Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969624	A. BUILDING: _____ B. WING _____	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN SWAN BY THE LAKE ALF	17331 SPRING TREE LANE BOCA RATON, FL 33487

(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 and Generator Monitoring survey was conducted on at Golden Swan By The Lake ALF. The facility had deficiencies related to the Relicensure and Generator Monitoring identified at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,	A 010		

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A 010	Continued From page 1 additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the	A 010		

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A 010	Continued From page 2 applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's	A 010		

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A 010	Continued From page 3 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities	A 010		

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A 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow the health care provider's order, as documented on the resident's Health Assessment form (AHCA Form 1823), regarding a special diet for 1 of 2 sampled residents (Resident #2). The findings included: During an interview on at approximately 8:20 AM, Staff B (Caregiver) was asked if residents have had breakfast and she stated yes. Staff B was asked what breakfast was served and she stated all the residents had some doughnuts, fruits, and coffee. Staff B was asked whether any residents had a special diet order and she stated no. During an interview on at approximately 9:50 AM, the Administrator was asked whether any residents had a special diet order. The Administrator stated no. Record review of Resident #2's file revealed an admission date of . A Health Assessment (AHCA Form 1823) dated and signed by an Advanced Practice Registered Nurse (APRN). Further review revealed special diet; as mechanical soft diet. During an interview on at approximately 3:30 PM, the Administrator was informed of concerns regarding the facility's failure to follow the health care provider's order for Resident #2's special diet. No additional information was provided.	A 010		

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A 010	Continued From page 5 Class III	A 010		
A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the	A 031		

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A 031	Continued From page 6 facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on interview, record review, and observation, it was determined that the facility failed to maintain documentation of communication from third-party service providers regarding physician-ordered treatments and services for 1 of 2 sampled residents (Resident	A 031		

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A	Continued From page 7 #4). The findings included: During a medication audit conducted on at approximately 8:15 AM, Staff B (Caregiver) was asked to provide the facility's Medication Observation Record (MOR). A review of the MOR for the period of through revealed that Resident #4 was receiving the following medication administered by a local home health agency (third-party service provider): , 1,000 mcg, inject 1ml, once monthly. During an interview on at approximately 10:00 AM, the Administrator was asked to provide the physician's order and documentation from the home health agency regarding Resident #4's monthly , 1,000 mcg injection. During an interview on at approximately 3:00 PM, the Administrator stated that the facility was unable to provide a physician's order for the , 1,000 mcg injection. The Administrator further stated that she was unaware that the facility was required to maintain written documentation from third-party service providers (home health agency). The Administrator acknowledged the findings. No additional information was provided. Class III	A 031		
A 077	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators	A 077		

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A 077	Continued From page 8 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible];	A 077		

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A 077	Continued From page 9 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing	A 077		

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A 077	Continued From page 10 and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility Administrator failed to appoint a manager in writing for Facilities A and B, while serving as the Administrator for two	A 077		

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A 077	Continued From page 11 Assisted Living Facilities (ALFs). The Administrator failed to ensure that a manager was designated to assist with the operation and maintenance of each facility. The findings included: During an interview conducted on at approximately 8:30 AM, Staff B (Caregiver) stated that the Administrator was not present at the facility and would be notified that the Agency was conducting a relicensure survey. Staff B was asked whether the facility had a manager or Assistant Administrator. Staff B stated that the facility did not have either position. During an interview conducted on at approximately 11:00 AM, the Administrator was asked whether she owned other facilities. The Administrator confirmed that she owned two facilities. She was asked whether she served as the Administrator for Facility B, and she stated yes. The Administrator was then asked to provide an employee roster that included employee names and job titles. A review of the Agency's website, www.quality.healthfinder.fl.gov, revealed that Staff A (Administrator) was listed as the Administrator for both Facility A and Facility B. Further review of facility records failed to reveal documentation that a manager had been appointed in writing for Facility A to assist with the operation and maintenance of the facility. During an interview conducted on at approximately 3:30 PM, the Administrator was reminded that state regulations require the , , of a manager in writing for each facility. The Administrator confirmed that Facilities	A 077		

