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	06/11/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, interview and record review, the facility failed to ensure the call light was in reach for 1 of 33 sampled residents (Resident #463). The findings included: Review of the policy titled, Call-Light System, issued 09/2020, documented in part, 1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring the resident access to the call light. 2. With every interaction in the resident's room, staff will ensure the call light is within reach of the resident and secured. Review of the record revealed that Resident #463 was admitted to the facility on [DATE] with a readmission on [DATE]. Review of the current minimum data set (MDS) assessment dated [DATE] documented Resident #463 had a Brief Interview for Mental Status (BIMS) score of 14, on a 0-15 scale, indicating the resident was cognitively intact and that he required physical assistance for self-care needs. During an initial interview on 06/08/25 at 11:25 AM, when Resident #463 was asked how do you get help when you need it, he responded that he uses the call light but that he usually could not find it. The call light cord was observed to be wedged between the bedrail and the bottom of the mattress with the bulb of the call light hanging down close to the floor out of reach of Resident #463. (Photographic evidence obtained). During an observation on 06/09/25 at 12:38 PM, it was noted that the call light was out of reach for Resident #463. (Photographic evidence obtained). During interview on 06/10/25 at 8:05 AM, Resident #463 reported that he needed help to get changed, but he could not reach the call light. (Photographic evidence obtained). Staff H, Licensed Practical Nurse (LPN) was asked to come to Resident #463's room. The resident told Staff H, LPN that he could not reach his call light. Staff H went over to the left side of the bed and had to lower the head of the bed to release the call bell cord that had been stuck between the bottom of the mattress and the bedrail.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, observation and interview, the facility failed to provide liners for sharps containers for 2 out of 4 wings in the facility. The findings included: Review of the facility policy titled, Regulated (Biohazard) Medical Waste provided by the Director of Nursing (DON), implemented 03/2021 documented in the Policy Statement: It is the policy of this facility to ensure that regulated medical waste is managed, handled, stored and transported as per Federal, State and local guidance and regulations. Definition: Regulated Waste means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials. Compliance Guidelines: 1. Examples of regulated medical waste include: .f. Sharp items (e.g. needles, scalpels) contaminated with blood .3. The facility will adhere to Federal, State, and local guidelines and regulations in regard to what categories of regulated medical waste are subject to regulation and requirement for treatment and disposal .9. Contaminated sharps will be placed in appropriate sharps containers located at the point of use. Items to be considered into placement within sharps containers include discarded laboratory tubes with small amounts of blood, scalpel blades, needles and syringes, and unused sterile sharps. 10. Sharps containers must be the following: a. Closable; b. Puncture resistant; c. Leak proof on sides and bottom; d. Labeled with the appropriate biohazard labels as per OSHA standards. 11. Sharps containers must be maintained replaced routinely. Do not overfill the container. 12. Sharps containers will be closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage or transport . During an observational resident room tour on both 06/08/25 and on 06/09/25, the following were noted (Photographic Evidence Obtained of all below): #1) On 06/08/25 at 12:37 PM observation of resident room [ROOM NUMBER] east wing revealed that there was a wall mounted needle box container with used sharps and connector tubing, and other discarded items noted in the bottom, with no red container receptable liner, nor box inside to store them in. #2) On 06/08/25 at 1:25 PM observation of resident room [ROOM NUMBER] east wing revealed that there was a wall mounted needle box container with several old, used, contaminated sharps and connector tubing and some trash/garbage/discarded items noted in the bottom; with no red container receptable liner, nor box inside to store them in. #3) On 06/09/25 at 12:28 PM observation of resident room [ROOM NUMBER] south wing revealed that there was a wall mounted needle box container, with several used, sharps and connector tubing, and other discarded items, noted in the bottom of the container with no red container receptable liner, nor box inside to catch and house them in. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#4) On 06/09/25 at 12:48 PM observation of resident room [ROOM NUMBER] south wing revealed that there was an unlocked and open wall mounted needle box container, with several used, sharps and connector tubing, and other discarded items, noted in the bottom, with no red container receptable liner, nor box inside to store them in. #5) On 06/09/25 at 12:42 PM further observation of multiple resident rooms on the newer section of the 400 South wing hallways, revealed that there were wall mounted needle box containers, with several used, sharps, connector tubing and other discarded items, noted in the bottom, with no red container receptable liners, nor boxes inside to store them in. # of needle sharps boxes in the facility was On 06/09/25 at 3:15 PM, 06/09/25 at 3:20 PM and 06/09/25 at 3:25 PM three (3) separate interviews were conducted with Staff O, Registered Nurse , Staff A, RN, Staff P, Licensed Practical Nurse/Unit Manager (LPN/UM), all three (3) nurses acknowledged that the needle sharps containers in the resident rooms had no liner, nor box container inside to catch and house the used, sharps, connector tubing, nor the laboratory paraphernalia inside along with other discarded items inside. On 06/09/25 at 3:38 PM, on 06/09/25 at 3:44 PM, and on 06/09/25 at 3:50 PM again, three (3) consecutive, separate interviews were conducted with Staff Q, LPN Staff R, RN/UM, and the DON, in which all three (3) were asked about the un-lined and non-boxed sharps needle boxes mounted in the resident's rooms. Staff Q, and Staff R acknowledged that the, used, needle sharps containers in the resident's rooms had no liner, nor box container inside to state the sharps, connector tubing, laboratory paraphernalia inside with other garbage, and other discarded items. The resident room needles sharp box containers were not emptied, cleaned, lined and properly maintained, until after surveyor intervention.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, interviews, observation and record review, the facility failed to follow treatment and services for heel pressure ulcers for 1 of 2 sampled residents (Resident #463) reviewed for not offloading heels as a preventative pressure ulcer measure. The findings included: Review of the policy titled, .Wound Care issued 04/2020, documented, in part, 1. It will be the standard of this facility to provide assessment and identification of residents at risk of developing pressure injuries, other wounds and the treatment of skin impairment. 2. Preventative measures, such as utilization of pressure-relieving surfaces, floating heels, protective boots and use of positioning devices can be employed. Review of the summary of a nursing in-service dated 05/21/25 titled, Prevention of skin impairment (Certified Nursing Assistant), did not include staff training on the facilities policy to utilize pressure-relieving surfaces and floating heels as preventative measures. Review of the record revealed that Resident #463 was admitted to the facility on [DATE] with a readmission on [DATE]. Review of the current minimum data set (MDS) assessment dated [DATE] documented Resident #463 had a Brief Interview for Mental Status (BIMS) score of 14, on a 0-15 scale, indicating the resident was cognitively intact and that he required physical assistance for self-care needs. Review of progress notes dated 06/06/25 documented in part, Resident #463 skin integrity assessment reveals left heel with flattened blister tissue measures 8 x 5.6 x 0. Plan of care with intervention in place including offloading heels while in bed. Review of the Treatment Administration Record (TAR) revealed orders dated 05/20/25, Offload heels with pillow while in bed every 12 hours as needed for prevention. During an observation on 06/09/25 at 12:38 PM, Resident #463 reported that his left foot was hurting. His left foot (heel) was observed positioned on the mattress and the right foot (heel) was positioned on top of a pillow (not offloaded but resting on the pillow). (Photographic evidence obtained). On 06/10/25 at 8:05 AM, observations revealed Resident #463's heels were both positioned on top of pillows and not offloaded. During observation on 06/10/25 at 10:52 AM, it was noted that Resident #463 had been assisted with morning care and was dressed and waiting to go to Physical Therapy (PT) and both of his feet were on top of two pillows (one pillow positioned vertically under each foot) not offloaded. During an interview on 06/10/25 at 11:04 AM, Staff E, Certified Nursing Assistant (CNA), who assisted Resident #463 with dressing that morning, was asked what does offloading of heels with pillows mean. Staff E replied, sometimes the heel should not touch the pillow. At that time, she was asked to look at Resident #463 to see if his heels were offloaded. R#463's heels were on top of the pillows. When Staff E was asked if that is offloading, Staff E replied, No, the pillow needs to be higher on Resident #463's calf, so his heel is off the edge of the pillow. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/11/25 at 7:35 AM, Resident # 463 was in bed eating breakfast with his right heel on top of a pillow (not offloaded) and his left heel on top of the mattress (no pillow and not offloaded). (Photographic Evidence obtained).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, observation, interview and record review, the facility failed to properly secure catheter for 1 of 1 sampled resident observed during Foley Catheter care, Resident #82. The findings included: Review of the facility policy titled Foley Catheter Care Policy provided by the Director of Nursing (DON) implemented 03/2020 documented in the Policy Statement: It is the policy of this facility to provide catheter care to all residents that have an indwelling catheter in an effort to reduce bladder and kidney infections. Policy Explanation and Compliance Guidelines: 1. Catheter care will be performed every shift and as needed by the nursing assistant .21. Assist resident to a comfortable, appropriate position .25. Document care and report any concerns noted to the nurse on duty. Resident #82 was re-admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, Chronic Kidney Disease stage 3, Diabetes Mellitus Type II, Osteomyelitis, Hypertension and Adult Failure to Thrive. She had a Brief Interview Mental Status (BIM) score of 00, indicative of severe impairment. During a Peri and Foley catheter care observation of Resident #82 on 06/11/25 10:06 AM, the resident was observed lying down in bed resting. Peri-care was observed being performed by Staff K, Certified Nursing Assistant (CNA), after having washed her hands for 35-40 seconds. Staff K was assisted by Staff S, CNA, who also washed her hands for 35-40 seconds prior to the procedure. Both Staff K and Staff S retrieved a gown from the container located just outside of Resident 82's room, in order to perform this procedure. Resident #82 provided permission for this surveyor to observe her peri Foley catheter care. However, it was observed during the care that the Foley catheter strap with anchor was not properly secured in place, as per the Medical Doctor (MD) written order. Further observation revealed that the Foley catheter strap was old, frayed, discolored and fading and the leg strap was triple wrapped around Resident #82's right leg. This Foley catheter strap was also observed to be slipping off, moving and sliding slowly down Resident #82's leg and not properly secured and anchored in place to prevent movement. Photographic Evidence Obtained. On 06/11/25 at 10:22 AM two (2) consecutive, but separate interviews were conducted with both Staff K and Staff S regarding the above and both indicated that they did not know when the Foley catheter strap was last changed, and neither did they know often this was supposed to be done. But both staff members acknowledged that the strap needed to be changed to a new one because it was not supposed to be fitting on the resident, as observed. On 06/11/25 at 10:32 AM Interview was conducted with Staff T Licensed Practical Nurse (LPN), also regarding the above and she initially had a difficult time trying to identify exactly what the item was when asked, then Staff T indicated that it looked like a Foley catheter strap. Next, Staff T stated that she had not changed one of those. Staff T immediately stated that the Foley catheter strap was not properly placed on the resident. Finally, Staff T ended by saying that the Foley catheter straps were changed every three to four (3-4) days by the night shift nurse. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a demonstration conducted on 06/11/25 at 10:37 AM by Staff U, Registered Nurse (RN), he showed the proper positional placement for the Foley catheter strap with anchor on the resident, as provided by Staff R, RN/Unit Manager (RN/UM) East wing. Photographic Evidence Obtained. A brief interview was conducted on 06/11/25 at 10:41 AM with Staff U, in which he acknowledged that the Foley catheter strap, that was previously placed, had been done so improperly, for Resident #82. On 06/11/25 at 10:44 AM an interview was conducted with Staff R regarding the improperly placed Foley catheter strap, and he said that he was not aware of when the last time this strap had been changed. Staff R went on to say that every time the Foley catheter is changed every 15 days and as needed (PRN), it must be monitored every shift, by the nurse. He ended by acknowledging that the previously placed Foley catheter strap had been improperly placed on this resident. On 05/26/25 the physician's order documented, to Monitor and keep leg strap on and ensure catheter bag is always strapped to the side to prevent trauma/dislodgement. Record review of Resident 82's Care plan revised 04/28/25 indicated Focus: Resident has an indwelling catheter and is at risk for Urinary Tract Infection (UTI) and other catheter related problems . Interventions: Provide indwelling catheter care as per facility protocol. Goal: Resident #82 will be able to function normally with catheter and signs and symptoms of UTI or other urinary problems will be identified early for prompt intervention through the next review date. A side-by-side record review was conducted with Staff R, of the Treatment Administration Record (TAR) for June 2025, in which it had been documented that the nursing staff had been initialing in the boxes that this was being done, per the physician's ordered dated 05/26/25 which indicated to, Monitor and keep leg strap on and ensure catheter bag is always strapped to the side to prevent trauma/dislodgement. However, direct observation clearly revealed that this was not being done by nursing staff. Resident # 82's Foley catheter strap was not changed and properly placed on the resident, until after surveyor intervention. The DON further recognized and acknowledged on 06/11/25 at 1:45 PM that the resident's Foley catheter strap should be routinely monitored, positioned and changed, as per protocol.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to monitor the dialysis (Central Venous Catheter) CVC access site for 1 of 1 sampled resident reviewed for dialysis (Resident #35). The findings included: A chart review revealed Resident #35 was readmitted to the facility on [DATE] with diagnoses of End Stage Renal Disease and Anemia and Depended on Renal Dialysis. The admission Minimum Data Set (MDS) showed a Brief Interview of Mental Status (BIMS) score of 15, indicating cognitive integrity. A review of the physician's order showed the following: an order for hemodialysis on Tuesday, Thursday, and Saturday, with a right upper chest catheter, dated 05/20/20/2025. Further review of the orders did not show an order to monitor the CVC dialysis site for any bleeding, bruising, or signs of infection. The Care plan dated 06/02/25 documented to check the access site for signs and symptoms of infection, pain, or bleeding daily. In an interview conducted on 06/10/25, at 9:01 AM, the Director of Nursing (DON) stated that when a resident is on dialysis with a CVC access site, they will follow up on labs and monitor the access site for signs of infection, including redness, color changes, temperature fluctuations, and bleeding. The orders to monitor dialysis access sites are the facility ' s protocols and are part of batch orders attached on admission. It is then documented in the Medication Administration Record (MAR) and Treatment Administration Record (TAR). In an interview conducted on 06/10/25 at 9:10 AM with Staff A, Registered Nurse (RN), she stated that the CVC access site is monitored daily for signs and symptoms of swelling, redness, pain, or bleeding. When asked where it is documented, she said it is on the progress note in the electronic system. A chart review revealed that an order was placed in the system for Hemodialysis - Assess site for bruising, bleeding, or symptoms of infection, which was entered into the electronic system at 9:12 AM on 06/10/25.

