| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22651<br><br>Based on observation and interviews the facility failed to ensure 2 (residents #32 and #54) of 20 sampled residents on the secure unit had a safe and clean environment. The facility also failed to ensure 1 (Front Hall Medicine Cart) of 4 medicine carts was routinely cleaned and kept in a manner to prevent disease-causing organisms, failed to ensure walls were in good repair, furniture was maintained in good repair, linens were in good repair, privacy curtains were free from stains, air conditioners were kept clean and ceiling tiles were in good repair, and floors in rooms were clean and free of wear and stains.<br><br>The findings included:<br><br>1. On 08/04/21, at 10:19 a.m., the third day of observation in room [ROOM NUMBER], a brush was laying on the sink. The brush did not have an identifier noting the owner. The room had two residents, #32 and #54; resident #32 in bed (A) has a Brief Interview for Mental Status (BIMS) score of 2 and resident #54 in bed (B) has a BIMS score of 5 on their comprehensive assessments. This means the residents were severely cognitively impaired. The residents are not able to be interviewed and did not answer questions. The resident when questioned as to the owner of the brush neither resident answered.<br><br>**Photographic evidence obtained**<br><br>On 8/4/21, at 10:38 a.m., during interview with, Unit Manager of the Secured Unit, she said, I'm not sure who the brush belongs to.<br><br>The room also had floor mats on both sides of bed (A). The mats were worn and are stained with brown spots.<br><br>**Photographic evidence obtained**<br><br>On 8/4/21, at 1:59 a.m., during an interview with the Housekeeping Supervisor she stated, The floor mats on the floor around the Resident's bed is our responsibility for cleaning and assessing if they need to be replaced. We missed it. That's on us, we will take care of it, and look at them all.<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 08/5/21, at 1:09 a.m., observation of the medicine cart of the front hall. During the medicine cart observation there was a brown bug running in the drawers of the cart. The medication nurse said, I don't know when they cleaned the cart.<br><br>**Photographic evidence obtained**<br><br>On 8/5/21, at 1:54 p.m., during interview the Maintenance Manager said, I just found out that will be my responsibility. I found out last Friday and was told just now to get on it. I will take them out, pressure wash, spray them and let them sit for a while. I have been here for 5 weeks. I never knew this was part of my responsibility. I do not have past reports or schedule of when the carts were cleaned last.<br><br>30599<br><br>2. On 8/2/21 at 9:24 a.m. the bathroom wall in room [ROOM NUMBER] was observed with multiple holes and was in disrepair.<br><br>On 8/2/21 at 10:30 a.m. the bathroom floor in room [ROOM NUMBER] was stained and there was a rust buildup was observed by the toilet. There were stains observed at the base of the toilet. The shower chair in the shower stall was observed to have rust on the metal legs.<br><br>On 8/2/21 at 11:43 a.m. observation of room [ROOM NUMBER] revealed the privacy curtain was had stains in several areas. The bedside table was observed to be rusted and stained. There was a detached baseboard behind bed B. There was missing veneer along base of dresser with exposed wood. The wall next to air conditioner unit was in disrepair. There was a detached floor base observed in the bathroom. The toilet had brown stains at the base. There were several areas of the walls that had been partially repaired but were not finished and painted.<br><br>On 8/2/21 at 11:48 a.m. a detached air conditioner wall unit was observed in room [ROOM NUMBER]. Dust was observed in gap where the unit was detached and there was an open area observed leading to the outside of the building. The bathroom floor was observed to be stained and marred.<br><br>On 8/2/21 at 11:59 a.m. the ceiling tiles were observed to be bowed, drooping, and stained in room [ROOM NUMBER]. The bottom of the dresser was observed to be missing veneer.<br><br>On 8/2/21 at 12:00 p.m. the floor of bathroom in room [ROOM NUMBER] was observed to be stained and marred with a gouged area in center. The base of toilet was stained. The area behind toilet seat had metal plate with sharp edges protruding behind the toilet seat. There were unlabeled unmarked personal care items observed being stored in bathroom. The air conditioner unit filter was observed to have a build-up of dust.<br><br>On 8/2/21 at 12:05 p.m. a television cable box was observed in room [ROOM NUMBER]. The box was detached and hanging from the wall. Unlabeled denture cups, with dentures inside, were observed on top of sink in bathroom. The air conditioner unit vent had an accumulation of dust built up on the vent. The bathroom floor was stained, and there were discolored stains at the base of toilet. Dirt build-up was observed on the outside of the window by the air conditioner.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 8/2/21 at 12:24 p.m. the footboard in room [ROOM NUMBER] was observed to be missing veneer and there were jagged edges around the base of the dresser. The air conditioner unit was detached from the wall and there was dust build-up in the area of detachment.<br><br>On 8/2/21 at 10:43 a.m. in room [ROOM NUMBER] two floor mats were observed on both sides of the bed. Both mats were observed to be dirty and stained with a brown substance. There was a hairbrush observed in the bathroom with no identifier noted as to who was using the hairbrush.<br><br>On 8/2/21 at 11:42 a.m. the bed in room [ROOM NUMBER] was observed to have holes and the threads of the sheet and the sheet was observed to be worn.<br><br>On 8/5/21 at 9:38 a.m. the Maintenance Director said he had been here 5 weeks. I have not had an assistant over the last month. The nurses put in anything that needs to be repaired. A lot of the stuff the nurses have put in I am waiting on parts. I'm going to have to get a contractor in and replace some of these floors. I was not aware of the rust and need to replace with a new chair. room [ROOM NUMBER] floor needs replaced, and the metal was left over from rails and needs to come off the toilet this was not reported. room [ROOM NUMBER] needs to have the bed board at the foot of the bed replaced. I will have to order another. The AC needs or be repaired. There is no excuse for the bedside tables to be rusted. The Certified Nursing Assistants are no better. They should report any equipment that needs repaired.<br><br>On 8/5/21 9:58 a.m. the Director of Housekeeping said the windows on the outside are cleaned every 6 months. I have only been here 2 months. I have not seen any paperwork on when they were last cleaned and does not know when they were last cleaned. Housekeeping staff are to report to maintenance verbally if they see things that need repaired. Most of the stains at the doors come off but a lot needs repainted. She said she gets rid of the worn-out sheets, and she tells her assistant, but she is not sure if she understands her because her assistant speaks Spanish.