STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105474	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF VERO BEACH	**1310 37TH ST VERO BEACH, FL 32960**

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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to assess and implement appropriate interventions to identify and clarify resident's behavior and failed to provide appropriate supervision for Resident #3. These failures contributed to incidents of sexual misconduct for 2 of 3 sampled residents (Resident #2 and Resident #5) who were dependent on staff for care and safety and were unable to consent to sexual activity due to Dementia. The findings included: Facility policy titled Abuse, Neglect, Exploitation & Misappropriation dated 11/30/14 documents Sexual abuse is non-consensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to: Unwanted intimate touching of any kind especially of breast or perineal area, Forced observation of masturbation and all types of sexual assault. Generally, sexual contact is non-consensual if the resident either: appears to want the contact to occur, but lacks the cognitive ability to consent or does not want the contact to occur. Prevention: Monitoring of residents who may be at risk is the responsibility of all facility staff. This include monitoring residents who are at risk or vulnerable for abuse, for indications of changes in behavior, changes in condition or other non-verbal indication of abuse. Protection: Increased supervision of the alleged victim and residents. Record review conducted on 07/08/20 revealed Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#2 was assessed as severely impaired for skills of daily decision making, displayed no behaviors, and required extensive assistance with Activity of Daily Living (ADL). Care Plans initiated for the resident dated 12/12/19 included the resident has impaired cognitive function or impaired thought process related to dementia. Nurses Notes dated 06/18/20 at 3 PM documents Staff member redirected male resident (Resident #3) out of resident room when found touching vaginal area while resident was asleep. Resident was also a memory care resident. Clinical record review of Resident #3 revealed the resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Minimum Data Set, Quarterly assessment with reference date 04/10/20 documents the resident was assessed as moderately impaired for skills of daily decision making, with a BIMS (Brief Interview Mental Status) score of 10 and had other behavioral symptoms not directed towards other (e.g. public sexual acts). Behavior of this type occurred one to three days during the seven-day lookback period. Care Plans initiated for the resident on 07/09/19 included Impaired cognitive function or impaired thoughts related to dementia and on 04/15/20, Resident has potential to be physically aggressive related to poor impulse control. Resident #3 was assessed for elopement risk on 04/20/20 and was deemed not at risk. The resident had no exit seeking behavior, does not wander oblivious to safety needs and has no history of elopement. Psychiatric Progress Notes dated 06/19/20 documents Since last seen, patient has been hypersexual. wandering into peers rooms but was initially redirectable. per staff, there was an incident yesterday in which patient was found in a female peer's room while her pants were not completely pulled up. Upon interview, patient is somewhat irritable. Denies this event happened yesterday but does admit that things like this happened in the past. upon review of his records from the medical hospital. he was previously followed by a psychiatrist for [MEDICAL CONDITION] disorder. Nurses Notes dated 06/21/20 documents Resident #3 continued on 15 minutes checks throughout the shift. Resident was last observe in dining room around 6:15 AM before incident occurred at 6:20 AM, resident was found in a female room (Resident #5) leaning over her bed and placing a kiss on her buttocks area. Resident was immediately removed and placed on 1:1. Management notified of incident and report given to upcoming nurse. Clinical record review of Resident #5 revealed a MDS annual assessment with reference date 04/30/20. The assessment documents the resident is severely impaired for skills of daily decision making, has [DIAGNOSES REDACTED]. Nurses Notes dated 06/23/20 documents Patient with one on one supervision throughout the day, noted wondering and seeking of another female resident with dementia. Resident redirected resident attempted contact or visualization of another resident, multiple attempts. Interview conducted on 07/08/20 at 11:22 AM with The Staffing Coordinator revealed on 06/18/20 at approximately 2:45 PM, she was walking down the hallway towards the nurses' station in the secured unit, when passing by Resident #2's room, she saw Resident #3 in the room and walked back to see what he was doing. Resident #3 was in the room standing next to the resident's bed. She then went behind him, leaned over, and saw Resident #2 lying in bed with her eyes closed, her pants were down to her knees and her adult brief was neatly opened and folded. Resident #3's hands were touching Resident #2's vaginal area. She then asked him what are you doing? removed the resident from the room and immediately reported the incident to management. Interview with Staff D, a Certified Nursing Assistant, on 07/08/20 at 12:45 PM revealed she was on duty on 06/18/20. Staff D recalls returning from lunch and seeing Resident #3 going in a resident's room, she could not recall which room. Staff D redirected the resident to get out of the room, she thought he was behind her as she walked away towards the nurses' station. Later on, she heard from the staffing coordinator who told her the resident was in Resident #2's room and what transpired. Staff D stated she returned from lunch around 2:30 or 2:45 PM. Interview conducted on 07/08/20 at 1:47 PM with Staff C, an MDS Coordinator, revealed she completed the assessment for Resident #3 dated 04/10/20 and answered the question on the MDS regarding behaviors not directed towards others (MDS E0200) as Behavior of this type occurred 1 to 3 days due to reports the resident was masturbating. The Activity Director had reported the incident. Staff C was asked how the facility dealt with the behavior and explained the resident was redirected back to his room, encourage to wash hands and try to involve him in activities. Staff C added she did not witness the behavior but everyone knows and confirmed there is no care plan for this behavior. Interview with the Administrator on 07/08/20 at 1:55 PM revealed she was not aware Resident #3 was masturbating and there is no documentation on the record to validate the alleged behavior, Resident #3 stands around with his hands inside his pockets. The Administrator walked to the MDS office and questioned Staff C, as to statement given to the surveyor, and Staff C again stated she received reports from the prior Activity Director that the resident was masturbating, she did not witness the event and confirmed there is no documentation of this behavior, the source for her coding the MDS assessment was interview with the staff. Interview conducted on 07/08/20 at 2:01 PM with Staff B, Unit Manager, revealed Resident #3 resided in the Friar unit. Two female residents voiced concerns regarding Resident #3, he was standing outside their doors, looking inside their rooms and that made them uncomfortable. Then, another resident complained that she was in bed, woke up and Resident #3 was standing inside her room, next to her bed and that made her uncomfortable. Resident #3 was then relocated to the Essex wing which is a secured unit and was placed in room [ROOM NUMBER], across from the nurses' station. The Unit Manager shared Resident #3 refuses his medications at times, and most likely, this has contributed to changes in his health status. The resident is now in a separate unit due to other medical issues. Interview conducted on 07/08/20 at 2:16 PM with The Social Service Director revealed Resident #3 was relocated to the secured unit to keep him contained and to keep a closer eye on him. The decision to move him was done by the Director of Nursing (DON) and the Administrator. The Social Worker denied having knowledge of the [MEDICAL CONDITION] captured on the MDS assessment. Interview conducted on 07/08/20 at 2:36 PM with The Administrator, DON and Risk Manager revealed Resident #3 likes to wander and stands in front of other resident's doors. The