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	105495	A. Building B. Wing	06/11/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, interviews, and record review, the facility failed to ensure sufficient qualified nursing staff were always available to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being. The findings include: On Sunday 06/08/25 at 9:15 AM an initial tour of the facility was conducted. During the entrance, the surveyors were informed that the Director of Nursing (DON) was in the building, however, after further investigation, the receptionist stated that the DON was on her way. During the tour, nursing staff were interviewed, and no specific person was designated as in charge. Staff DD, Registered Nurse (RN), who stated she has worked at the facility for 2 years in the [NAME] wing. She was asked who she contacts if something goes wrong, she stated a name but could not recall the last name (the name was not on the staff board as one of the unit managers or supervisors) and stated that this person is usually the unit supervisor when she comes in at 7:00 AM; however she believes she left for the day. Then, Staff DD stated she was not sure who is in charge right now. Review of the units listed unit supervisors' names on the staff board, however at 9:23 AM no supervisor was seen on the units. At 9:48 AM while touring the South wing noted the Assistant Director of Nursing (ADON), one of the unit managers and the DON. An interview was conducted on 06/10/25 at 8:45 AM with Staff X, CNA, who stated she has worked at the facility for 1 year as a floater. She stated that on Sundays some staff members have called out and the residents are divided among the CNAs that are in the facility. She stated this can add an additional 2 to 3 residents to her schedule. On 06/10/25 at 9:19 AM an interview was conducted with Staff M, Licensed Practical Nurse (LPN), who stated she has worked at the facility for over a year part time and usually in the Central wing. She stated that she does not often work on the weekends and sometimes just Saturdays. She has noticed that on occasion they are short staff during the Saturday. She stated currently her assignment is 30 residents. During an interview conducted on 06/10/25 at 2:17 PM with Staff BB, CNA, who stated she has worked at the facility for over 10 years. She stated she has noticed that on some weekends she has had 12 plus residents scheduled to provide care due to staff members calling out. Staff AA said she currently cares for 10 residents which is her usual. On 06/10/25 at 3:20 PM an interview was conducted with the Director of Nursing (DON), who stated she started about a week and a half ago. She was made aware that the facility was flagged low weekend staffing. She stated that it will not happen again, she was aware that the staff was not happy with previous management. During an interview conducted on 06/10/25 at 4:32 PM with Staff Z, CNA, who stated she has worked at the facility for 10 years. She stated that she is often scheduled to care for 10 residents, however, there have been days that she has to provide care for 13 plus residents due to not having enough staff, especially on the weekends. (continued on next page)