<br><br>33250<br><br>3. On 8/2/21 at 7:30 a.m., and 8/3/21 at 8:30 a.m. observation of the kitchen revealed the alcove across from the dietary office had biogrowth present along wall base; the metal frame around the door was gouged, soiled, and rusted; metal carts holding kitchen equipment were rusted; and the utility carts had rusted wheels. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33250<br><br>Based on record review, staff and family members interview, the facility failed to protect vulnerable residents' rights to be free from abuse.<br><br>The facility failed to adequately supervise 1 (Resident #29) of 1 sampled resident with known behaviors with a likelihood to result in physical and sexual abuse.<br><br>On 6/2/21 in the evening, a Certified Nursing Assistant (CNA) reported witnessing Resident #29 having inappropriate sexual contact with his roommate, Resident #11.<br><br>The facility allowed the perpetrator (Resident #29) to remain in the same room with the alleged victim (Resident #11) until the evening of 6/7/21.<br><br>Resident #29 was allowed to wander about the facility unsupervised and exposed his penis to Resident #68.<br><br>Resident #29 also attempted to enter Resident #62's room, verbalizing the desire to commit a sexual act toward Resident #62.<br><br>The facility failure to follow their policy and procedure and protect residents after an allegation of inappropriate sexual contact placed Resident #11 and other vulnerable residents at risk for further abuse.<br><br>Residents #11, #62, and #68 have severe cognitive impairment and could not consent to sexual activities.<br><br>Applying the reasonable person concept, Resident #11 would likely suffer serious psychosocial harm, not yet realized, because he was not able to consent to sexual activity which diminished his self-worth and self-respect. Survivors of sexual abuse may develop depression, anxiety, post-traumatic stress, personality disruptions, attachment issues and addiction. There is a chance of passing sexually transmitted infections during unprotected sexual activities, which can lead to further health complications and death.<br><br>The Administrator was notified of the Immediate Jeopardy on 8/6/21 at 7:27 p.m. and provided the IJ templates.<br><br>The findings included:<br><br>Cross Reference to F607, F609, F610 and F835.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Facility's Abuse, Neglect, and Exploitation policy and procedure with a reviewed/revised date of 7/14/21, defines Sexual Abuse as non-consensual sexual contact of any type with a resident. An immediate investigation is warranted when suspicion or reports of abuse, neglect or exploitation occur. Under section VI. Protection of Resident- the facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include responding immediately to protect the alleged victim and integrity of the investigation; Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increased supervision of the alleged victim and residents; and room or staffing changes, if necessary to protect the resident(s) from the alleged perpetrator.<br><br>In an interview on 8/3/21 at 9:30 a.m., Resident #11's spouse said she was informed a couple of months ago a CNA found her husband's roommate (Resident #29) to have his hands down her husband's pants. She said they told her his roommate was moved out of his room into another room and the facility was going to investigate the incident.<br><br>On 8/4/21, the facility's abuse investigation and federal immediate report was reviewed. The facility reported on 6/8/21 during the evening after dinner (no date) CNA Staff O saw Resident #29 at the foot of his roommate's bed (Resident #11). The CNA observed resident #29 with his hand in the top part resident #11's brief.<br><br>CNA Staff O's written statement dated 6/8/21 was reviewed. The CNA noted at approximately 9:35 p.m. (no date), he observed Resident #29 in the dining room facing Resident #68. He heard Resident #68 say put it away. At that time, he observed Resident #29 had his penis out and said to Resident #29, You want it and Resident #68 began to curse at Resident #29. He then took Resident #29 to the unit and informed the nurse of his observation. CNA Staff O noted there was another incident that occurred before the weekend during the evening, after dinner. He saw Resident #29 in his room with his hand inside of Resident #11's brief. His statement noted he informed Registered Nurse (RN) Staff S at the time of the incident.<br><br>In an interview on 8/5/21 at 2:36 p.m., CNA Staff O said there were 2 incidents involving Resident #29. The first was when he found him at the bedside of roommate Resident #11 with his hands down the front of Resident #11's brief. The next incident occurred about a week later when he came through the dining room and Resident #29 was exposing his penis to Resident #68. Right after this incident, Resident #29 was moved out of the room he shared with resident #11 into a different room. The CNA said he notified RN Staff S after the first incident.<br><br>The facility's staffing schedule was reviewed and indicated both RN Staff S and CNA Staff O were working on the evening of 6/2/21.<br><br>Resident #29's clinical record review revealed he is a cognitively impaired [AGE] year-old male with an admitted [DATE]. His diagnoses included traumatic brain injury, seizure disorder and sexually inappropriate behavior.<br><br>Resident #29's most recent comprehensive annual assessment, dated 3/8/21, revealed no coding for behaviors or wandering. His most recent quarterly assessment, dated 6/8/21, revealed no coding for behaviors or wandering. The quarterly assessment coded Resident #29 as requiring supervision for locomotion on unit.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The care plan initiated on 4/20/20 noted Resident #29 had episodes of asking for sexual favors and/or making sexual inappropriate comments to other residents, verbal aggression, taunting. The interventions included to redirect resident gently but firmly from unacceptable behaviors (sexual inappropriate comments).<br><br>The clinical record lacked documentation the care plan was updated to include additional supervision for Resident #29 on 6/3/21.<br><br>In a progress note the Advanced Practice Registered Nurse(APRN) noted on 6/3/21 at 10:13 a.m., staff requested she evaluate Resident #29's sexually inappropriate behavior. Staff reported Resident #29 had been approaching men in the building (staff and residents) and requesting sexual favors. He was redirected by staff when this behavior occurred; He just laughed and left the situation.<br><br>On 6/3/21 at 10:44 a.m., the facility's Social Services Director (SSD) noted, today Resident #29's representative was informed about this resident's sexually inappropriate behavior.<br><br>On 6/8/21 at 6:40 a.m., Licensed Practical Nurse (LPN) Staff G noted Resident #29 entered Resident #62's room during care. The CNA asked Resident #29 to leave the room and the resident responded No. The CNA asked the resident why is he going into Resident #62's room, and he responded, I wanna [sic] chew his balls off . Resident #29 was observed previously at 5:24 a.m., and 6:01 a.m., attempting to enter Resident #62's room.