STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105265	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Coast Center	114 Third Street SE Fort Walton Beach, FL 32548

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28603 Based on record review, staff interview, resident interview, hospital staff interview, and policy review, the facility failed to appropriately document the discharge of a resident into law enforcement custody, failed to permit the resident to remain in the facility by informing law enforcement of an active warrant and pressuring law enforcement to remove the resident from the facility, and failed to convey necessary information regarding resident medical conditions and required medications to law enforcement, resulting in the resident presenting to the hospital emergency room for treatment of high blood glucose for 1 of 1 sampled residents discharged into the custody of law enforcement. (Resident #1) The findings include: A review of Resident #1's electronic medical record revealed the resident was admitted to the facility on [DATE] and discharged from the facility on 3/22/24 into the custody of local law enforcement. A progress note dated 3/18/24 at 7:00 PM indicated Resident #1 and his roommate were heard in the hallway arguing. The note stated that a hit was heard. The police were called, but the roommate refused to press charges. The police found an active warrant for Resident #1 in another county. The police were unable to transfer Resident #1 at that time to pursue action. The roommate was not injured. A post event note dated 3/18/24 at 10:23 PM indicated Resident #1 hit his roommate in the abdomen. A progress note documented by the Director of Nursing (DON) dated 3/22/24 at 3:28 PM (4 days later) indicated Resident #1 was escorted out of the facility by the police department for an outstanding warrant. The progress note also stated that the resident will not be permitted back into the facility as a result of assault and aggression towards a vulnerable resident. Resident #1 was made aware of the discharge. No other altercations with other residents were reported or found during the record review. On 4/23/24, the DON was requested to provide any other documentation of behavioral concerns for Resident #1. The DON provided 2 notes, one on 9/15/23 in which Resident #1 was documented to be non-compliant with the smoking rules by having a lighter in his possession and one on 12/7/23 when Resident #1 was observed to be smoking on the smoking patio during a non-smoking time. The DON was unable to provide any other documentation to support Resident #1 endangering other residents. On 4/23/24 at 11:10 AM, the DON stated the facility had several other residents who go out and give other residents cigarettes, which they are not supposed to do. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Emerald Coast Center		STREET ADDRESS, CITY, STATE, ZIP CODE 114 Third Street SE Fort Walton Beach, FL 32548	