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	105495	A. Building B. Wing	06/11/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/10/25 at 4:41 PM an interview was conducted with Staff Y, CNA. She stated she has worked at the facility for 16 years and scheduled to the [NAME] wing. Staff Y stated she currently cares for 9 to 10 residents, however on some weekends she can be scheduled to provide care to 11 to 12 residents and often she feels rushed to provide the care and finish on time.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure controlled substance medication reconciliation was accurate for 4 of 9 sampled residents (Resident #70, #115, #147 and #47) and failed to obtain a physician order for a controlled medication for 1 of 9 sampled residents (Resident #70) reviewed during the controlled drugs record review. The findings included: Review of the facility's policy titled, 4.0 Schedule II Controlled Substance Medication, undated, included the following: This policy is to ensure adherence to state and federal laws relating to the dispensing of Scheduled II controlled substance medications. In a non-emergency situation, Schedule II controlled medications will NOT be dispensed without a written or electronic prescription. Procedure: H. Dispensing of Controlled Dangerous Substances (CDS) 5.When a CDS medication is administered, in addition to following proper procedure for the charting of medications, the nurse must document on the declining inventory sheet the date of administration, the quantity administered, the amount of medication remaining and his/her initials. 1) Record review for Resident #70 revealed that the resident was admitted to the facility on [DATE] with a readmission on [DATE] and with diagnoses that included: Dementia, Schizoaffective Disorder and Major Depressive Disorder. Review of the Physician's Orders showed that Resident #70 had an order dated 04/25/25 for Lorazepam 0.5 mg tablet to give every 8 hours as needed for Anxiety for 14 days, with an end date of 05/09/25. Further review revealed no current physician's order for Lorazepam 0.5 mg. Review of Resident #70's Medication Monitoring/Control Record or the declining inventory sheet (DIS) for Lorazepam 0.5 mg revealed the medication was removed from the locked box for administration on the following dates: 05/03/25 at 9:00 AM 05/05/25 at 9:00 AM 05/10/25 1330 (1:30 PM) 05/15/25 12:15 PM 05/20/25 0600 (6:00 AM) 06/01/25 2108 (9:08 PM) (continued on next page)

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	105495	A. Building B. Wing	06/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May and June Medication Administration Record (MAR) documented Resident #70 was administered Lorazepam 0.5 mg on 05/03/25 at 8:08 AM and 05/05/25 at 11:35 AM. No other administration entry for Lorazepam 0.5 mg was documented in the MAR. Furthermore, the May MAR revealed the Lorazepam 0.5 mg order was completed on 05/09/25. 2) Record review for Resident #115 revealed that the resident was admitted to the facility on [DATE] with no readmissions and with diagnoses that included: Fracture of Nasal Bones and Pedestrian injured in traffic accident. Review of the Physician's Orders showed that Resident #115 had an order dated 09/09/24 for Percocet (Oxycodone w/Acetaminophen) 5-325 mg tablet give every 6 hours as needed for non-acute pain scale of 6 to 10. Review of Resident #115's DIS for Percocet 5-325 mg revealed the medication was removed from the locked box for administration on the following dates: 06/08/25 at 2300 (11:00 PM) 06/09/25 at 8:58 AM 06/09/25 at 1732 (5:32 PM) 06/09/25 at 2300 Review of the June MAR documented Resident #115 administered Percocet 5-325 mg on the following dates: 06/08/25 at 9:30 AM with a pain level of 0 out of 10. 06/09/25 at 8:57 AM with a pain level of 6 out of 10. 06/09/25 at 2300 with a pain level of 5 out of 10. 3) Record review for Resident #147 revealed that the resident was admitted to the facility on [DATE] with a readmission on [DATE] with diagnoses that included: Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region. Review of the Physician's Orders showed that Resident #147 had an order dated 05/04/25 for Oxycodone HCl 5 mg tablet give every 6 hours as needed for non-acute pain. Review of Resident #147's DIS for Oxycodone HCl 5 mg revealed the medication was removed from the locked box for administration on the following dates: 06/09/25 at 0001 (12:01 AM) 06/09/25 at 1300 (1:00 PM) 06/09/25 at 2100 (9:00 PM) (continued on next page)