<br><br>Resident #11's clinical record review revealed a [AGE] year-old male with a diagnosis of Lewy Bodies Dementia, Cerebral Infarction with resulting paralysis, aphasia (loss of ability to express speech), and total dependence on staff for all activities of daily living (ADL's).<br><br>Resident #11's most recent quarterly Minimum Data Set (MDS) assessment, dated 5/4/21 revealed the resident was severely cognitively impaired. The resident was coded for rejection of care 1 to 3 days per week during the assessment period. There were no other behaviors noted. Resident #11 activities of daily living assistance ranged from extensive assistance to total dependence.<br><br>There was no documentation Resident #11 was examined for evidence of physical or psychological harm until 6/8/21, 6 days after Resident #29 was observed with his hands down his pants. Resident #11 was not interviewable.<br><br>On 8/6/21 at 5:15 p.m., in a second interview Resident #11's wife stated her husband would feel violated if he was able to express how he felt about the incident with Resident #29.<br><br>Resident #68's clinical record review revealed a diagnosis of Cerebral Infarction with partial paralysis, dementia, major depression, cognitive communication deficit, severe cognitive impairment, and required extensive assistance with most ADL's.<br><br>Resident #62's clinical record review revealed he is a [AGE] year-old male with a diagnosis of traumatic brain injury, persistent vegetative state, non-verbal, and total dependence on staff. The resident was noted to be unable to state or express needs. Resident #62 was observed to be in a private room and in bed all days of survey. The resident was non-responsive to attempts to be interviewed on 8/2/21.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 8/5/21 at 1:29 p.m., the Director of Nursing (DON) said there was no report of the incident involving Resident #29 inappropriately touching Resident #11, and she was not aware this had occurred until the morning of 6/8/21. The Administrator at the time had directed staff to move the resident to a different room on the night of 6/7/21. Resident #29 was sent out to the hospital that morning and one to one supervision (1:1) was started upon his return.<br><br>In an interview on 8/5/21 at 3:49 p.m., the Administrator said he started employment at the facility on 6/25/21 and was not here at time of incident. He revealed the facility did not follow its abuse policy and did not protect Resident #11 from further abuse by allowing the alleged perpetrator to continue to share a room for 5 days. Facility documentation review revealed the APRN, and SSD were also aware of the inappropriate sexual contact on 6/3/21 but no indication of any action taken to prevent Resident #29 from having further contact with Resident #11. On 6/7/21, Resident #29 was relocated to a different room, but several entries were made by LPN Staff G of resident being seen trying to enter the room of another vulnerable resident's (#62) room. There was no evidence of the resident being on a 1:1 supervision during this time. The Administrator said he would look to see if there was any documentation of this being done.<br><br>On 8/6/21 at 10:38 a.m., in an interview the APRN said on 6/3/21 a nurse notified her about the episodes with Resident #29 and Resident #11. She was told staff walked into their shared room to give care to Resident #11, Resident #29 had his hand inside of Resident #11's brief. She said Resident #29 was very mobile in his wheelchair and all over the facility. The APRN said she thought the episode may have happened the day before, on 6/2/21. She did not realize Resident #29 was still in the room with Resident #11 as she usually saw him outside of the room.<br><br>On 8/6/21 at 12:27 p.m., in an interview the SSD said the nursing team informed her someone had seen Resident #29 with his hand in Resident #11's brief. She wrote the note on 6/3/21 after she heard of it. The SSD said they also discussed it in morning meeting and were putting Resident #29 on one-to-one supervision. All the department heads including the Administrator were in the meeting. She notified Resident #29's family. The SSD said they talked about a room change, and the 1:1 supervision was to be 24 hours a day. She was told about the incident involving Resident #68 and talked to him about it on 6/8/21. She said Resident #68 was offended by the incident and said Resident #29 was nasty. The SSD could not explain how the incident occurred if Resident #29 was on one-to-one supervision.<br><br>On 8/6/21 at 12:50 p.m., in an interview the Administrator said he was unable to provide any evidence of one-to-one supervision for Resident #29 from 6/3/21 to 6/8/21 and upon his return from the hospital from 6/10/21 to 6/12/21.<br><br>The facility provided evidence of some monitoring for the evening of 6/12/21 but lacked consistent documentation for the evening and night shifts when Resident #29 was more likely to exhibit these behaviors.<br><br>The immediate actions implemented by the facility according to their Immediate Jeopardy removal plan and verified by the survey team, included the following:<br><br>On 6/7/21 Resident #29 was placed in a room by himself.<br><br>On 6/8/21 Resident #29 was placed on one-to-one supervision and [NAME] Act initiated.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 6/8/21 the facility initiated a thorough investigation, interviewed all interview able residents for any concern regarding any unwanted sexual advances.<br><br>On 6/8/21 a full skin assessment was completed on Resident #11.<br><br>On 6/8/21 Resident #11 was assessed by the APRN, no evidence of injuries noted.<br><br>On 6/8/21 interview with Resident #68 was conducted. Resident showed no fear or anxiety towards interviewer. Mood unchanged and thorough investigation conducted. Interviewed all interviewable residents for any concerns regarding any unwanted sexual advances. No concerns noted.<br><br>On 6/10/21 Resident #29 returned to the facility and was placed on every 30 minutes monitoring and placed in a private room.<br><br>On 6/12/21 Resident #29 was placed on one-to-one supervision.<br><br>On 7/14/21 The Abuse, Neglect and Exploitation / Reporting Alleged Violations policies were reviewed during Monthly Quality Assurance and Performance Improvement (QAPI) meeting.<br><br>On 7/22/21 Resident #29 moved to a different room related to positive cases in the building and remained on one-to-one monitoring.<br><br>On 8/5/21 Resident #29 was placed in a room by himself and placed on one-to-one supervision.<br><br>On 8/7/21 Residents #29, #11 and #68 were evaluated by psychiatry services.<br><br>The psychiatrist conducted a psychological evaluation of Resident #29 and medications: Estradiol dosage increased. No concerns noted for Resident #11 and #68.