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	07/18/2024

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 28603 Based on record review, staff interview, family interviews, and policy review, the facility failed to notify the resident or responsible party of the risks and benefits of an anti-psychotic medication and alternative treatment options, prior to initiating the medication for 1 of 5 sampled residents reviewed for unnecessary medications. (Resident #95) The findings include: During a review of Resident #95's medical record revealed the resident started the anti-psychotic medication Olanzapine on 2/16/24. The record did not contain any documentation of the resident's representative being notified of the resident being placed on the medication. The resident had a diagnosis of dementia and cognitive impairment. An interview was conducted with the Director of Nursing (DON) on 7/18/24 at 10:36 AM. The DON stated she had no documented evidence of the facility notifying the family the resident started Olanzapine in February 2024. A telephone interview was conducted with Family Member #1 on 7/18/24 at 11:02 AM. She stated the facility may have informed the other family member about the Olanzapine starting in February, but they did not notify her. A telephone interview was conducted with Family Member #2 on 7/18/24 at 11:06 AM. He stated he was not made aware of the Olanzapine starting in February and the facility does not make him aware of medication changes. Review of the facility policy for Use of Anti-Psychotic Medication (4.9.1 effective October 2021) revealed the facility would educate the resident/representative regarding benefits/side effects of the medication and document the education and the resident/representatives understanding of the risks and benefits in the medical record.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 43857 Based on observation, resident record review, interviews and facility policy review, the facility failed to evaluate a resident for self-administration of medications for 1 of 1 residents sampled (Resident # 61). The findings include: On 7/15/24 at 10:57 AM, Resident #61 was observed with an inhaler at bedside. On 7/15/24 at 11:52 AM, the inhaler remained at the bedside. (Photographic evidence obtained) A review of Resident #61's medical record was conducted. A review of the physician's orders revealed an order for Breztri Aerosphere Inhalation Aerosol (Budesonide-Glycopyrrolate-Formoterol Fumarate), 2 puff inhale orally two times a day for Chronic Obstructive Pumonary Disease dated 3/28/24. The Medication Administration Record (MAR) revealed Budesonide-Glycopyrrolate-Formoterol Fumarate inhaler was scheduled and documented at 9:00 AM and 5:00 PM daily. The resident's care plan was reviewed and did not include goals nor interventions related to self-administration of medications. On 7/15/24 at 1:21 PM, an interview was conducted with the interim Director of Nursing (DON). The DON reviewed resident #61's records. The DON stated Resident # 61 had not been care planned for self-administration of medications and so the inhaler should not have been left at bedside. On 7/16/24 at 8:59 AM, Resident #61 was interviewed. She stated staff would leave the inhaler at bedside for her to use when she was ready for it. A review of facility policy Self-Administration by Resident dated 2007 was reviewed. The policy stated that residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. Under Procedures, the policy stated that if the resident desires to self-administer, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 50783 Based upon record review, observations, and interviews the facility failed to verify the correctness of the Level I PASRR and to ensure a Level II PASRR screening was completed for resident 85 with a mental health condition. The findings include: A record review for Resident #85 revealed a Level I PASSR was completed prior to admission on 05/12/24. Resident #85 had a diagnosis of undifferentiated schizophrenia upon admission to facility on 5/25/24. The Level I PASRR does not indicate diagnosis of any mental health disorder. Further review of current medical records a new diagnosis was given to Resident #85 of paranoid schizophrenia. There was no evidence of a Level II screening being completed or requested. During an interview with the Assistant Director of Nursing (ADON) on 07/16/24 at approximately 02:43 PM, it was revealed that facility policy is to ensure that all residents have a PASRR prior to completion, verify that the PASRR is correct upon admission, and submit a Level II PASRR if a resident has a new diagnosis of mental health condition or Intellectual disability. The ADON reviewed Resident #85's current PASRR. She stated, This resident should have had a level II PASRR done. But it is not in her medical record. The ADON called and verified that no level II PASRR was completed or submitted for Resident #85. The ADON further stated, Someone here at the facility should have caught this and verified that the level I PASRR was correct prior to admission. A level II PASRR should have been completed and submitted in May and/or one should have been submitted in September 2023 when she had a definitive diagnosis of Paranoid Schizophrenia. A review of policies and procedures for admission operations (effective April 12, 2023), reveals, every