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	06/11/2025

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/10/25 at 1300 Review of the June MAR documented Resident #147 was administered Oxycodone HCl 5 mg on the following dates: 06/09/25 at 0138 (1:38 AM) with pain level of 6 out of 10. 06/09/25 at 2058 (8:58 PM) with pain level of 5 out of 10. 06/10/25 at 2128 (9:28 PM) with pain level of 7 out of 10. An interview was conducted on 06/11/25 at 10:15 AM with Staff G, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 3 years. She stated for administration of controlled substance medication, she would first check the physician's orders on the computer, compare the order to the declining inventory sheet (DIS), dispense the medication and sign the DIS. Once administered, Staff G stated she would then document in the MAR that the medication was given. She agreed that both the IDS and the MAR should correlate the date and time when the controlled substance was given. On 06/11/25 at 10:28 AM, a side-by-side review of Resident #70's DIS and May MAR for Lorazepam 0.5 mg tablet to give every 8 hours as needed for Anxiety for 14 days, was conducted with Staff H, LPN and the Director of Nursing (DON). The review revealed no physician's order in Resident #70's chart for Lorazepam 0. 5 mg and no documentation for administration on the above dates. Staff H stated that after 14 days the order is completed, the nurse or supervisor would contact the doctor for a new order for the medication. In addition, Staff H stated if she is to administer a controlled substance medication, she first checks if there's a physician's order, then compares the order with the DIS, dispenses the medication, administers the medication to the resident and then documents in the computer and the DIS almost at the same time. Both DON and Staff H acknowledged there's discrepancy between the DIS and the MAR for controlled substance medications. 4) Resident #47 was admitted to the facility on [DATE] with the diagnoses that included Cerebral Infarction due to Occlusion or Stenosis of a Small Artery, Osseus and Subluxation Stenosis of Intervertebral Foramina of the Lumbar Region, and Malignant Neoplasm of the Colon. A review of the most recent Minimum Data Set (MDS) assessment dated [DATE] under Section C of the Brief Interview of Mental Status (BIMS) revealed a score of 15, indicating Resident #47 had intact mental cognition. A review of orders revealed Oxycodone Hydrochloride, 5 mg (milligram), 1 tablet every 6 hours as needed for pain. During a medication storage review with Staff G, Licensed Practical Nurse (LPN) on 06/10/25 at 10:35 AM, the Narcotic sheet revealed the Bingo medication dispenser for Oxycodone was received on 04/23/25 with 25 pills. Staff G, LPN verified the Narcotic sheet and the Bingo medication dispenser both had 21 remaining pills, and the administrations on these dates, 06/07/25 at 11:20 AM, 06/08/25 at 10:55 PM, and 06/10/25 at 10 PM were also documented in the MAR. A further review revealed the 06/07/25 at 11:47 AM recorded administration on the Narcotic sheet was not documented on Resident # 47's Medication Administration Record (MAR). (continued on next page)

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	06/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff G, an LPN on 06/11/25 at 10:54 AM, she verified that a Nurse with the written initials on the Narcotic sheet had removed 1 pill on 06/07/25 at 11:47 AM, but she does not know why it was not documented on Resident # 47's MAR. She added that every time a controlled substance is taken from the medication Bingo dispenser, it must be initialed by a nurse with a date and a time on the Narcotic sheet. This documentation must correspond with the MAR documentation, indicating the exact date, time and with the same Nurse's initials.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to monitor the behaviors of residents on psychotropic medication for 2 of 5 sampled residents reviewed for unnecessary medications (Resident #134 and Resident #173). The findings included: A review of the facility's policy titled Using Psychotropic Medications, revised on 10/2024, showed the following: the facility will manage and monitor the residents' medication regimen to promote and maintain the resident's practicable mental, physical, and psychosocial well-being. This includes tracking behavior and monitoring progress. A chart review showed Resident #134 was admitted to the facility on [DATE] with diagnoses of Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, and Anxiety. The Quarterly Minimum Data Set (MDS) assessmentdated 5/20/25 revealed Resident #134 had a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. A review of the physician's order documented the following orders: Risperidone (an antipsychotic medication), 0.5 milligrams twice a day. It further documented to monitor Behaviors with the following code: 0) No 1) Fear 2) Anger 3) Scream 4) Danger/Self/Others 5) [NAME]/Hall 6) Sad 7) Other(desc) dated 11/14/2024. An order for Risperidone (antipsychotic medication), 0.25 milligrams two times a day. It further documented to monitor Behaviors with the following code: 0) No 1) Fear 2) Anger 3) Scream 4) Danger/Self/Others 5) [NAME]/Hall 6) Sad 7) Other(desc) dated 11/14/2024. A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed that no behaviors were documented, if any, or '0' documented for no behaviors if none were observed. The Care plan dated 5/14/25 revealed the following: Resident #134 is on antipsychotic therapy related to Schizophrenia and Bipolar. Administer Antipsychotic medications as ordered by physicians. Monitor behavioral symptoms and side effects. In an interview with Staff F, a Registered Nurse, on June 11, 2025, at 10:10 AM, she stated that the behaviors of Resident #134 are monitored daily and documented on the MAR and TAR. If there are no behaviors, she puts 0 in the electronic system. She then proceeded to show this Surveyor the documentation in the MAR and TAR. Staff F stated that she did not know why there is no section to document behaviors and said that it only gives her an option for Yes or No. In an interview conducted on 6/11/2025 at 10:20 AM with the Director of Nursing (DON), she stated that she started working in the facility a week ago and was not aware that documentation for behaviors was not done according to the specific order and that the nursing staff were filling in only a checkmark instead of the particular codes as above. she further acknowledged that this needs to be corrected. (continued on next page)

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	105495	A. Building B. Wing	06/11/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #173 was admitted on [DATE] with diagnoses that included Cerebral Infarction, Unspecified Dementia, unspecified severity, without Behavioral Disturbance, Psychotic Disturbance and Anxiety, Acute Kidney Failure, and Presence of Prosthetic Heart Valve. A review of the recent Minimum Data Set (MDS) assessment under Section C of the Brief Interview of Mental Status (BIMS) revealed a score of 4 indicating Resident #173 had severely impaired cognition. A review of orders revealed the following:1). Lorazepam 0.5 milligram (mg), give 1 tablet by mouth, 2 times a day for Anxiety; 2). Citalopram Hydrobromide 20 mg, give 1 tablet by mouth one time a day for depression. Use the following behavior codes :0=No, 1=Fear, 2=Anger, 3=Scream,4=Danger to self and others, 5=Delirium, 6=Sad, 7=Other. The following were the codes for Interventions: 1= Music, 2=reminisce, 3=Ex, 5= Quiet, 6=PRN (as needed). Additional orders revealed the following: 3). Seroquel 100mg tablet, give 1 tablet by mouth at bedtime for psychosis:4). Depakote sprinkles, delayed release 125 mg, give 2 capsules by mouth, 2 times a day for mood disorder: 5). Donepezil Hcl 5 mg, give 1 tablet by mouth at bedtime for dementia: 6). Lorazepam 0.5 mg, give 1 tablet by mouth, 2 times a day for anxiety; Use the following behavior codes: 0=No, 1=Fear, 2=Anger, 3=Scream, 4=Danger to self and others, 5=[NAME]/hall, 6=Sad, 7=Other (describe). The following were the intervention codes:1=Music, 2=Reminisce, 3=Ex, 4=1:1, 5=Quiet, 6= PRN. The following were the codes for the outcome: 1=improve, 2=same, 3=worse. The following were the side effects codes: 0=none,1=eps, 2=tardive dyskinesia, 3= hypotension, 4= behavior, 5= drowsy, 6=dizzy. A further review of June 2025 MAR revealed on 06/07/25 and 06/08/25 during day shifts, there were yes responses, with check marks and nurses' initials, but no behavior codes were documented for Citalopram, Depakote, Lorazepam, Seroquel, and Zoloft. On 06/08/25 at 6:00 AM, an intervention code 8 for Lorazepam 0.5 mg was documented for a 0 behavior code, with a check mark and nurse's initials. There was no code 8 per physician order. An additional review of the same MAR for the box corresponding to the monitoring of the outcome of intervention (12 hours), revealed only check marks and nurses' initials from 06/01/25 until 06/10/25 during the day and night shifts. The supposedly used codes were U for unchanged, W for worsened, and the above corresponding codes. In an interview with Staff G, Licensed Practical Nurse (LPN) on 06/11/25 at 10:45 AM, when she was asked about behavior monitoring, she responded, Yes, I monitor the resident's behavior, and I document them in the MAR. She added that she observed resident's behavior before and after administrations of psychotropic medications. She added that she uses the behavior and intervention codes as ordered by physicians, and she documents these codes in MAR. (continued on next page)

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	06/11/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Medical Director on 06/11/25 at 2:30 PM, when he was asked why behavior, and side effects monitoring is important for the resident, he responded, he (Resident # 173) is receiving 2 antidepressants and one anxiety, which were the medications he used to take at home. He added, During my previous record reviews, these medications were necessary, but now I think I have to stop 1 antidepressant (I do not know which one yet), and I will try to start weaning him from the Benzodiazepine.