<br><br>The Interdisciplinary Team (IDT) reviewed and revised Resident #29's care plan to better identify patterns in resident's behavior and implement interventions. Care Plan revisions and interventions communicated to front line staff caring for resident.<br><br>On 8/7/21 The Interdisciplinary Team reviewed residents with behaviors that could result in any abuse behaviors. They were identified and care plans personalized to reflect residents' preferences and the Kardex updated to assist with redirection to prevent other residents from suffering further physical abuse, sexual abuse, or any type of abuse.<br><br>On 8/6/21, Federal Immediate report for abuse was filed to the Agency for Resident #11, Adult Protective Services was notified.<br><br>On 8/6/21, a facility investigation was initiated by the Administrator in conjunction with the Director of Nurses. The IDT team has concluded the root cause analysis of this concern was lack of education related to identifying abuse, neglect policy and procedures including compliance with reporting allegations of Abuse/Neglect/Exploitation.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 8/6/21, the facility initiated a Quality Monitor audit review for current residents residing in the facility with a Brief Interview of Mental Status (BIMS) of 9 or above, interviewing and assessing for potential abuse.<br><br>On 8/6/21, the facility initiated a Quality Monitor audit to review non-interview able residents by interviewing staff and resident families.<br><br>The Administrator, DON, designee will complete a Quality Monitor to identify any resident with sexual behaviors with likelihood to result in physical and sexual abuse.<br><br>On 8/6/21 and 8/7/2021 re-education initiated for Facility Staff by Administrator, DON, and Designee on:<br><br>Abuse, neglect, exploitation with emphasis on abuse prevention and reporting investigation. In the event of any future resident-to-resident sexual abuse, the perpetrating resident will immediately be placed on one-to-one supervision until physician, and psych evaluation can be completed and reviewed by IDT.<br><br>Outcomes of these evaluations will result in one-to-one supervision or the initiation of discharge planning to a facility with a focus on behavior management.<br><br>Abuse/Neglect/Exploitation and Reporting allegations posters were placed at each nursing station, employee breakrooms, and by the time clock. Targeted Ad Hoc education completed to attain and maintain compliance.<br><br>On 8/6/21, the Regional Director of Operations re-educated the Administrator and Director of Nursing as it relates to Federal Regulation F 600, Freedom from Abuse,<br><br>Neglect and Exploitation and oversight of care and services.<br><br>On 8/6/21, an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review a Performance Improvement Plan (PIP) inclusive of Abuse, Neglect and Exploitation (ANE). The Medical Director was also Involved in the QAPI review.<br><br>On 8/7/21 an Ad-Hoc QAPI meeting was held to review any concerns identified on the quality monitoring tools along with any PIP inclusive of ANE.<br><br>Abuse, Neglect and Exploitation, Reporting Alleged Violations policies have been reviewed by the committee. The committee also updated the Facility assessment.<br><br>Ad-Hoc Quality Assurance meetings will be held after Morning Meeting to review the PIP and Quality Monitoring.<br><br>Facility Staff will not be permitted to work until education completed. Newly hired staff members will receive<br><br>education and training during the orientation period upon hire, by the Director of Nursing or designee.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 30599 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33250<br><br>Based on record review, policy review, and staff interview, the facility failed to operationalize their policy and procedure and failed to protect vulnerable residents' rights to be free from resident-to-resident incidents of sexual abuse.<br><br>The facility failed to adequately supervise 1 (Resident #29) of 2 sampled residents with known behaviors with a likelihood to result in physical and sexual abuse.<br><br>Resident #29 had a care plan for sexually inappropriate behavior since April 2020. The facility failed to implement adequate supervision and protection of vulnerable residents resulting in Resident #29 displaying sexually inappropriate behaviors toward Resident #11 and #68.<br><br>On 6/2/21 in the evening, a Certified Nursing Assistant (CNA) reported witnessing Resident #29 having inappropriate sexual contact with his roommate, Resident #11.<br><br>The facility allowed the perpetrator (Resident #29) to remain in the same room with the alleged victim (Resident #11) until the evening of 6/7/21.<br><br>Resident #29 was allowed to wander about the facility unsupervised and exposed his penis to Resident #68.<br><br>Resident #29 also attempted to enter Resident #62's room, verbalizing the desire to commit a sexual act toward Resident #62.<br><br>The facility failure to follow their policy and procedure and protect residents after an allegation of inappropriate sexual contact placed Resident #11 and other vulnerable residents at risk for further abuse.<br><br>Residents #11, #62, and #68 have severe cognitive impairment and could not consent to sexual activities.<br><br>Applying the reasonable person concept, Resident #11 would likely suffer serious psychosocial harm, not yet realized, because he was not able to consent to sexual activity which diminished his self-worth and self-respect. Survivors of sexual abuse may develop depression, anxiety, post-traumatic stress, personality disruptions, attachment issues and addiction. There is a chance of passing sexually transmitted infections during unprotected sexual activities, which can lead to further health complications and death.<br><br>The Administrator was notified of the Immediate Jeopardy on 8/6/21 at 7:27 p.m. and provided the IJ templates.<br><br>After the facility submitted an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed on 8/8/21 at 6:30 p.m. and the scope and severity were reduced to a D.<br><br>The findings included:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Cross Reference to F600, F609, F610 and F835.<br><br>The facility Abuse, Neglect, and Exploitation policy and procedure with a reviewed/revised date 7/14/21, defines Sexual Abuse as non-consensual sexual contact of any type with a resident. Under Section V. Investigation-An immediate investigation is warranted when suspicion or reports of abuse, neglect or exploitation occur. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation.<br><br>Under section VI. Protection of Resident- the facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include: responding immediately to protect the alleged victim and integrity of the investigation; Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increased supervision of the alleged victim and residents; and room or staffing changes, if necessary to protect the resident(s) from the alleged perpetrator.