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F 0622 Level of Harm - Actual harm Residents Affected - Few	Further review of the resident's medical record revealed the resident had a diagnosis of diabetes and required Lantus insulin administration 20 units by injection every morning. He also required blood sugar testing 4 times daily with a sliding scale dose of Novolog insulin per injection of 4 units of insulin if his blood sugar was 151-200, 8 units if his blood sugar was 201-250, 12 units if his blood sugar was 251-300, 14 units if his blood sugar was 301-350, 16 units if his blood sugar was 351-400, and if above 400 call the physician and give 16 units. A review of a law enforcement event report dated 3/18/24 revealed law enforcement officer #1 responded to the facility report of Resident #1 allegedly assaulting his roommate. Resident #1's roommate stated that, while pushing Resident #1 in his wheelchair, Resident #1 swung his arm around in what the roommate described as a playful manner. The roommate stated the strike did not appear intentional in nature and he did not wish to pursue the situation further. Review of a law enforcement arrest report dated 3/22/24 revealed law enforcement officer #2 was dispatched to the facility in reference to a wanted person located. The arrest report stated the officer was advised by staff Resident #1 had an outstanding warrant. The outstanding warrant was in reference to failure to appear on amphetamine possession in a different county and issued nearly 3 years prior, on 6/9/21. Review of a hospital emergency room report dated 3/26/24 revealed Resident #1 presented to the emergency room from the jail with high blood sugar at 1:51 AM. The hospital presentation note, dated 3/26/24 at 1:51 AM, indicated Resident #1 called emergency medical services (EMS) to check his blood sugar because he had a feeling it was high; his physician had prescribed 20 unit of Lantus insulin every morning and Humalog insulin on a sliding scale and the staff at the jail were not giving him the prescribed insulin. EMS reported his blood sugar was 440. The hospital case management note dated 3/26/24 at 10:14 AM indicates the hospital contacted the nursing home and the nursing home would not allow the resident to return because they stated they were in the process of discharging the resident from their facility. The resident was then discharged from the hospital to a men's shelter in Pensacola, FL on 3/26/24. Review of additional hospital records revealed the resident was admitted to a second hospital in Pensacola later the same day on 3/26/24 through 4/3/24 with diabetic ketoacidosis (diabetic ketoacidosis develops when the body does not have enough insulin to allow blood sugar into the cells for use as energy. Instead, the liver breaks down fat for fuel, a process that produces acids called ketones. When too many ketones are produced too fast, they can build up to dangerous levels in the body). The resident was discharged from the hospital to a different nursing home about 40 miles away in Pensacola on 4/3/24. An interview was conducted with the Administrator from Emerald Coast Center on 4/22/24 at 11:32 AM. She stated Resident #1 spent the night in jail on 3/22/24 and then law enforcement sent him to the hospital. The hospital called her on 3/26/24 requesting to discharge him back to the facility and she told the hospital the facility had discharged the resident to the police department. The Administrator stated the facility chose not to readmit Resident #1 because of the open warrant for his arrest and the assault on his roommate. An interview was conducted with Employee B (certified nursing assistant) on 4/22/24 at 1:18 PM. Employee B stated she was working at the facility on 3/18/24 when law enforcement came to the facility regarding Resident # 1. The Administrator informed law enforcement there was an active warrant for Resident #1's arrest. Employee B stated the Administrator was encouraging law enforcement to arrest Resident #1. Law enforcement was not able to transport the resident from the facility on 3/18/24 because he could not physically get in the vehicle. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with Employee C (scheduler) on 4/22/24 at 2:29 PM. Employee C stated she was working on 3/18/24 when law enforcement came to the facility regarding Resident #1. She stated the officer came out to the smoking area and stated the Administrator informed him Resident #1 had an active warrant in another county. She stated she heard the Administrator state Resident #1 had an active warrant for arrest and could not stay in the facility. A telephone interview was conducted with Employee D (licensed practical nurse) on 4/22/24 at 1:48 PM. Employee D stated she was working on 3/18/24 when law enforcement came to the facility regarding Resident #1. Employee D stated the Administrator informed law enforcement Resident #1 had a warrant for arrest in another county. The Administrator told employee D that her (Administrator's) supervisor had her call law enforcement and press the issue to send the resident to jail. An interview was conducted with employee A (licensed practical nurse) on 4/23/24 at 11:05 AM. Employee A stated she stopped Resident #1 when law enforcement was taking him from the facility on 3/22/24 so she could check his blood sugar and give his insulin. She did not offer to send any medications or medical information with the resident or law enforcement. She stated she was not aware of a process to do so when a resident was arrested and removed from the facility. An interview was conducted with the Director of Nursing (DON) on 4/23/24 at 10:40 AM. The DON stated, when they admit a resident, this is considered their home. She stated the facility does not have a process to ensure continued medical care if a resident is arrested such as sending medications or medical records with them. She understood the facility could not take Resident #1 back because of the altercation with the other resident. She stated they have several residents in the facility with warrants. A telephone interview was conducted on 4/23/24 at 1:47 PM with the hospital case manager of the first hospital that Resident #1 visited on 3/26/24. She stated the facility declined to take Resident #1 back on 3/26/24, stating they were in the process of discharging him because he struck someone. Law enforcement was not present with Resident #1 at the hospital, nor did they request to be notified upon his discharge from the hospital. An interview was conducted with Resident #1 on 4/25/24 at 10:05 AM. The resident stated the facility staff gave him an insulin injection before he left with law enforcement on 3/22/24, but did not give him any medications or medical documents to take with him. Resident #1 stated the jail did not have any medications and he was sent to the hospital. A telephone interview was attempted for law enforcement officer number 1 on 4/22/24 at 2:53 PM and law enforcement officer number 2 on 4/22/24 at 6:36 PM, and in each case dispatch stated they would return to work until Thursday, 4/25/24 at 6:00 PM. Another attempt at a telephone interview was made for law enforcement officers number 1 and 2 on 4/25/24 at 6:50 PM. The attempt was not successful. Review of the facility policy Bed Hold- Florida (effective October 2023) revealed, .upon return from a higher level of care or therapeutic leave, the resident will be readmitted to their previous room, if it is available, or a similar room, if the resident requires services provided by the facility, and the facility is able to meet the resident's medical care needs. Review of the facility policy for Resident/Family Care and Services (Discharge Planning) (effective February 2021) revealed the facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (continued on next page)

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	105265	A. Building B. Wing	04/26/2024

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Emerald Coast Center	114 Third Street SE Fort Walton Beach, FL 32548

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F 0622 Level of Harm - Actual harm Residents Affected - Few	A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; D) The health of individuals in the facility would otherwise be endangered; E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or F) The facility ceases to operate. G) The facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. Review of the facility policy for Discharge Planning- Outside the Facility (effective February 2021 revealed a physician documents the need for resident transfer/discharge due to endangering the safety or health of individuals in the facility.