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	105495	A. Building B. Wing	06/11/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure it was free of significant medication errors for 1 of 5 sampled residents reviewed for medications (Resident #69). The findings included: A review of the facility's policy titled, Medication Preparation and Dispensing, undated, revealed to verify the medication is the right drug, at the right dose, the right route, at the right rate, at the right time for the right customer (G-1). Resident # 69 was admitted on [DATE] with diagnoses that included Parkinson's Disease without Dyskinesia (a condition characterized by abnormal involuntary movements), Encounter for Palliative Care, Unspecified Osteoarthritis, Unspecified Dementia, Anxiety, and Major Depressive Disorder. A review of quarterly Minimum Data Set (MDS) assessment dated [DATE] under Section C of the Brief Interview for Mental Status (BIMS) revealed a score of 2, indicating Resident # 69 had severely impaired cognition. A review of orders revealed the following: Tramadol Hydrochloride tablet, 25 milligram (mg), give 1 tablet, 2 times a day for pain; Carbidopa-Levodopa 25-100mg , give 1 tablet by mouth , three times a day for Parkinson's ; on 05/09/25, no routine laboratory, and weights to be performed, resident is under hospice care, decline expected due to terminal condition; Divalproex oral capsule delayed release, 125 mg, give 2 capsules every 12 hours related to Major Depressive Disorder. During a medication administration observation on 06/10/25 at 10:45 AM using Medication cart 2 on the East section, with Staff G, a Licensed Practical Nurse, (LPN) who stated, she was preparing the 9:00 AM medication for Resident #69. When she opened her computer screen, it revealed pink color on all the 9:00 AM scheduled medications. When she was asked what the screen tells her, she responded, I am administering the medications later than the scheduled time. The acceptable time is one hour before and one hour after the scheduled time. She started preparing the following medications: Divalproex Sodium 12.5 mg (milligram), two (2) capsules by mouth, Carbidopa Levodopa 25-100 mg, one (1) tablet, 2 times a day, with an expiration date of 05/29/26; and Tramadol 25 mg, 1 tablet, 2 times a day, Staff G, LPN went inside Resident #69's room at 10:50 AM. A record review of the Medication Administration Audit Report, revealed the following: Divalproex Sodium oral capsule 125 mg, 2 capsules, every 12 hours; Carbidopa-Levodopa 25-100 mg, 1 tablet , 3 times a day; and Tramadol 25 mg,1 tablet, 2 times a day, were all administered at 11:05 AM. In an interview with the Director of Nursing on 06/10/25 at 12:00 PM, when she was asked what is considered timely medication administration, responded, One hour before and one hour after the scheduled time is considered timely. (continued on next page)

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	105495	A. Building B. Wing	06/11/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with The [NAME] President of Clinical Practice on 06/11/25 at 11:25 AM, she stated that One hour before and one hour after the scheduled time is considered timely medication administration. When she was asked to verify the administration time stamp of the above medications, she responded, It was 11:00 AM.

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	105495	A. Building B. Wing	06/11/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of policy the facility's and procedures, observation and interview, the facility failed to 1) ensure that it secured the Wound Care treatment cart for 1 of 5 sampled Wound Care carts observed, East wing Wound Care cart; 2) ensure that it secured the Medication Administration Cart for 1 of 9 sampled Medication Administration carts observed, Medication cart A East wing; 3) secure medication in 1 of 8 medication carts observed, medication cart A, on the Center wing; and 4) failed to properly label medication for general population use for 1 of 9 medication carts, during a Medication Storage Observation (medication cart 2 of the East wing. The findings included: Review of the facility policy titled Labeling of Medications Storage of Drugs and Biologicals provided by the Director of Nursing (DON) issued 03/2020 documented in the Policy Statement: It is the policy of this facility to ensure that all medications and biologicals used in the facility will be labeled and stored in accordance with current state, federal regulations. Purpose: The purpose of this procedure is to ensure the accurate labeling of all medications and biologicals to facilitate consideration of precautions and safe administration of medications Storage of Drugs Safe and secure storage of all medication. Policy Explanation and Compliance Guidelines: 1. All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices 1) During an observational tour of the East wing on 06/08/25 at 10:02 AM, it was revealed that there was an unlocked Wound Care cart on the East wing containing several different resident topical prescriptions and over the counter (OTC) wound dressing ointments (e.g. B & C ointment dressing, muscle rub, Ciclopirx Olamine cream 0.77%, Nystatin powder), along with wound care supplies. The cart was unsecured, unattended and accessible to residents, visitors and other employees. (Photographic Evidence Obtained). On 06/08/25 at 10:06 AM an interview was conducted with Staff V, Registered Nurse (RN) in which she stated that she was the last nurse to use the East wing Wound Care cart, and she acknowledged that she had left the Wound Care cart unlocked, when she should have locked it. 2) On 06/09/25 at 04:10 PM during a random hallway tour, it was revealed that there was an unlocked Medication cart (A) on the East wing, containing twenty-four (24) active resident prescription and OTC medications, all unsecured, unattended and accessible to residents, visitors and other employees. (Photographic Evidence Obtained). On 06/09/25 at 4:20 PM separate consecutive interviews were conducted with Staff Q, Licensed Practical Nurse (LPN) and with Staff R, RN, Unit Manager (UM), who both acknowledged that the medication cart should not have been unattended and should have been kept locked. 3) On 06/10/25 at 2:59 PM during a Medication Storage Observation conducted with Staff F, RN, and Staff W, RN/UM for Medication cart A Center wing, it was observed that there was one (1) white, unidentified loose pill, in the bottom of the second drawer in the Medication cart. (continued on next page)

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	105495	A. Building B. Wing	06/11/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 06/10/25 at 3:11 PM with Staff F, and with Staff W, RN/UM, in which they both acknowledged that the medication pill should not have been found at the bottom of the medication drawer and should have been secured. The Wound Care Cart, the Medication Cart and the loose, unidentified pill were not secured and discarded, until after surveyor inquisition. The DON further acknowledged on 06/08/25 at 10:16 AM and on 06/09/25 at 04:25 PM, that both the Wound Care Cart and the Medication Carts and all medications should be secured, at all times. The findings included: Review of the facility policy titled Labeling of Medications Storage of Drugs and Biologicals provided by the Director of Nursing (DON) issued 03/2020 documented in the Policy Statement: It is the policy of this facility to ensure that all medications and biologicals used in the facility will be labeled and stored in accordance with current state, federal regulations. Purpose: The purpose of this procedure is to ensure the accurate labeling of all medications and biologicals to facilitate consideration of precautions and safe administration of medications Storage of Drugs Safe and secure storage of all medication. Policy Explanation and Compliance Guidelines: 1. All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices 1) During an observational tour of the East wing on 06/08/25 at 10:02 AM, it was revealed that there was an unlocked Wound Care cart on the East wing containing several different resident topical prescription and over-the-counter (OTC) wound dressing ointments (e.g. B & C ointment dressing, muscle rub, Ciclopirx Olamine cream 0.77%, Nystatin powder), along with wound care supplies. The cart was unsecured, unattended and accessible to residents, visitors and other employees. (Photographic Evidence Obtained). On 06/08/25 at 10:06 AM an interview was conducted with Staff V, Registered Nurse (RN) in which she stated that she was the last nurse to use the East wing Wound Care cart, and she acknowledged that she had left the Wound Care cart unlocked, when she should have locked it. 2) On 06/09/25 at 04:10 PM during a random hallway tour, it was revealed that there was an unlocked Medication cart (A) on the East wing, containing twenty-four (24) active resident prescription and OTC medications, all unsecured, unattended and accessible to residents, visitors and other employees. (Photographic Evidence Obtained). On 06/09/25 at 4:20 PM separate consecutive interviews were conducted with Staff Q, Licensed Practical Nurse (LPN) and with Staff R, RN, Unit Manager (UM), who both acknowledged that the medication cart should not have been unattended and should have been kept locked. 3) On 06/10/25 at 2:59 PM during a Medication Storage Observation conducted with Staff F, RN, and Staff W, RN/UM for Medication cart A Center wing, it was observed that there was one (1) white, unidentified loose pill, in the bottom of the second drawer in the Medication cart. (continued on next page)