<br><br>On 8/3/21 at 9:30 a.m., in an interview Resident #11's spouse said she was informed a couple of months ago a CNA found her husband's roommate (Resident # 29) to have his hands down her husband's pants. She said they told her his roommate was moved out of his room into another room and the facility was going to investigate the incident.<br><br>Resident #29's clinical record review revealed an admitted [DATE] with diagnoses including traumatic brain injury, seizure disorder.<br><br>The care plan initiated on 4/20/20 noted Resident #29 had episodes of asking for sexual favors and/or making sexual inappropriate comments to other residents, verbal aggression, taunting. The interventions included to redirect the resident gently but firmly from unacceptable behaviors (sexual inappropriate comments).<br><br>On 8/4/21, the facility's abuse investigation and federal immediate report was reviewed. The facility reported on 6/8/21 during the evening after dinner (no date) a CNA Staff O saw Resident #29 in his room at the foot of his roommate's bed (#11). The CNA observed resident #29 with his hand in the top part of the resident's brief.<br><br>CNA Staff O's written statement dated 6/8/21 was reviewed. The CNA noted at approximately 9:35 p.m., he observed Resident #29 in the dining room facing Resident #68. He heard Resident #68 say put it away. At that time, he observed Resident #29 had his penis out and said to Resident #29, You want it and Resident #68 began to curse at Resident #29. He then took Resident #29 to the unit and informed the nurse what he observed. Staff O noted there was another incident that occurred before the weekend during the evening, after dinner. He saw Resident #29 in his room with his hand inside of Resident #11's brief. His statement noted he informed Registered Nurse (RN) Staff S at the time of the incident.<br><br>There was no statement by RN Staff S found in the facility's investigation.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 8/5/21 at 2:36 p.m., in an interview CNA Staff O said there were 2 incidents involving Resident #29. The first was when he found him at the bedside of his roommate Resident #11 with his hands down the front of Resident #11's brief. The next incident occurred about a week later when he came through the dining room and Resident #29 was exposing his penis to Resident #68. Right after this incident, Resident #29 was moved out of the room he shared with resident #11 into a different room. The CNA said he notified RN Staff S after the first incident.<br><br>In a progress note the Advanced Practice Registered Nurse (APRN) noted on 6/3/21 at 10:13 a.m., in Resident #29's clinical record staff requested she evaluated the resident's sexually inappropriate behavior. Staff reported Resident #29 had been approaching men in the building (staff and residents) and requesting sexual favors. He was redirected by staff when this behavior occurred; He just laughed and left the situation.<br><br>On 6/3/21 at 10:44 a.m. the facility's Social Services Director (SSD) noted: today Resident #29's representative was informed about this resident's sexually inappropriate behavior.<br><br>On 6/8/21 at 6:40 a.m., Licensed Practical Nurse (LPN) Staff G noted Resident #29 entered Resident #62's room during care, The CNA asked the resident to leave the room and the resident responded No. The CNA asked the resident why was he going into Resident #62's room, and he responded I wanna [sic] chew his balls off . Resident #29 was observed previously at 5:24 a.m., and 6:01 a.m., attempting to enter Resident #62's room.<br><br>Resident #11's clinical record review revealed an admitted [DATE] with diagnoses including Lewy Bodies Dementia, Cerebral Infarction with resulting paralysis, aphasia (loss of ability to express speech), and total dependence on staff for all activities of daily living (ADL's).<br><br>On 8/5/21 at 1:29 p.m., in an interview the Director of Nursing (DON) said there was no report of the incident involving Resident #29 inappropriately touching Resident #11, and she was not aware this had occurred until the morning of 6/8/21. The Administrator at the time had directed staff to move the resident to a different room on the night of 6/7/21. Resident #29 was sent out to the hospital that same morning.<br><br>On 8/5/21 at 3:49 p.m., in an interview the Administrator said he started employment at the facility on 6/25/21 and was not here at time of incident. He revealed the facility did not follow its abuse policy, did not conduct a thorough investigation, and did not protect Resident #11 from further abuse by allowing the alleged perpetrator to continue to share a room for 5 days. Record review revealed documentation the APRN, and SSD were also aware of the inappropriate sexual contact on 6/3/21 but no indication of any action taken to report the incident or prevent the resident from having further contact with Resident #11. On 6/7/21, Resident #29 was relocated to a different room, but LPN Staff G made several entries of Resident #29 seen trying to enter the room of another vulnerable resident's (#62) room. There was no evidence of the resident being on a close supervision during this time. The Administrator said he would look to see if there was any documentation of this being done.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 8/6/21 at 10:38 a.m., in an interview the APRN said on 6/3/21 a nurse notified her about the episode with Resident #29 and Resident #11. She was told staff walked into their shared room to give care to Resident #11 and Resident #29 had his hand inside of Resident #11's brief. She said Resident #29 was very mobile in his wheelchair and all over the facility. The APRN said she thought the episode may have happened the day before, on 6/2/21. She did not realize Resident #29 was still in the room with Resident #11 as she usually saw him outside of the room.<br><br>On 8/6/21 at 12:27 p.m., in an interview the SSD said she was informed through the nursing team someone had seen Resident #29 with his hand in Resident #11's brief. She wrote the note on 6/3/21 after she heard of it. The SSD said they also discussed it in morning meeting and were putting Resident #29 on one-to-one supervision. All the department heads including the Administrator were in the meeting. The Administrator and DON were to do the reporting to the state agency, and she assumed this was taken care of. She notified Resident #29's family. The SSD said they talked about a room change, and the one-to-one supervision was to be 24 hours a day. She was told about the incident involving Resident #68 and talked to him about it on 6/8/21. She said Resident #68 was offended by the incident and said Resident #29 was nasty. The SSD could not explain how that would occur if Resident #29 was on one-to-one supervision.<br><br>On 8/6/21 at 12:50 p.m., in an interview the Administrator said he was unable to provide any evidence of Resident #29 being on one-to-one supervision after the incident on 6/3/21 to 6/8/21 before he left the facility.<br><br>The immediate actions implemented by the facility according to their Immediate Jeopardy removal plan and verified by the survey team, included the following:<br><br>On 6/7/21 Resident #29 was placed in a room by himself.