

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN SWAN OF BOCA ALF

**19494 HAMPTON DR
BOCA RATON, FL 33434**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Relicensure survey, Generator Assessment survey and a Focused Control survey was conducted on _____ at Golden Swan of Boca ALF. The facility had deficiencies at the time of the survey.	A 000		
A 008 SS=D	429.26() FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made	A 008		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER GOLDEN SWAN OF BOCA ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 19494 HAMPTON DR BOCA RATON, FL 33434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 008	Continued From page 1 available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and must be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or _____ nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER GOLDEN SWAN OF BOCA ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 19494 HAMPTON DR BOCA RATON, FL 33434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 008	Continued From page 2 Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of _____ require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a _____ to _____ medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or _____ services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of _____ or any other communicable _____, which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER GOLDEN SWAN OF BOCA ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 19494 HAMPTON DR BOCA RATON, FL 33434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 008	Continued From page 3 assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, _____, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170 . Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider. 2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. 3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. (c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER GOLDEN SWAN OF BOCA ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 19494 HAMPTON DR BOCA RATON, FL 33434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
A 008	Continued From page 4 days after admission. (d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida Form, for residents who do not wish _____ to be administered in the case of _____ or _____. (g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on observation, records review and	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN SWAN OF BOCA ALF

**19494 HAMPTON DR
BOCA RATON, FL 33434**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 008	Continued From page 5 interviews, it was determined that the facility failed to ensure that each resident's health assessment accurately documented the required ADLs for 3 of 6 sampled residents' health assessment (AHCA form 1823) reviewed. did not reflect the current physical health condition of the residents (Residents # #5 & #6). The findings included: During breakfast observation on at 8:55 AM, six residents (#1-#6) were noted to be at the facility table with only one staff member (Employee A). Observations revealed Resident #3-#6 required assistance with feeding and/or total feeding. Staff A, at the start of breakfast was the only staff present to assist with feeding, the residents were unable to feed themselves. Review of the Resident health assessments (AHCA form 1823) for Residents #4, 5, and #6 revealed that all three residents were documented eat independently. Yet, all three were observed to in need of feeding assistance. Additionally, the 1823 section 1A, dated, revealed that Resident #4 can eat independently. The same is recorded in Resident #5's 1823 dated and Resident #6 dated During a follow-up interview with the Administrator on at 12:00 PM, she indicated that Resident #4 declined following her hospital visit. However, she offered no reason for the decline of Resident #5 and #6 except to admit that Resident #5 occasionally eats by herself. The Administrator finally admitted the issue and said that she will have the physician update the health assessment. Class III	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER GOLDEN SWAN OF BOCA ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 19494 HAMPTON DR BOCA RATON, FL 33434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 028 SS=D	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on observation, records review, and interview, the facility failed to ensure that each resident received assistance with his/her Activities of Daily Living (ADLs) and that each resident is treated with respect and dignity while being assisted, for 5 out of 6 residents (Residents #2, #3, #4, #5, & #6). The findings included: On at 8:55 AM, during breakfast observation, Employee A was observed feeding Resident #3 while standing in front of the resident. As Resident #3 was being fed in haste, Resident # 5 was observed sitting at the table without any food, or drinks in front of her, while facing another resident who was eating independently. At 9:05 AM when Employee B who was contacted by Employee A arrived at the facility to assist, she too stood next to Resident #5 to feed her. Later at 9:17 AM, soon after the Administrator arrived at the facility, she hurriedly went to Resident #2's room and got her out of bed and brought her to the dining room partially covered with a pink towel. As, she pushed Resident #2's wheelchair to the dining room, this writer painfully observed Resident #2 attempting to cover herself to maintain her dignity. Then, at the request of the Surveyor, the Administrator	A 028		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN SWAN OF BOCA ALF

**19494 HAMPTON DR
BOCA RATON, FL 33434**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 028	Continued From page 7 returned to the Resident's room and brought a throw which was placed on Resident #2's while she somnolently sat in her wheelchair. At 9:29 AM, the Administrator was observed feeding Resident #4 and #5 at the same time at the table. Resident #4 was on the right while Resident #5 was on the left, and the Administrator stood in the middle. A few minutes later, her cell phone rung and she answered the phone while continuing to feed Resident #4. Then, she left the residents unattended and went to an adjacent room to continue the phone conversation. After a few minutes, she returned to the dining area, after she washed her in the bathroom, and continued to feed the residents. During Lunch, at 12:27 PM, four Residents (#1, #2, #3, #5, & #6) were observed at the table waiting for their meals. Resident #1 was the first to be served since she ate independently. Resident #5 was observed sitting on the left side of Resident #1 and was being fed by Employee A. Meanwhile, Resident #3 who sat on the right side at the end of table, but adjacent to Resident #1, made several attempts to reach and touch Resident #1's cup. Resident #1 got upset and attempted to hit Resident #3 on her Infuriated, Resident #1 eventually screamed at Resident #3 to stop. Thereafter, the Administrator came by and asked Employee A to move Resident #3 away from Resident #1. This Surveyor overheard Employee (A) saying that Resident #1 gets along better with Resident #6 who was at that time facing Resident #1 at the opposite side of the table. Although Resident #3 and Resident #6 were repositioned at the table, nothing was offered to them to eat or drink while they both patiently (Resident #6) and impatiently (Resident #3) waited to be fed.	A 028		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER GOLDEN SWAN OF BOCA ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 19494 HAMPTON DR BOCA RATON, FL 33434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 028	Continued From page 8 After Employee (A) was done feeding Resident #2, instead of feeding Resident #3 who indicated by her behavior that she needed to eat immediately, Employee A proceeded to feed Resident #6 instead. Again, Resident #3 was observed attempting to reach into Resident #6's plate to take some food and she was redirected by Employee A. All along, the Administrator and Employee B were both still at the facility. Review of the Health assessment record (AHCA form 1823) dated _____ indicated that Resident #6 is diagnosed with _____, type II _____ among others and she requires no feeding assistance. Section 1-A of the form indicated that Resident #6 ate independently. The health assessment record for Resident #3 revealed the diagnoses of _____ and others. She required assistance for all but one activities of daily living. She needed feeding assistance. During a follow-up interview with the Administrator on _____ at 2:03 PM, the Surveyor inquired about the apparent discrepancies or contradictions noted between the records and the actual needs of Resident #6. The Administrator reported that Resident #6 is not consistently able to perform that task sometimes, she does it independently, other times, she requires assistance. Finally, the Administrator provided no additional information and the findings were agreed upon. Class III	A 028		