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

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.

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resident has a potential for elopement as he looks like a visitor, that is the reason why he was moved to the secured unit. Resident #3 did not have a wanderguard, and is now in the COVID unit which has a secured entrance. The Administrator stated the dementia unit offered more supervision, there is one nurse, an activity aide and three nurses' aides. Confidential interview on 07/08/20 at 2:55 PM with Staff E revealed the staff had heard Resident #3 was masturbating in public areas. Confidential Interview on 07/08/20 at 3:02 PM with Staff F revealed the staff has heard the resident was masturbating, but never seen it. Phone interview with Staff A, prior Activity Director on 07/09/20 at 8:35 AM revealed she recalls Resident #3. Staff A, stated she had seen the resident putting his hands inside his pants and touching his private parts, masturbating in the public areas. Resident #3 never exposed himself. Staff A stated the resident exhibited this behavior multiple times and recalls two female residents also had complaints about Resident #3. One resident was uncomfortable because Resident #3 was standing at her door and she did not feel safe. The other resident stated he was standing at her door, masturbating and she was very uncomfortable. Staff A stated she had reported the incident during the morning meeting and reported it to the risk manager. Interview via phone on 07/09/20 at 3:22 PM with The Psychiatric Nurse Practitioner, revealed Resident #3 has a significant psychiatric history, and was not aware of sexual behaviors such as masturbation. The Practitioner explained after reviewing his records, Resident #3 was on antipsychotic medications that were discontinued and most likely resulted in the setback. The resident is to continue his antipsychotic regimen and that will manage his behaviors. Resident #3 is not a candidate for gradual dose reduction, he is true psychiatric patient, not just a resident with Dementia. The Practitioner also clarified the notation on her progress notes documenting Things like this has happen in the past. The resident admitted to prior [MEDICAL CONDITION] towards other women during her examination. Follow up interview with The Administrator on 07/09/20 at 5 PM revealed Resident #3 was relocated to the secured unit, to try to minimize possible altercations with other residents in the unit that would get upset when the resident wander into their rooms and also clarified the aide caring for Resident #2 left her pants half way up to her knees and was counseled on this practice. On 07/10/20 at 11:05 AM, The administrator explained the second incident dated 06/21/20; the night nurse misunderstood the report given, and thought the resident was no longer on one to one supervision. The nurse checked on the resident every 15 minutes and the one to one supervision was reinstated. Based on record reviews and interview, the facility staff failed to accurately assess and report Resident #3's [MEDICAL CONDITION], failed to implement a plan of care to manage the behavior and failed to implement appropriate level of supervision to minimize incidents of sexual misconduct.