<br><br>On 6/8/21 Resident #29 was placed on one-to-one supervision and [NAME] Act (Invuluntary Psychiatric Evaluation) initiated.<br><br>On 6/8/21 the facility initiated a thorough investigation, interviewed all interview able residents for any concerns regarding any unwanted sexual advances.<br><br>On 6/8/21 a full skin assessment was completed on Resident #11.<br><br>On 6/8/21 Resident #11 was assessed by the Advanced Practice Registered Nurse (APRN). The Resident showed no fear when approached by APRN. The Mood was unchanged from previous baseline. No anxiety noted.<br><br>On 6/8/21 interview with Resident #68 was conducted. The Resident showed no fear or anxiety towards interviewer. The Mood unchanged and thorough investigation conducted. Interviewed all interviewable residents for any concerns regarding any unwanted sexual advances. No concerns noted.<br><br>On 6/10/21 Resident #29 returned to the facility and was placed on every 30 minutes monitoring and placed in a private room.<br><br>On 6/12/21 Resident #29 was placed on one-to-one supervision.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 7/14/21 the Abuse, Neglect and Exploitation, Reporting Alleged Violations policies were reviewed during our Monthly Quality Assurance Performance Improvement (QAPI) meeting.<br><br>On 7/22/21 Resident #29 moved to a different room related to positive cases in the building and one-to-one monitoring continued.<br><br>On 8/5/21 Resident #29 was placed in a private room and placed on one-to-one supervision.<br><br>On 8/7/2021 Residents #29, #11 and #68 were evaluated by psychiatry services.<br><br>The Psychiatrist conducted a psychological evaluation of Resident #29 and medications: The Estradiol dosage was increased. No concerns noted for Residents #11 and #68.<br><br>The Interdisciplinary Team reviewed and revised Resident #29 care plan to better identify patterns in resident behavior and implement interventions.<br><br>Care Plan revisions and interventions communicated to front line<br><br>staff caring for resident.<br><br>On 8/6/21, a Federal Immediate report for abuse was filed to the Agency for Resident #11 and Adult Protective Services (API) was notified.<br><br>On 8/6/21, a facility investigation was initiated by the Administrator in conjunction with the Director of Nurses. The Interdisciplinary Team (IDT) concluded the root cause analysis of this concern was lack of education related to identifying abuse, neglect policy and procedures including compliance with reporting allegations<br><br>of Abuse/Neglect/Exploitation.<br><br>On 8/6/21, the facility initiated a Quality Monitor audit review for current residents residing in the facility with a Brief Interview for Mental Status (BIMS) of 9 or above, interviewing/assessing for potential abuse. Any Concerns identified will be<br><br>investigated immediately with state and Federal reporting as indicated.<br><br>On 8/6/21, the facility initiated a Quality Monitor audit to review non-interview able residents by interviewing staff and resident' families. Any concerns identified will be investigated immediately.<br><br>On 8/6/21 and 8/7/21 re-education initiated by Administrator/DON/Designee on for Facility Staff on:<br><br>Abuse, Neglect and Exploitation with emphasis on abuse prevention and reporting investigation. In the event of any future resident-to-resident sexual abuse, the perpetrating resident will immediately be placed on one-to-one supervision until physician, and psych evaluations can be completed and reviewed by IDT.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Outcomes of these evaluations will result in one-to- one supervision or the initiate of discharge planning to a facility with a focus on behavior management.<br><br>Abuse/Neglect/Exploitation and Reporting allegations posters were placed at each nursing station, employee breakrooms, and by the time clock. Targeted Ad Hoc education completed as indicated to attain and maintain compliance.<br><br>On 8/6/21, the Regional Director of Operations re-educated the Administrator and Director of Nursing as it relates to Federal Regulation F607.<br><br>On 8/6/21, an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review a Performance Improvement Plan (PIP) inclusive of Abuse, Neglect and Exploitation (ANE).<br><br>On 8/7/21 an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review any concerns identified on the quality monitoring tools along with any PIP inclusive of ANE.<br><br>Abuse, Neglect and Exploitation, Reporting Alleged Violations policies have been reviewed by the committee. The Facility assessment has been updated by the Committee.<br><br>Ad-Hoc Quality Assurance meetings to be held after Morning Meeting to review the Plan of Correction (PIP) and Quality Monitoring.<br><br>Facility Staff are not permitted to work until education completed. Newly hired staff members will receive education and training during the orientation period upon hire, by the Director of Nursing or designee.<br><br>30599 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>33250<br><br>Based on record review, policy review, and staff interviews, the facility failed to immediately report an alleged violation involving abuse to the appropriate officials, including to the State survey and certification agency, and adult protective services in accordance with State law. The facility failed to report the incident to the appropriate officials as soon as they became aware of the incident resident to resident sexual abuse involving Resident #29 and Resident #11.<br><br>The facility's administration was made aware of the allegation on 6/3/21 and allowed Resident #11 to remain in the same room with the perpetrator until the evening of 6/7/21. Resident #29 was also allowed to wander about the facility unsupervised resulting in him exposing his penis to Resident #68, and attempting to enter Resident #62's room, verbalizing the desire to commit a sexual act toward the resident.<br><br>The facility failed to take immediate action to protect Resident #11 and other residents from further sexual abuse inflicted by Resident #29.<br><br>Residents #11, #62, and #68 have severe cognitive impairment and could not consent to sexual activities.<br><br>Applying the reasonable person concept, Resident #11 would likely suffer serious psychosocial harm, not yet realized, because he was not able to consent to sexual activity which diminished his self-worth and self-respect. Survivors of sexual abuse may develop depression, anxiety, post-traumatic stress, personality disruptions, attachment issues and addiction. There is a chance of passing sexually transmitted infections during unprotected sexual activities, which can lead to further health complications and death.<br><br>The failure to immediately report and appropriately intervene for sexually inappropriate behaviors of Resident #29 toward other residents resulted in noncompliance at the Immediate Jeopardy level starting on 6/3/21.<br><br>The Administrator was notified of the Immediate Jeopardy on 8/6/21 at 7:27 p.m. and provided the IJ template.