patient admitted requires a level I PASRR. PASRR to be completed prior to admission with copies kept in patient medical record. (a) If PASRR is not received prior to admission, facility designee will complete PASRR for the new admission. (b) verify if patient requires a Level 2 PASRR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 28603 Based upon observations, record reviews, and interviews, the facility failed to provide a comprehensive person-centered care plan for four out of twenty-five residents reviewed. (Resident #95, #97, #39, and #85) The findings include: Resident #95 A review of Resident #95's medical record revealed the resident began taking the physician ordered, anti-psychotic medication Olanzapine on 2/16/24. A review of the quarterly minimum data set, with an assessment reference date of 7/5/24, revealed the resident was receiving an anti-psychotic medication. A review of the resident's current comprehensive plan of care, with a target date of 10/7/24, revealed no care plan or reference to the anti-psychotic medication use. An interview was conducted with the Clinical Reimbursement Coordinator on 7/18/24 at 10:46 AM. She stated care planning was part of the interdisciplinary team's (IDT) responsibility. She stated they usually include the diagnosis, the medication, type of medication, interventions, behaviors, and goals specific to the behavior and the medication used to treat the behavior in the care plan. An interview was conducted with the Director of Clinical Services on 7/18/24 at 10:56 AM. She stated, You should be able to review the care plan and determine the resident is taking an anti-psychotic medication. 44730 Resident #97: A review of Resident #97's record revealed a diagnosis of Diabetes Mellites type II (DM Type 2, high blood sugar), depression, and Unspecified atrial fibrillation (a-fib. an irregular heartbeat). A review of resident #97's medications revealed he is ordered the following medications: Novolog Flex Pen subcutaneous solution pen-injector 100 unit/milliliter (ML) inject 1 unit subcutaneously twice a day for diabetes, Insulin Glargine Subcutaneous Solution 100 unit/ML, inject 20 unit subcutaneously at bedtime for DM Type 2, Sertraline HCL oral tablet 50 milligrams (MG), one tablet by mouth one time a day for depression, and Apixaban Oral Tablet 5 MG Give 1 tablet by mouth two times a day for anticoagulant (a blood thinner used to treat irregular heart rate as a preventative measure for side effects of blood clots forming.) Resident #97's record revealed no care plan for DM type 2, Depression, or A-fib with use of anticoagulant. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at approximately 11:30 AM, an interview was conducted with the Clinical Reimbursement Director (CRD), whose duties include developing the resident's care plans. The CRD confirmed that there was not a care plan for DM Type 2, Depression, or for Anticoagulant use. The CRD indicated that there should be a care plan in place for these diagnoses that includes the medications to treat the diagnosis for monitoring of side effects. The CRD confirmed that the current plan of care would not be considered a complete patient centered care plan. Resident #39: An observation and interview was conducted on 07/16/24 at 09:38 AM with Resident #39. He has a diagnosis of complete quadriplegia c1- c4, neuromuscular scoliosis, contracture of muscles at multiple sites, right knee contracture, and left knee contracture. The resident has bilateral finger and hand contractures. A current review of the comprehensive assessment indicates he has limited range of motion. He stated, I use to wear splints but not anymore, not sure what happened to them. Upon further review of the record, Resident #39 is not care planned for limited range of motion or contractures. During an interview conducted on 7/18/24 at approximately 11:00 am with the CRD, she indicated that Resident #39's comprehensive assessment does not indicate any contractures. The CRD was asked how she obtains information to complete assessments and care plan needs of the resident. She stated, We go over physician orders and clinical review of the notes and I note anything that has changed with the residents. I also get information from the therapy department regarding changes in residents' functional abilities. When the CRD was asked if a limited range of motion / contractures would be important information to note and ensure that was carried over to the resident's comprehensive assessment and care plan, she stated, Yes, I believe it would. The CRD confirmed that Resident #39 did not have a care plan for the limited range of motion / contractures. Resident #85 A record review of Resident #85 on 07/16/24 revealed that she has a diagnosis of Paranoid Schizophrenia, major depression disorder, and panic attacks / anxiety. Resident #85 is currently prescribed Risperdal 4 mg two times a day, Trazadone 100mg at bedtime, and Ativan 0.5mg twice a day to treat these conditions. In addition, the resident is seen by psychiatric services at facility. A review of the comprehensive care plan revealed no plan of care in place for monitoring anti-psychotropic medication use. The CRD was asked about an anti-psychotropic medication monitoring care plan for Resident 85. The CRD acknowledged that this care plan did not exist but she should have one. Review of the facility policy Care Plan-Interdisciplinary Plan of Care from Interim to Meeting (C.1 effective February 2024) revealed that the comprehensive care plan is developed by members of the IDT and the resident, resident's family, or representative, as appropriate, in conjunction with completion of the Admission, Annual, Significant Change in Assessment or other comprehensive assessment, and the associated Care Area Assessments. The comprehensive care plan describes or includes: i. The services that are to be furnished and goals that reflect the Resident ' s wishes, choices, and exercise of rights. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. Any services that would normally be provided but are not provided due to the resident ' s exercise of rights, including the right to refuse treatment, and any alternative means or options to address the problem. iii. The needs, strengths, and preferences identified in the comprehensive resident assessment. iv. Prevention of avoidable declines in functioning or functional levels v. Standards of current professional practice vi. Adequate information provided to make informed choices regarding treatment. The comprehensive care plan is completed within regulated timeframes. The comprehensive care plan is completed hardcopy or electronically. The comprehensive care plan is reviewed and revised by members of the IDT and the resident, resident ' s family, or representative, as appropriate, in consultation with completion of the Quarterly Assessment. The IDT members make a quarterly care plan review note within the designated discipline ' s progress notes which includes: i. If goals are met or unmet ii. If care plan will remain in effect for resident. The quarterly care plan review note is completed hardcopy or electronically.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 42756 Based on observation and interview, the facility failed to maintain garbage and refuse properly in dumpsters and around the perimeter of the facility. The findings included: On 7/15/24 at approximately 10:30 AM, observations were made of two dumpsters behind the facility. One had an open lid with trash piled on top of the dumpster. The other dumpster had open lids with overflowing garbage. There were cigarette butts and other trash scattered around the entire perimeter of the facility. An overturned trash can was also noted on the side of the facility. (Photographic evidence was obtained) On 7/16/24 at approximately 9:45 AM, it was still noted that cigarette butts and trash were scattered around the perimeter of the facility and the overturned trash can remained in the same position. On 7/17/24 at approximately 1:15 PM, an interview was conducted with the Dietary Manager. She was shown pictures of the dumpster outside behind the kitchen. She was asked if the dumpsters appeared properly maintained. She indicated that waste was not managed properly in the images. She also explained that the issue would be addressed immediately. On 07/18/24 at approximately 9:11 AM, an interview was conducted with the Maintenance Director. The observed findings regarding trash on grounds and dumpster was discussed. He indicated that the trash can was removed on 7/16/24. After viewing the pictures, the Maintenance Director indicated that daily rounds are conducted and that the trash should have been picked up.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 50783 Based upon record review, resident interview, and staff interview, the facility failed to provide a clear understanding of the arbitration agreement prior to having residents sign this agreement for two of three residents. (Resident #353 and #354) The findings include: Resident #353 Upon interview with Resident #353 on 07/16/24 at approximately 12:59 PM, when asked what her understanding was of an arbitration agreement, she stated, I do not know what arbitration means. What is that word and what does it mean? I have not ever heard of that word before. When Resident #353 was provided with a copy of arbitration agreement booklet, she stated, I have not seen this before. When Resident #353 was asked if that was her signature on the back page of the arbitration agreement, she stated, yes, that is my signature. But I've never saw this book or this agreement except for the last page. I did not date it, or check any of the boxes on that page. She stated, I signed some papers when I first got here to the facility, two ladies came in here to my room early one morning and asked me to sign some paperwork for Medicaid so they can file with my insurance. So, I signed them and went back to sleep. I know that if I don't understand something I will not sign and wait for my mom to be with me, so she will understand it and explain it to me before signing anything. Resident 353 further stated, No one has explained any of this to me. Resident #353's arbitration agreement was signed and dated on 07/12/24. On 6/2/24, Resident #353 was determined to have a Brief Interview of Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The resident did not initial page 1, page 2, page 3, or page 4 of the agreement. The admission director's initials were noted on each page of the agreement. (photographic evidence obtained). Resident #354 Upon interview concerning the arbitration agreement with Resident #354 on 07/16/24 at approximately 2:00 PM, Resident #354, What are you talking about? She further