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A 077	Continued From page 12 A and B did not have an appointed manager at that time. She stated that she was unaware of the state regulation requirements. Class III	A 077		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable	A 078		

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A 078	Continued From page 13 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility _ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure direct care staff had documented evidence of a negative ( ) examination and Communicable Status for 1 of 3 sampled Staff (Staff B)	A 078		

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A 078	Continued From page 14 The findings included: During an interview on at approximately 9:50 AM, the Administrator was asked to provide the employee file for Staff B. Review of the personnel file for Staff B (Caregiver/Medication Technician) with hire date of . Further review revealed the personnel file did not contain documentation of a negative ( ) screening and Communicable Status Statement completed within 30 days of hire. During an interview on at approximately 3:30 PM, the Administrator was informed of the missing training documentation identified above. No additional documentation was provided. Class III	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the	A 081		

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A 081	Continued From page 15 employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.	A 081		

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A 081	Continued From page 16 (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident ,	A 081		

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A 081	Continued From page 17 neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure direct care staff completed required Inservice training for 2 of 3 sampled staff (Staff B and C).	A 081		

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A 081	Continued From page 18 The findings included: During an interview on at approximately 9:50 AM, the Administrator was asked to provide the employee files for Staff B and Staff C. 1) Review of the personnel file for Staff B (Caregiver/Medication Technician) revealed a hire date of . Further review revealed no documentation of required Preservice Orientation and Control training. 2) Review of the personnel file for Staff C (Caregiver/Medication Technician) revealed a hire date of . Further review revealed no documentation of required preservice orientation, Elopement training, Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures and Incident Reporting Training. . During an interview on at approximately 3:30 PM, the Administrator was informed of the missing training documentation identified above. No additional documentation was provided. Class III	A 081		
A 083	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student	A 083		

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A 083	Continued From page 19 to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure direct care staff maintained required First Aid training for 1 of 3 sampled staff (Staff C). The findings included: During an interview on at approximately 9:50 AM, the Administrator was asked to provide the employee file for Staff C. Review of the personnel file for Staff C (Caregiver/Medication Technician) revealed a hire date of . Further review revealed no documentation of required First Aid training. Review of the staffing schedule revealed Staff C was the only staff member assigned to work from 7:00 PM through 7:00 AM. During an interview on at approximately 3:30 PM, the Administrator was informed of the missing training documentation identified above. No additional documentation	A 083		

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A 083	Continued From page 20 was provided. Class III	A 083		
A 092	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices. (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply	A 092		

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A 092	Continued From page 21 with the food service continuing education requirements specified in rule 59A-36.011, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined that the facility failed to ensure planned meals met established nutritional standards and the nutritional needs of residents. This deficient practice had the potential to affect the nutritional status of four residents. The findings included: On , between 8:15 AM and 8:45 AM, this surveyor observed a food menu approved by a Registered Dietitian Nutritionist (RDN) posted in the kitchen area. Additional observations revealed doughnuts from a local doughnut shop on the kitchen counter. During an interview on at approximately 8:20 AM, Staff B (Caregiver) was asked if residents have had breakfast and she stated yes. Staff B was asked what breakfast was served and she stated residents had some doughnuts, fruits, and coffee. During an interview on at approximately 9:50 AM, the Administrator was asked to provide the facility's approved menu for the current menu cycle. The Administrator was also asked who was responsible for the day-to-day supervision of food services and confirmed that Staff B was designated to oversee the food service provided by the facility. Additionally, the Administrator was asked whether any residents had a special diet order. The Administrator stated that no residents had a special diet.	A 092		