<br><br>After the facility submitted an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed on 8/8/21 at 6:30 p.m., and the scope and severity were reduced to D.<br><br>The findings included:<br><br>Cross Reference to F600, F 607, F610, and F835.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility's Reporting Alleged Violations policy dated January 2021, revised date of July 12. 2021; included purpose is to assure that all alleged violations are reported immediately to the facility administrator and other officials. Under the section Response and Reporting of alleged violations: anyone in the facility can report an alleged violation. When an alleged violation is suspected, the Licensed Nurse should respond to the needs of the resident and protect them from further incident. Notify the Director of Nursing and Administrator. Complete an incident report and initiate an investigation immediately. Notify the attending physician, resident's family/legal representative and Medical Director. Obtain statements from direct care staff. Document actions taken in the medical record. The Administrator should follow-up with government agencies, during business hours, to confirm the report was received and to report the results of the investigation when final, as required by state agencies.<br><br>In an interview on 8/3/21 at 9:30 a.m., Resident #11's family member said she was informed a couple of months ago that her husband's roommate (Resident # 29) was found by a CNA to have his hands down her husband's pants. She said they told her his roommate was moved out of his room into another room and the facility was going to investigate the incident.<br><br>On 8/4/21, the facility's abuse investigation and federal immediate report was reviewed. On 6/8/21 the facility reported during the evening after dinner (no date) a CNA Staff O saw Resident #29 in his room at the foot of his roommate's bed (#11). The CNA observed resident #29 with his hand in the top part of the resident's brief.<br><br>CNA Staff O's written statement dated 6/8/21 was reviewed. The CNA noted at approximately 9:35 p.m., he observed Resident #29 in the dining room facing Resident #68. He heard Resident #68 say put it away. At that time, he observed Resident #29 had his penis out and said to Resident #68, You want it and Resident #68 began to curse at Resident #29. He then took Resident #29 to the unit and informed the nurse what he observed. Staff O noted there was another incident that occurred before the weekend during the evening, after dinner. He saw Resident #29 in his room with his hand inside of Resident #11's brief. His statement noted he informed Registered Nurse (RN) Staff S at the time of the incident.<br><br>In an interview on 8/5/21 at 2:36 p.m., CNA Staff O said there were 2 incidents involving Resident #29. The first was when he found him at bedside of roommate Resident #11 with his hands down the front of Resident #11's brief. The next incident occurred about a week later when he came through the dining room and Resident #29 was exposing his penis to Resident #68. Right after this incident, Resident #29 was moved out of the room he shared with resident #11 into a different room. The CNA said he notified RN Staff S after the first incident.<br><br>The facility's staffing schedule was reviewed and indicated both RN Staff S and CNA Staff O were working on the evening of 6/2/21.<br><br>Resident #29's clinical record was reviewed and revealed a history of sexually inappropriate behavior. In a progress note the Advanced Registered Nurse Practitioner (APRN) noted on 6/3/21 at 10:13 a.m., staff requested she evaluate the resident's sexually inappropriate behavior. Staff reports Resident #29 has been approaching the men in the building (staff and residents) and requesting sexual favors. He was redirected by staff when this behavior occurred; He just laughed and left the situation.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 6/3/21 at 10:44 a.m., the facility's Social Services Director (SSD) noted: today Resident #29's representative was informed about this resident's sexually inappropriate behavior.<br><br>On 6/8/21 at 6:40 a.m., Licensed Practical Nurse (LPN) Staff G noted Resident #29 entered Resident #62's room during care, The CNA asked the resident to leave the room and the resident responded No. The CNA asked the resident why is he going into Resident #62's room, and he responded I wanna chew his balls off . Resident #29 was observed previously at 5:24 a.m., and 6:01 a.m., attempting to enter Resident #62's room.<br><br>In an interview on 8/5/21 at 1:29 p.m., the Director of Nursing (DON) said there was no report of the incident involving Resident #29 inappropriately touching Resident #11, and she was not aware this had occurred until the morning of 6/8/21. The Administrator at the time had directed staff to move the resident to a different room on the night of 6/7/21 and reported the incident to the state agency.<br><br>In an interview on 8/5/21 at 3:49 p.m., the Administrator said he did not start employment at the facility until 6/25/21 and was not here at time of incident. He revealed the facility did not follow its abuse policy, did not immediately report the allegation, and did not protect Resident #11 from further abuse by allowing the alleged perpetrator to continue to share a room for 5 days. Record review revealed documentation the APRN, and SSD were also aware of the inappropriate sexual contact on 6/3/21 but no indication of any action taken to report the incident, or prevent the resident from having further contact with Resident #11. On 6/7/21, Resident #29 was relocated to a different room, but several entries were made by LPN Staff G of resident being seen trying to enter the room of another vulnerable resident's (#62) room. There was no evidence of the resident being on one-to-one supervision during this time.<br><br>In an interview on 8/6/21 at 10:38 a.m., the APRN said on 6/3/21 she was notified by a nurse about the episode with Resident #29 and Resident #11. Was told staff walked into their shared room to give care to Resident #11 and Resident #29 had his hand inside of Resident #11's brief. She said Resident #29 was very mobile in his wheelchair and all over the facility. The APRN said she thinks the episode may have happened the day before, on 6/2/21. She did not realize he was still in the room with Resident #11 as she usually saw him outside of the room. The APRN said she is a mandatory reporter, but the facility's social worker was also aware and thought she would have filed a report.<br><br>In an interview on 8/6/21 at 12:27 p.m., the SSD said she was informed through nursing team that someone had seen Resident #29 with his hand in Resident #11's brief. She wrote the note on 6/3/21 after she heard of it. The SSD said they also discussed it in morning meeting and were putting Resident #29 on 1:1 supervision. All the department heads including the Administrator were in the meeting. The Administrator and DON were to do the reporting to the state agency and assumed this was taken care of. She did notify the family of Resident #29.