stated, a lady came in her room early this morning and asked her to sign some admission paperwork for the facility, the lady did not explain anything to me about what I was signing she just told me that I needed to sign it. I know what an arbitration agreement is but no one from here told me about it or that I was signing one. When provided a copy of the arbitration agreement, Resident #354 looked over the agreement and stated, I haven't seen this before, this is not what I signed. When shown the last page where her signature was, she verified that it was her signature, but she had not seen this booklet before now. Resident #354 was determined to have a BIMS score of 12 on 7/16/24, which indicates she has some moderately impaired cognition. Resident #354's arbitration agreement was signed on 07/15/24. The Admissions Director's initials are noted on the last page of the agreement. (photographic evidence obtained). (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 07/17/24 at approximately 09:47 AM with the Admissions Director (AD). When asked what the policy and process was for new admits to the facility, she stated, I go over the admission paperwork with them. I have it on an electronic iPad which makes it easier for them and myself. I go over the different pages of the admission process, bed hold policy, insurance, and the consent to treat. When asked if she is responsible for reviewing and having a resident sign the arbitration agreement, the AD stated, This is no longer online, it is a paper agreement. If the resident signs it, we place it in the resident's financial folder and keep it in the business office. I go over the agreement with the resident and explain it to them before they sign. I keep it simple as I possibly can because of all the legal terminology in the agreement. I basically tell the resident or family member that, if there is a grievance or complaint, we asked that the resident or family come to us first (meaning the facility), instead of seeking an attorney from the outside. Most of the residents do sign the agreement. Almost every place you go to now ask for you to sign an arbitration agreement. The AD was asked how she ensures that a resident knows what they are signing prior to obtaining their signature. She states, I will go to social services first and see what their BIMS score is and I have a conversation with the resident. If I feel like they are not understanding what I am telling them, then I will speak to their family or representative to obtain a signature. When asked if she reviews the arbitration agreement with the residents or their families prior to them signing the agreement, the AD stated, Yes but again, I use simple language, so they understand it before they sign the agreement. If they don't understand the agreement, I don't have them sign it. Sometimes I must send the admission paperwork through email to the residents' families for signatures. When asked if she explained the agreement to Resident #353, she stated, yes, but she probably doesn't remember me going over it with her, her memory is not that great. She doesn't always understand. I did send a copy of the paperwork to her mother for review. When asked if she reviewed and explained the agreement to Resident #354, the AD stated, I don't know why she doesn't remember signing it; it could be because it was early in the morning. I try and get the signatures from residents in the morning and then I am out marketing the rest of the day. I am usually out of the office before 10:00 am most days. An interview with the administrator of the facility was conducted on 07/18/24 at approximately 11:30 AM. She stated, I have done arbitration agreements before, but not here at this facility. Our admissions director does them here. When asked what her expectations are for the arbitration agreement process and her understanding of how it should be presented to the residents, she replied that each page of the agreement should be discussed with them. They should be able to ask questions, and we should ensure they fully understand what they are signing. Then before they sign anything, have them recall what was said about the agreement, so we know that they are fully aware of what the agreement states, and then have them sign it, if they wish to do so. It is not a condition for admittance to the facility and they have a right to refuse if they choose to do so. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon review of facility policy and arbitration agreement on 7/16/24 at approximately 09:30 AM revealed: Arbitration agreement (1) as explicitly, stated below, both the resident and the facility hereby acknowledge that they understand that the resident has the right to seek legal counsel concerning this voluntary section of admission agreement. (2) the execution of this voluntary section of the admission agreement is not a precondition to the furnishing of services to the resident by the facility and (3) this voluntary section of the admission agreement may be revoked by written notice to the facility from the resident within thirty days of signature. Upon review of the arbitration agreement booklet page 1 states If you do not feel you understand the agreement, please do not sign. Let the person presenting the agreement know that you do not understand and would like further explanation, translation, or other assistance.