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A 092	Continued From page 22 Record review of Resident #2's chart revealed a Health Assessment (AHCA Form 1823) dated and signed by an Advanced Practice Registered Nurse (APRN). Further review revealed special diet; as mechanical soft diet. A review of an informational website, www.medicinenet.com revealed, when starting on a mechanical soft diet, make sure that you're still eating a variety of foods to get the nutrition that you need. A mechanical soft diet includes foods that are soft and don't take a lot of effort to chew or swallow. It is for people who have difficulty chewing or swallowing. Record review of the facility's approved menu provided by the Administrator documented as follows: , Week of, Week 1, Effective date with expiration date of . Signed and dated by a Registered Dietitian Nutritionist (RDN) Monday, Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday (breakfast, lunch and dinner) Review of the breakfast menu revealed the following planned meal items: 4 ounces orange or cranberry juice 1 serving seasonal fresh fruit 4 ounces hot oatmeal cereal 1 hard-boiled egg 1 plain or cinnamon raisin bagel 2 ounces cream cheese 2 ounces tomatoes and cucumbers 6 ounces coffee, tea, or milk Record review of Staff B's employee file revealed a hire date of . The file also contained documentation of Nutrition and Food Service Designee training (2 hours), dated ,	A 092		

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A 092	Continued From page 23 and Nutritional and Safe Food Handling training (1 hour), dated . During an interview on at approximately 3:30 PM, the Administrator was informed of concerns regarding Staff B's failure to follow the approved menu. The Administrator stated that a family member had brought doughnuts to the facility and that Staff B served the doughnuts as part of breakfast. Class III	A 092		
A 093	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a	A 093		

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A 093	Continued From page 24 licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to	A 093		

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document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.
(g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on .
(h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local

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A 093	Continued From page 26 disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on interview, record review and observation, it was determined that the facility failed to maintain a 3-day emergency supply of non-perishable food and water for residents that reside at the facility. The findings included: During an interview on at approximately 10:30 AM, the Administrator was asked to provide the facility's emergency food menu and to show the facility's three-day supply of non-perishable food and water. A review of the facility's emergency food menu, titled Three (3) Day Disaster Menu, signed by a registered dietitian, with an effective date of and an expiration date of (Photo evidence was obtained) documented: A) Breakfast (Day 1, 2 and 3) 4oz peach juice, pineapple juice, mango juice, 4 oz corn flakes cereal, 4 oz cheerios cereal, 4 oz canned pineapples, 4 oz canned tangerines, 4 oz canned peaches, 1 fruit bar, 1 granola bar, 1 berry bar, 8 oz milk. B) Lunch (Day 1, 2 and 3) 4 oz canned tuna, 4 oz canned chicken, 4 oz canned sausages, 4 oz baked beans, 4 oz corn, 4 oz sweet potato, 4 oz chocolate pudding, 1 chocolate muffin, 4 oz apple strawberry sauce, 4 oz milk, juice and coffee. C) Dinner (Day 1, 2 and 3) 6 oz tomatoes soup/crackers, 6 oz vegetable soup/crackers, 6 oz chicken noddle, 4 oz corn beef, 4 oz peanut butter, 4 oz beef ravioli, 4 oz	A 093		

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GOLDEN SWAN BY THE LAKE ALF	17331 SPRING TREE LANE BOCA RATON, FL 33487

(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 093	Continued From page 27 green peas, 4 oz green beans, 4 oz carrots, 4 oz fruit jelly, 4 oz chocolate and vanilla cookies, 4 oz milk, juice and coffee. D) Snacks (Day 1, 2 and 3) 4 oz pudding, 2 graham crackers, 4 oz applesauce, 4 oz peach juice, 4 oz pineapple juice, 4 oz mango juice. During an interview on at approximately 1:30 PM, the Administrator was asked to show this surveyor the facility's three-day supply of non-perishable food and emergency water, as listed on the Three (3) Day Disaster Menu. At that time, the Administrator confirmed that the facility did not maintain a three-day emergency supply of non-perishable food and water. Class III	A 093		