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	105495	A. Building B. Wing	06/11/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 06/10/25 at 3:11 PM with Staff F, and with Staff W, RN/UM, in which they both acknowledged that the medication pill should not have been found at the bottom of the medication drawer and should have been secured. The Wound Care cart, the Medication Cart and the loose, unidentified pill were not secured and discarded, until after surveyor inquisition. The DON further acknowledged on 06/08/25 at 10:16 AM and on 06/09/25 at 04:25 PM, that both the Wound Care cart and the Medication Carts and all medications should be secured, at all times. 4) During a medication storage observation of medication cart 2 on the East wing, with Staff G, Licensed Practical Nurse, on 06/10/25 at 10:35 AM, the fourth (4th) drawer revealed a bottle of Elder Tonic, without an opened date label, and an unreadable expiration date. When Staff G, LPN was asked why the bottle of medication was inside the cart, she responded, some residents are using the medication. When asked if Nurses verify the expiration dates and the opening dates of the medication before administration, she responded, Nurses always check the expiration dates, and the date a medication bottle was opened before storing them back inside the Medication cart. When she was asked to provide the opening date and the expiration date of the Elder Tonic bottle, she stated, There was no label for opening date, and I cannot read the expiration date. When she was asked how often Nurses check the Medication cart assigned to them, she responded, During every shift change, a Nurse must check his/her own Medication cart to verify if there are expired medications, loose pills from the Bingo dispenser, unlabeled medications, available supplies, and the cleanliness of the entire cart specially the bottom areas where all fluids are stored. She added that she also checks if there is a bottle of drug buster to discard expired or unused medications. She added that We do not keep bottles of medications with opening dates of more than a year. In an interview with the Director of Nursing (DON) on 06/10/25 at 11:55 AM, when she was asked about the facility's policy when storing medications inside the Medication Cart, she responded, Nurses must put the opening date of any bottle of medications for general use, and Nurses must check the expiration dates. She added, Nurses also check the Medication cart during their shifts.

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	105495	A. Building B. Wing	06/11/2025

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2). Resident #13 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly MDS, with a reference date of 05/08/25, Resident #13 had a BIMS score of 06, indicating a severe cognitive impairment. The assessment documented that the resident required partial/moderate assistance for eating. Resident #13's diagnoses at the time of the assessment included: Anemia, Hypertension, Renal insufficiency, Alzheimer's disease, Non-Alzheimer's dementia, Malnutrition, Depression, Chronic lung disease, Respiratory failure, Muscle wasting and atrophy, Immunodeficiency, Osteoarthritis, SOB, (Shortness of Breath), Dysphagia, Cognitive communication deficit. Resident #13's care plan for nutrition documented: Care plan for nutrition: Resident is at risk for a decline in nutritional parameters due to dependence on a mechanically altered diet with thickened liquids, multiple diagnoses, multiple medications, underweight, History of significant weight loss, abnormal labs, and inadequate oral intake. Date Initiated: 02/13/2025 Revision on: 02/13/2025. The goal of the care plan was documented as: Resident will maintain adequate nutritional status as evidenced by gaining 0.5-1.0# per month, no signs and symptoms of malnutrition, and consuming meals daily through the next review date. Date Initiated: 02/13/2025 Revision on: 02/13/2025 Target Date: 07/31/2025 Interventions of the care plan included, provide and serve diet as ordered. Monitor intake and record meals. Date Initiated: 02/13/2025 Record review revealed Resident #13's diet orders included: Regular diet, Pureed (PU4) texture, Nectar/Mildly Thick consistency - 03/24/25. On 06/09/25 at 8:36 AM, Resident #13 was observed in bed sleeping with breakfast and pre-packaged and commercially processed snacks on an over bed table that were not consistent with the resident's diet orders. During an interview, on 06/11/25 at 10:20 AM, with the Speech Language Pathologist (SLP), and the SLP were shown a photo of the meal with the snacks. When asked about the snacks being appropriate for a resident with orders for pureed diet, the SLP confirmed that the snacks were not appropriate. When asked about the risk of not following the pureed diet order, the SLP replied, in general, the risk is aspiration, choking and decreased PO (oral) intake (continued on next page)

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	06/11/2025

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3). Resident #89 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, an Annual MDS, with a reference date of 05/19/25, Resident #89 had a BIMS score of 15, indicating the resident was cognitively intact. The assessment documented that the resident required partial/moderate assistance for eating. Resident #89's diagnoses at the time of the assessment included: Anemia, Atrial fibrillation, Hypertension, Hyperlipidemia, Alzheimer's disease, Malnutrition, Anxiety disorder, Depression, Chronic lung disease, Vitamin D deficiency, Tinea Unguium, Muscle weakness, Dysphagia, Irritable Bowel Syndrome and the need for assistance with personal care Resident #89's care plan for nutrition documented: Residents have potential nutritional problems related to Hypertension, Chronic Obstructive Pulmonary Disease, Atrial fibrillation, anemia hyperlipidemia, dysphagia, overweight, Irritable Bowel Syndrome, assistance by staff for meals, mechanically pureed, nectar thickened liquid diet. History of edema, with fluid shifts anticipated. Renal diet provided. Significant weight loss - 05/18/22 with a revision date of 02/15/24. The goal of the care plan was documented as: Residents will maintain adequate nutritional status as evidenced by absence of unplanned significant weight changes, no (signs / symptoms) of malnutrition, and consuming adequate food/fluids through review date. Date Initiated: 12/10/2024 Revision on: 06/09/2025 Target Date: 08/10/2025 Interventions of the care plan included: o Provide, serve diet/supplement as ordered. Monitor intake and record (every) meal. Date Initiated: 05/18/2022 o RD to evaluate and make diet change recommendations PRN. Date Initiated: 05/18/2022 Record Review revealed Resident #89's diet orders included. Renal diet, Pureed (PU4) texture, Nectar /Mildly Thick consistency - large entree portions - 03/24/25. On 06/09/25 at 8:35 AM, Resident #89 was observed in bed with breakfast on an overbed table. The oatmeal that was served to the resident in an insulated cup did not appear to be smooth and had lumps of oatmeal in the cup. An interview was attempted with the resident; however, the resident fell asleep during the meal and observation. During an interview, on 06/11/25 at 10:20 AM, with the Speech Language Pathologist (SLP), SLP was shown a photo of the oatmeal being appropriate for a resident with orders for pureed diet, the SLP confirmed that the oatmeal was not appropriate. When asked about the risk of not following the pureed diet order, the SLP replied, in general, the risk is aspiration, choking and decreased PO (oral) intake. (continued on next page)

