STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105495	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing and Rehabilitation Center	4200 Washington St Hollywood, FL 33021

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, observation, interview and record review, the facility failed to follow physician's orders to administer Insulin medications to a Diabetic resident; and failed to check and document a Diabetic resident's Blood Sugar Level (BSL). This affected 1 of 2 sampled residents reviewed, Resident #1. The findings included: Record review of the facility's Policy and Procedure titled, Medication Dispensing System (not dated) documented, All medications will be prepared and administered in a manner consistent with .general requirements .G. Prior to Medication Administration: 2. Verify that the Medication Administration Record (MAR) reflects the most recent medication order Record review of the facility's Policy and Procedure titled, Blood Glucose Monitoring, revised 05/2023 documented, It is the policy of this facility to perform blood glucose monitoring to Diabetic residents as per physician's orders. Policy Explanation and Compliance Guidelines: 1. The facility will perform blood glucose monitoring as per physician's orders Record review of the facility's Policy and Procedure titled, Policy & Procedure: Changes in Condition revised 03/22/24 documented, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician .Procedure: The facility must inform the resident, consult with the resident's physician .when there is a change requiring such notification .2. A significant change in the resident's physical, mental or psychological status, that is a deterioration in health, mental, or psychological status in either life-threatening conditions or clinical complications Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Fracture of Neck of Left Femur, Spastic Paraplegia, Type II Diabetes Mellitus without Complications and Hypertension. He had a Brief Interview Mental Status (BIMS) score of 13, indicating intact cognition. Record review revealed on 09/09/24 at 12:05 PM, a nursing progress note by Staff A, a Licensed Practical Nurse (LPN) documented, Therapist notified that patient was sweating profusely and that he was acting off exhibiting altered mental status in his room. Patient was quickly assessed, vital signs within normal limits. Blood sugar was 499. Provider was contacted and Novolog 12 units administered. Patient's family was at bedside and they insisted that patient be evaluated at the hospital. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed on 09/09/24 at 8:02 PM, the facility's Medical Director documented, was notified by nursing that Blood Glucose 499, patient somnolent. Concerns for Diabetic Ketoacidosis (DKA) Upon review, there appears to have been an error in Insulin administration. Recommend emergent transfer to hospital for further evaluation and management of suspected DKA. Diagnosis. An interview was conducted with Staff A, on 10/02/24 at 2:51 PM, regarding Resident #1's elevated BSL and she stated that she did contact Resident #1's doctor on Sunday 09/08/24 at 11:19 AM for a BSL of 403 and obtained the following new order, Insulin Glargine (Long-acting) Solution 100 unit/ml Inject 10 unit subcutaneously in the morning for Diabetes Mellitus (DM) - Start Date Sunday 09/09/24 for 0600 AM. Staff A also stated that she does recall verbally reporting this new order to the on-coming Nurse Staff B, Licensed Practical Nurse (LPN). However, there was no documentation to indicate that this was done. Record review of the nursing progress notes by Staff A dated 09/08/24 documented, Provider gave new orders for high lunch Insulin. 15 units of short acting Insulin now, as scheduled + 10 units of long acting. New order to add long-acting insulin in the AM - 10 Units. Further record review revealed that on Monday 09/09/24 at 11:46 AM, Staff A, documented that she had checked Resident #1's BSL; it was now at 499. The resident's physician was contacted, and he was sent out on Monday 09/09/24 at 12:02 PM to the hospital per family request. Review of the two facility's nursing progress notes computer entry for the dates of Sunday 09/08/24 at 6:26 AM were only noted as documenting the Orders - Administration Note of the physician's orders for: 1) Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Aspart) (Fast acting). Inject as per sliding scale: if 70 - 150 = 0; 151 - 200 = 2 units; 207-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-300 = 10 units; >400 call MD; which did indicate that the resident's Insulin medication had been administered by the nurse at that time, on that day. The facility's nursing progress notes computer entry for the dates of Monday 09/09/24 at 5:55 AM were only noted as documenting the Orders - Administration Note of the physician's orders for: Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Aspart) (Fast acting). It is usually used in combination with a medium- or long-acting Insulin product). Inject 15 unit subcutaneously before meals related to Diabetes Mellitus Type II without complications. Further review revealed the two nurses' facility record entries reflected the doctor's orders, but not whether or not the resident's Insulin had actually been administered by the nurse on those two days. There was no evidence to reveal that the new order for 10 units of the morning Insulin had been given; only that the sliding scale of four (4) units had been administered. Staff B, an LPN who could not be reached, was unavailable and did not respond back to this surveyor, for interview, during this survey. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Staff C, Registered Nurse (RN)/Unit Manager (UM) South wing, on 10/03/24 at 12:54 PM regarding Resident #1's elevated BSL and he stated that on the morning of Monday 09/09/24, he was called by the nurse on duty, into Resident #1's room and once entering the room, with the nurse, he said that he noted that Resident #1 was sleepy, hard to arouse and he was sweating; no pain at that time. Staff C said that both he and the nurse repositioned the resident, took his vital signs and placed Oxygen on the resident. He stated that Resident #1's vitals were all stable, except for the BSL, which was high. The resident was ultimately sent out to the hospital with a BSL of 499. During this interview, a side-by-side record review was also conducted with Staff C, Staff C indicated that he had acknowledged all of the following as having been reviewed: there were two BSLs not recorded in Resident#1's record on Sunday 09/08/24 before breakfast and Sunday 09/08/24 at bedtime; there were two Insulin medications that were not initialed as having been administered on Sunday 09/08/24, Insulin Glargine Solution, to inject 22 units subcutaneously at bedtime, nor was the Insulin Glargine Solution, to inject 10 units subcutaneously at 6 AM on Monday 09/09/24. Staff C further acknowledged that on Sunday 09/08/24 there was no BSL recorded on the Medication Administration Record (MAR) and no indication as to whether or not the Novolog Flexpen subcutaneous solution pen injector (Insulin Aspart) per sliding scale had been administered that day. The Unit Manager revealed that the only Insulin that had been documented as having been administered to the resident on Monday 09/09/24 at 6:30 AM, was for Novolog Flexpen subcutaneous solution pen injector (Insulin Aspart) per sliding scale for four units of Insulin coverage; with Resident #1's BSL recorded as 250 mg/dl. Staff C concluded by saying that the nurse only covered the sliding scale orders, but not the routine standing orders. A side-by-side record review was also conducted with the DON of both Resident #1's Physician's orders, MAR as well as of the nursing progress notes, in which it was noted/indicated that Resident #1 was ultimately ordered the following four Insulin type medications: On Friday 08/30/24 at 9:06 PM the physician's order was written for: Insulin Glargine Solution 100 unit/ml (Long-acting man-made insulin) Inject 22 unit subcutaneously at bedtime for diabetes related to Diabetes Mellitus (DM) Type II without complications. On Friday 08/30/24 at 8:57 AM the physician's order was written for: Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Aspart) (Fast acting). It is usually used in combination with a medium- or long-acting Insulin product). Inject 15 unit subcutaneously before meals related to Diabetes Mellitus Type II without complications. There was no indication that this Insulin had been administered to this resident, at that time. On Friday 08/30/24 at 10:40 PM the physician's order was written for: Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Aspart) (Fast acting). Inject as per sliding scale: if 70 - 150 = 0; 151 - 200 = 2 units; 207-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-300 = 10 units; >400 call MD. Four units of this sliding scale Insulin for BSL of 250 was initialed as being given on the MAR on Monday 09/09/24 at 6:30 AM; subcutaneously Abdomen - Left Upper Quadrant (LUQ). On Monday 09/09/24 at 0600 AM, the physician's order was written for Insulin Glargine Solution 100 unit/ml. Inject 10 unit subcutaneously in the morning for DM. Record review of the MAR revealed that there was no BSL result recorded for this resident on Sunday 09/08/24 at 6:30 AM; only an X recorded in the spot, nor on Sunday 09/08/24 at 8 PM; only an X recorded in the spot. However, further record review of the MAR indicated that there is a blank/empty space for the morning date of: Monday 09/09/24 at 0600 AM and not initialed as being given on the MAR. There was no BSL result recorded for this resident on Monday 09/09/24 at 0600 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's BSLs checked during his ten short facility stay from 08/30/24 at 11:39 PM thru 09/09/24 at 11:46 AM, showed that his BSLs ranged from: 70 to 499 mg/dL. During an interview conducted on 10/02/24 at 4:45 PM with the DON, she revealed that she was in the facility on Monday 09/09/24, at the time, when the Medical Director had been called by the morning shift nurse re: the BSL 499. She said that he gave an order for Resident #1 to be transferred out of the facility to the hospital; around the same time that same day, the DON said that she was also contacted specifically by telephone by the Medical Director on 09/09/24 after the resident had been transferred out of the facility because he was concerned, after reviewing the resident's electronic record in Point-Click-Care (PCC) and noted that Resident #1's long-acting Insulin had not been administered by the facility, and he wanted to ensure that the night nurse was educated on appropriate Insulin administration. The DON added that the night nurse did not contact the Doctor, the Supervisor nor her regarding Resident #1's elevated BSL, nor did she document any notes, to that effect. Record review of the Resident #1's Care plan initiated and revised 09/02/24 indicated Focus: Resident #1 is at risk for complications of abnormal blood sugar related to Diagnosis: Diabetes Mellitus. Interventions: Give medication (s) as ordered. Monitor blood sugar as ordered. Notify MD if result is above or below specified parameters. Monitor compliance with diet. Monitor for signs/symptoms of hyperglycemia such as weakness, stupor, headache, diaphoresis, lethargy, blurred vision, tingling sensations, confusion and test blood glucose and give sliding scale as ordered. Monitor for signs/symptoms of hypoglycemia such as nausea, vomiting, extreme thirst, dizziness, excessive urination, flushed dry skin, fruity breath, suddenly becomes drowsy or confused and notify MD as indicated. Monitor skin daily during care and report any changes in skin condition. Nourishing snacks as allowed within dietary limitations. Podiatry consult as needed and ordered. Goal: will not develop signs and symptoms of Hypo/Hyperglycemia daily thru next review date. There was no evidence in the resident's record to show that the new physician's Insulin order dated for Monday 09/09/24 at 0600 AM---Insulin Glargine Solution 100 unit/ml Inject 10 unit subcutaneously in the morning for DM - Start Date 09/09/2024 at 0600, nor that two previous physician Insulin orders dated Sunday 09/08/24 at 8 PM Insulin Glargine Solution 100 unit/ml Inject 22 unit subcutaneously at bedtime for diabetes related to Type 2 Diabetes Mellitus without Complications - Start Date 09/08/2024 2000, nor that Monday 09/09/24 at 6:30 AM---Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Aspart) Inject 15 unit subcutaneously before meals related to Type II Diabetes Mellitus without Complications - Start Date 08/31/2024 at 0630 AM, had been carried out/followed up or administered by the facility, prior to Resident #1's transfer to the hospital on 09/09/24 at 12:05 PM. The DON further recognized and acknowledged that on 10/02/24 at 4:45 PM, the physician's Insulin order should have been followed and carried out; this was not done.