to injury.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on facility record reviews, the facility failed to maintain an up-to-date admission and discharge log listing the names of all residents and each residents date of admission, the facility or place from which the resident was admitted and date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged, for 2 out 4 residents (Resident # 1 and Resident # 3).

The Findings Included:

A review of Resident # 1's file revealed an admission date of . A review of the facility's Admission/ Discharge Log revealed Resident # 1's admission date. The discharge log does not have

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documentation of a discharge date or location for Resident # 1.

A review of Resident # 3's file revealed an admission date of . The facility's admission log found no documentation of Resident # 3's admission date.

In an interview with the ALF Manager on at 10 AM, he stated Resident # 1 was discharged a few days ago but he is not sure of the date. Further review of the logs found no admission date or date for Resident # 3. On , the ALF Manager acknowledged the missing information.

Class