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	105495	A. Building B. Wing	06/11/2025

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews, and record review, the facility failed to provide the correct Pureed diet consistency for 1 of two observations in the main kitchen. This has the potential to affect 22 residents out of 209 residents, according to the facility ' s census, including Resident #89 and Resident #13. The findings included: A review of the facility policy titled Policy on IDDSI (International Dysphagia Diet Standardization Initiative) Implementation, not dated, showed the following: On the Pureed diet, foods are smooth, pureed, and require no chewing. This level is designed for individuals with severe difficulties in chewing and swallowing. 1. In an observation conducted on 06/08/2025 at 1:27 PM in the main kitchen during the lunch tray line, the following was noted: A metal container of Pureed seasoned spinach was noted with a texture that was not fully smooth and contained irregularities such as small lumps and fibrous strands. A metal container of Pureed Chorizo and Cheddar Quiche with lumps and stringy pieces and did not have a smooth texture. In this observation, the Surveyor explained that the above textures do not meet the standard definition of an actual pureed texture as recognized by the clinical guidelines of IDDSI. The Food Service Director acknowledged the findings and stated that she would correct the problem. In an interview conducted on 06/09/25 at 11:45 AM with Staff B, the Language Pathologist stated for the Pureed diet consistency, the food needs to be smooth and pureed with no lumps or pieces.

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	105495	A. Building B. Wing	06/11/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.). During an observation of the mechanical ware washing machine, as part of the initial kitchen tour, it was noted that the water temperature of the rinse cycle did not reach the 160 degrees necessary for hot water sanitizing, and that there was an accumulation of residue on the spray arms and nozzles inside of the ware washing machine. At the time of the observation, the Food Service Director acknowledged the concerns and stated that the machine will default automatically to chemical sanitizer when hot water sanitizing was not working appropriately. 4). During an observation of lunch being served to the residents in the Dining Room, on 06/08/25 at 1:04 PM, the following were noted a. Saff K, Restorative Aide, was observed pouring coffee into the basin of the only hand washing sink in the Dining Room. Moments after pouring the coffee into the sink, Staff L, Restorative Aide, approached the sink and began washing her hands, without having the sink cleaned and disinfected sine pouring the coffee into the basin. b. Single serve condiments, coffee cups, single use and disposable utensils were stored on a counter directly under a pest control device with a glue board. At the conclusion of the meal, the Food Service Director acknowledged understanding of the concerns. Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety and sanitary conditions and to prevent foodborne illnesses during two of the two visits to the main kitchen. The findings included: 1. In a tour of the main kitchen on 6/08/2025 at 9:15 AM with the Food Service Director, the following issues were noted: Five out of eight air conditioning air filters were noted to be clogged and soiled, accumulated with a grease-like substance and other contaminants typical of a kitchen environment. The Delfield reach-in refrigerator had a thermometer located in the back with a reading of 59.0 Degrees Fahrenheit (F), rather than the necessary 41 degrees F or below. The Delfield reach-in refrigerator had an expired 8 ounces of soy milk with an expiration date of March 8, 2025. The Delfield reach-in refrigerator had two expired 46 ounces of nectar honey thickened lemon water with an expiration date of June 3, 2025, and May 9, 2025. The walk-in refrigerator was noted to have 4 rolls of 10 pounds each of raw ground beef sitting on a flat, open tray with red liquid all over it. Closer observation did not show the date that the ground beef was placed in the walk-in refrigerator or an expiration date. (continued on next page)

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	105495	A. Building B. Wing	06/11/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A large tray of roast beef with a date of 06/04/25 indicating when the roast beef was placed in the walk-in refrigerator. A large bag of shredded red cabbage showing it was placed in the walk-in refrigerator on 5/02/2025, but no expiration date was noted on the bag. Two large cooking pots were noted to be coated with a black-like residue on both their interior and exterior surfaces. This black substance is typically composed of carbon-like deposits, which result from the overheating of oils and fats during cooking. The Hood area was noted to have 3 out of 7 light bulbs not working. The dry storage area was noted with 7 expired boxes of honey thickened liquids (46 ounces each) all expired last month. The Food Service Director noted a hairnet that was only half covering her hair, with the bottom portion of her hair exposed. In this tour, the Food Service Director was asked to calibrate a facility's thermometer to take the temperatures of food items pulled from the Delfield reach-in refrigerator. She was observed taking a cup of ice and overflowing it with water before placing the thermometer inside the cup. The temperature of the iced water did not go down to the necessary ranges of 32 degrees F. The Food Service Director did not make sure that the ice in the cup was mostly ice with just enough water to fill the gaps too much water will raise the temperature above 32°F (0°C). This Surveyor intervened to ensure that the correct method of calibration was used. 2. During a second tour of the main kitchen conducted on June 10, 2025, at 11:45 AM, the following was observed: Staff C, the Dietary Aid, was observed without a facial hairnet. During the tour Staff CC, Cook, was noted in the food production area, preparing Chicken Fajita. He removed his gloves, touched the oven door, and then a dirty rag on the food counter. He then placed a new pair of gloves on without washing his hands first and continued to prepare the Chicken Fajita. Staff D, [NAME] was noted in the tray line plating the lunch plates. Closer observation showed that she was wearing loop earrings about 2 inches in length. In an interview conducted on 06/11/25 at 2:30 PM with the Administrator, he was informed of the findings.

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	105495	A. Building B. Wing	06/11/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to follow the Center for Disease Control and Prevention (CDC) guidelines for infection control standards on residents for Enhanced Barrier Precautions (EBP) for 1 of 37 residents for EBP (Resident #37) and failed to properly clean the nebulizing equipment after a resident's treatment (Resident #132). The facility also failed to properly dispose of glucose strip containers used on an EBP resident and failed to follow their own policy for blood glucose monitoring for 1 of 37 sampled residents (Resident #37). The findings included: According to the Center for Disease Control and Prevention (CDC) Enhanced Barrier Precautions, it revealed the following: Everyone must clean their hands, including when both entering and leaving the room: Providers and Staff must also wear gloves and a gown for the following; high-contact care resident care activities, dressing, bathing-showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting: Device care or use; central line, urinary catheter, feeding tube, tracheostomy: Wound care with any skin opening requiring a dressing. https://www.cdc.gov/long-term-care facilities/media/pdfs/ A review of a policy titled, Blood Glucose Monitoring, with an implementation date of 03/20 revealed the following procedure: clean the intended site with an alcohol pad and allow to dry completely (7), f required by the facility, wipe away the first drop of blood using a gauze pad (10). An additional review of a policy titled, Medication Preparation for Dispensing, undated, page 6-2, revealed to discard any unused medication supplies (e.g. alcohol swabs, syringes, etc.). A further review of policy titled, Nebulizer Therapy, with a revision date of 02/21 revealed the following: clean the equipment after each use, disassemble parts after each treatment, and rinse the nebulizer cup and mouthpiece with sterile or distilled water, shake off excess water, air dry on absorbent towel, once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag. 1) Resident # 132 was admitted on [DATE] with diagnoses that included Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebro Vascular Accident affecting Left Non-Dominant Side, Type 2 Diabetes Mellitus, and Pleural Effusion. A review of Minimum Data Set (MDS) assessment dated [DATE] under Section C of the Brief Interview of Mental Status (BIMS) score of 15 indicating Resident #132 had intact cognition. A review of orders dated 04/27/25 revealed Pulmicort Inhalation Suspension 0.25 milligram (mg)/2 milliliter (mg), I unit, inhaled orally every 12 hours. During a medication observation on 06/10/25 at 9:36 AM with Staff G, Licensed Practical Nurse (LPN) who stated she would give nebulizing treatment to Resident #132. Staff G, LPN applied the nebulizing mask after instilling the medication to resident's face on 06/10/25 at 9:51 AM. On 06/10/25 at 10:00 AM, she removed the resident's nebulizing mask and stated I am done with the treatment. She removed the mask from the resident's face and put it back inside a plastic bag. She did not clean the nebulizing equipment she used for the resident before storing it inside the bag. (continued on next page)