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F 0623 Level of Harm - Actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28603 Based on record review, staff interviews, and facility policy review, the facility failed to notify the resident and the resident's representative in writing of the reason for discharge, effective date of discharge, discharge location, the resident's appeal rights, and the Ombudsman contact information prior to discharge, and with at least 30 days advance notice for 1 of 1 sampled residents reviewed for facility-initiated discharge, who was discharged into the custody of law enforcement. (Resident #1) The findings include: Review of Resident #1's electronic medical record revealed the resident was admitted to the facility on [DATE] and discharged from the facility on 3/22/24 into the custody of local law enforcement. A progress note dated 3/18/24 at 7:00 PM indicated Resident #1 and his roommate were heard in the hallway arguing. The note stated that a hit was heard. The police were called, but the roommate refused to press charges. The police found an active warrant for Resident #1 in another county. The police were unable to transfer Resident #1 at that time to pursue action. The roommate was not injured. A post event note dated 3/18/24 at 10:23 PM indicated Resident #1 hit his roommate in the abdomen. A progress note documented by the Director of Nursing (DON) dated 3/22/24 at 3:28 PM indicated Resident #1 was escorted out of the facility by the police department for an outstanding warrant. The progress note also stated that the resident will not be permitted back into the facility as a result of assault and aggression towards a vulnerable resident. Resident #1 was made aware of the discharge. No other altercations with other residents were reported or found during the record review. On 4/23/24, the DON was requested to provide any other documentation of behavioral concerns for Resident #1. The DON provided 2 notes, one on 9/15/23 in which Resident #1 was documented to be non-compliant with the smoking rules by having a lighter in his possession and one on 12/7/23 when Resident #1 was observed to be smoking on the smoking patio during a non-smoking time. The DON was unable to provide any other documentation to support Resident #1 endangering other residents. On 4/23/24 at 11:10 AM, the DON stated the facility had several other residents who go out and give other residents cigarettes, which they are not supposed to do. The record did not contain an appropriate discharge notice to the resident and resident representative. A review of a law enforcement event report dated 3/18/24 revealed law enforcement officer #1 responded to the facility report of Resident #1 allegedly assaulting his roommate. Resident #1's roommate stated that, while pushing Resident #1 in his wheelchair, Resident #1 swung his arm around in what the roommate described as a playful manner. The roommate stated the strike did not appear intentional in nature and he did not wish to pursue the situation further. Review of a law enforcement arrest report dated 3/22/24 revealed law enforcement officer #2 was dispatched to the facility in reference to a wanted person located. The arrest report stated the officer was advised by staff Resident #1 had an outstanding warrant. The outstanding warrant was in reference to failure to appear on amphetamine possession in a different county. (continued on next page)

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F 0623 Level of Harm - Actual harm Residents Affected - Few	Review of a hospital emergency room report dated 3/26/24 revealed Resident #1 presented to the emergency room from the jail with high blood sugar. The hospital case management note dated 3/26/24 at 10:14 AM indicates the hospital contacted the nursing home and the nursing home would not allow the resident to return because they stated they were in the process of discharging the resident from their facility. The resident was then discharged from the hospital to a men's shelter in Pensacola, FL on 3/26/24. Review of additional hospital records revealed later, on the evening of the same day, Resdient #1 was admitted to another hospital in Pensacola on 3/26/24 through 4/3/24 with diabetic ketoacidosis (diabetic ketoacidosis develops when the body does not have enough insulin to allow blood sugar into the cells for use as energy. Instead, the liver breaks down fat for fuel, a process that produces acids called ketones. When too many ketones are produced too fast, they can build up to dangerous levels in the body). The resident was discharged from the hospital to a different nursing home in Pensacola, FL on 4/3/24. An interview was conducted with the Administrator on 4/22/24 at 11:32 AM. She stated Resident #1 spent the night in jail on 3/22/24 and then law enforcement sent him to the hospital. The hospital called her on 3/26/24 requesting to discharge him back to the facility and she told the hospital the facility had discharged the resident to the police department. The Administrator stated the facility chose not to readmit Resident #1 because of the open warrant for his arrest and the assault on his roommate. The Administrator stated the facility had no intent to discharge the resident, so they did not issue a discharge notice. An interview was conducted with the DON on 4/22/24 at 12:13 PM. The DON stated the facility did not issue a discharge notice to Resident #1 because the facility was actively looking for a discharge location. She stated law enforcement removed him from the facility. A further interview was conducted with the Administrator on 4/23/24 at 8:43 AM. The Administrator stated the first hospital that Resident #1 was treated at on 3/26/24 called her on 3/26/24 and asked if they could send a new referral form for the resident for admission. She told them no, because he had been recently incarcerated and this violated the facility admissions policy. She stated again the facility did not issue a discharge notice to Resident #1. Review of the facility policy Discharge Planning- Outside the Facility (effective February 2021) revealed, . transfers or discharges initiated by the facility and not by the resident or by the resident's physician or legal guardian or representative may require the completion of state specific process and documentation, in accordance with applicable laws. The resident and/or legal representative will be notified of transfers in writing, except when a transfer is due to unplanned, acute clinical need. Review of the facility policy for Transfer/Discharge Documentation Recommendations (effective February 2021) revealed the Social Services Department will adhere to the following Discharge Documentation requirements and timeframe's as indicated. For reason of non-payment or facility initiated discharge - a 30-day notice is required (Agency for Healthcare transfer/discharge form page 1 and 2.) A copy of the transfer/discharge document must be sent to the State Ombudsman's Office.