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	105495	A. Building B. Wing	06/11/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked what the proper procedure is after providing nebulizing treatment to the resident, she responded, 'I will check him again to see if he is having respiratory distress. The Surveyor stayed with Staff G, LPN until 11:05 AM, but she did not disinfect or clean Resident #132's nebulizing face mask. 2) Resident #37 was admitted on [DATE] with diagnoses that included Partial Arterial Traumatic Amputation of the Right Foot, Type 2 Diabetes Mellitus with Hyperglycemia, Peripheral Vascular Disease, Immunodeficiency, and Local Infection of the Skin and Subcutaneous tissues. A review of Minimum Data Set (MDS) dated [DATE] under Section C of the Brief Interview of Mental Status (BIMS) revealed a score of 15 indicating Resident #37 had intact cognition. A review of orders dated 04/29/25 revealed Humalog Kwik pen subcutaneous solution pen injector 100 unit/ml, inject subcutaneously before meals and at bedtime for Type 2 Diabetes Mellitus. Inject per sliding scale: if 70 - 150 = 0u; (units) 151 - 200 = 2u; 201 - 250 = 4u; 251 - 300 = 6u; 301 - 350 = 8u; 351 - 400 = 10u; 401+ = 12u Administer. Call MD, During a medication observation with Staff H, an LPN (Licensed Practical Nurse) on 06/10/25 at 11:13 AM, she stated she needed to perform blood glucose test for Resident # 37. Staff H gathered supplies including 2 lancets with no expiration dates. She stated when Staff opened the lancet box, they checked the expiration dates, but there is no way for them to put the expiration date inside the medication cart. She also gathered 2 Assure needles, a whole plastic container of glucose strips, a glucometer wrapped in a plastic bag, alcohol wipes, tissue paper, and Resident #37's Lispro Kwik pen insulin. She placed them all inside a small Styrofoam tray. On 06/10/25 at 11:17 AM, Staff H, an LPN entered Resident #37's room without performing hand hygiene and immediately put her Styrofoam tray with all prepared supplies for blood glucose testing on top of the resident's meal table, without asking for the resident's permission and without cleaning and disinfecting the table. Staff H went to the bathroom and performed hand washing. She went back to the resident's side with the table and told the resident what she was going to do. She then put on gloves. (continued on next page)

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	105495	A. Building B. Wing	06/11/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff H wiped the resident's finger using an alcohol wipe and immediately pricked it with the lancet. She did not wait for the alcohol to dry. She wiped the area with tissue paper and started squeezing the resident's finger. With the same right-gloved hand, Staff H, LPN opened the glucose strip container to get a glucose strip. She put the strip inside the top of the glucometer and continued to squeeze Resident #37's finger. Once the reading was obtained, she removed her gloves, put on new ones, and manipulated the Insulin Kwik pen. She alcohol wiped the resident's right upper arm and immediately touched it with her gloved hands. The surveyor had to remind her that she had just sanitized the area. Staff H, LPN changed her gloves and used another alcohol wipe to sanitize resident's right upper arm. This time she let the area dry before injecting the insulin. She removed her gloves and discarded the used supplies. Staff H, LPN performed hand washing, put on gloves and put the supplies including the Insulin pen, directly on top of resident's table. Then she gathered all her supplies including the glucometer, and a plastic container of glucose strips from the top of the resident's table and left the room. She did not return the table to the resident and did not disinfect the table. In front of the medication cart, she disinfected the glucometer using the purple top Sani-cloth wipes, but did not disinfect the plastic container of the glucose strip which she put in the first drawer of medication cart 2 south section. During an observation on 05/10/25 at 11:37 AM, the Assistant Director of Nursing (ADON) entered Resident #37's room without performing hand hygiene. There was a blue post with a picture of a nurse above the resident's name outside . During a medication admisnitration, on 06/10/25 at 11:17 AM, this surveyor observed a CDC post for EBP was observed above the head part of the resident's bed.The resident had dressing on the foot and an IV access line. After talking with the resident for 6 minutes, he (ADON) left the room and did not perform hand hygiene. On 06/10/25 at approximately 11:42 AM, the Director of Nursing (DON) was informed of where Staff H, LPN put the glucose strip container, but the DON did not ask Staff H to remove the glucose strip container from the medication cart. The surveyor stayed for 10 minutes, but the whole plastic container of the glucose strip used on an EBP resident stayed in the medication cart. In an interview with the Assistant Director of Nursing (ADON) on 06/10/25 at 2:39 PM, when asked if the facility follows the CDC guidelines and recommendations for EBP, he responded, Yes'. When asked why he did not follow the CDC guidelines regarding performing hand hygiene before entering and after leaving the room of a resident with an EBP post, he responded, I entered the room to translate for a few minutes, and I did not touch anything inside the resident's room. When the ADON was asked if he knew the resident had an EBP post, he responded, Yes, a Staff could easily identify before entering that a resident was under EBP protocol because of a blue nurse post outside the resident's room. Upon entering the resident's room, a CDC poster for EBP was on top of resident's bed, indicating EBP guidelines must be followed for that resident. The ADON admitted that he did not perform hand hygiene before entering and after leaving the resident's room because he just answered the resident's questions. In an interview with the Infection Preventionist on 06/10/25 at 4:10 PM, she stated that medical equipment and resident's area are disinfected with Sani cloth purple top wipes, when performing blood glucose test. These wipes have a contact time of 2 minutes and a drying time of 2 minutes indicating Staff must disinfect the area for 2 minutes, let it completely dry for another 2 minutes before storage or reuse for another resident. (continued on next page)

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	105495	A. Building B. Wing	06/11/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When she was asked if Staff must bring the whole glucose strip container inside a resident's room when performing blood glucose test, she responded, No, due to infection control practices, we do not let Staff bring any medication supplies that would be reused for another resident. Any glucose strips, lancets and syringes must be discarded once they entered a resident's room even if they were unused. When she was informed regarding a Staff LPN who brought the whole glucose strip container inside the resident's room, who also did not perform disinfection of the glucose container after bringing it inside the resident's room, then put it back inside medication cart 2 on the south section, she responded, The Staff should not have done all those things. She should have thrown away the glucose strip container. In an interview with Staff G, LPN on 06/11/25 at 11:00 AM, when asked to explain the process of a blood glucose test, she responded, We wipe the area with alcohol and let it dry before puncturing with a lancet. We do not use the first drop of blood and wipe it off with a gauze pad or tissue paper. We disinfect the glucometer after use, but discard all other supplies brought inside the resident's room. When she was asked if she ever brought the whole plastic container of glucose strip, she responded, No, due to infection control practices, it is not allowed, but if I forgot, then I must discard the whole container. I will not use the strips for another resident, and I will not put them back inside my medication cart.