<br><br>On 8/8/21 the facility submitted an acceptable removal plan. Verified implementation of removal plan through record review of staff Inservice records and staff interviews. Administration was re-educated on regulatory requirements of reporting abuse/neglect. Resident #29 was observed on 1:1 observation.<br><br>The immediate actions implemented by the facility according to their Immediate Jeopardy removal plan and verified by the survey team, included the following:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 8/6/21, a Federal Immediate report for abuse was filed to the State Agency for Resident #11, and Adult Protective Services (API) was notified.<br><br>On 8/6/21, the facility initiated a Quality Monitor audit review for current residents residing in the facility with a Brief Interview for Mental Status (BIMS) of 9 or above, interviewing/assessing for potential abuse. Any Concerns identified will be<br><br>investigated immediately with state and Federal reporting as indicated.<br><br>On 8/6/21, the facility initiated a Quality Monitor audit to review non-interview able residents by interviewing staff and resident families. Any concerns identified will be investigated immediately with State and Federal reporting as indicated.<br><br>On 8/6/21 and 8/7/21 re-education initiated by Administrator/DON/Designee on for Facility Staff on:<br><br>Abuse, Neglect, Exploitation with emphasis on abuse prevention and reporting investigation.<br><br>On 8/6/21 the Regional Director of Operations reeducated the Administrator and Director of Nursing as it relates to Federal Regulation F 609.<br><br>On 8/6/21, an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review a Performance Improvement Plan (PIP) inclusive of Abuse, Neglect and Exploitation (ANE).<br><br>On 8/7/21 an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review any concerns identified on the quality monitoring tools along with any PIP inclusive of ANE.<br><br>Ad-Hoc Quality Assurance meetings to be held after Morning Meeting to review Plan of Correction (PIP and Quality Monitoring).<br><br>Facility Staff are not permitted to work until education completed. Newly hired staff members will receive education and training during the orientation period upon hire, by the Director of Nursing or designee.<br><br>30599 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33250<br><br>Based on record review, policy review, and staff interview, the facility failed to have evidence of a thorough investigation after an allegation of inappropriate sexual contact and potential abuse was reported for 1 (Resident #29) of 1 resident sampled with sexual inappropriate behaviors.<br><br>The allegation was reported on the evening of 6/2/21 and there was no investigation into the potential sexual abuse until 6/8/21.<br><br>This failure to investigate and operationalize the abuse policy led to the alleged victim (Resident #11) remaining in the same room with the perpetrator (Resident #29) until the evening of 6/7/21.<br><br>Resident #29 was also allowed to wander about the facility unsupervised resulting in him exposing his penis to Resident #68, and attempting to enter Resident #62's room, verbalizing the desire to commit a sexual act.<br><br>The failure to not investigate the allegation of potential sexual abuse placed Resident #11 and other vulnerable residents at risk for further abuse.<br><br>Applying the reasonable person concept, Resident #11 would likely suffer serious psychosocial harm, not yet realized, because he was not able to consent to sexual activity which diminished his self-worth and self-respect. Survivors of sexual abuse may develop depression, anxiety, post-traumatic stress, personality disruptions, attachment issues and addiction. There is a chance of passing sexually transmitted infections during unprotected sexual activities, which can lead to further health complications and death.<br><br>The noncompliance resulted in Immediate Jeopardy starting on 6/3/21.<br><br>The Administrator was notified of the Immediate Jeopardy on 8/6/21 at 7:27 p.m. and provided the IJ template.<br><br>After the facility submitted an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed on 8/8/21 at 6:30 p.m., and the scope and severity were reduced to D.<br><br>The findings included:<br><br>Cross Reference to F600, F607, F609, and F835.<br><br>The facility's Abuse, Neglect, and Exploitation policy and procedure with a reviewed/revised date 7/14/21, defines Sexual Abuse as non-consensual sexual contact of any type with a resident. Under Section V. Investigation-An immediate investigation is warranted when suspicion or reports of abuse, neglect or exploitation occur. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Under section VI. Protection of Resident- the facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include: responding immediately to protect the alleged victim and integrity of the investigation; Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increased supervision of the alleged victim and residents; and room or staffing changes, if necessary to protect the resident(s) from the alleged perpetrator.<br><br>In an interview on 8/3/21 at 9:30 a.m., Resident #11's family member said she was informed a couple of months ago that her husband's roommate (Resident # 29) was found by a CNA to have his hands down her husband's pants. She said they told her his roommate was moved out of his room into another room and the facility was going to investigate the incident.<br><br>On 8/4/21, the facility's abuse investigation and federal immediate report was reviewed. On 6/8/21 the facility reported during the evening after dinner (no date) a CNA Staff O saw Resident #29 in his room at the foot of his roommate's bed (#11). The CNA observed resident #29 with his hand in the top part of the resident's brief.<br><br>CNA Staff O's written statement dated 6/8/21 was reviewed. The CNA noted at approximately 9:35 p.m., he observed Resident #29 in the dining room facing Resident #68. He heard Resident #68 say put it away. At that time, he observed Resident #29 had his penis out and said to Resident #68, You want it and Resident #68 began to curse at Resident #29. He then took Resident #29 to the unit and informed the nurse what he observed. Staff O noted there was another incident that occurred before the weekend during the evening, after dinner. He saw Resident #29 in his room with his hand inside of Resident #11's brief. His statement noted he informed Registered Nurse (RN) Staff S at the time of the incident.<br><br>There was no statement by RN Staff S found in the facility's investigation.<br><br>In an interview on 8/5/21 at 2:36 p.m., CNA Staff O said there were 2 incidents involving Resident #29. The first was when he found him at bedside of roommate Resident #11 with his hands down the front of Resident #11's brief. The next incident occurred about a week later when he came through the dining room and Resident #29 was exposing his penis to Resident #68. Right after this incident, Resident #29 was moved out of the room he shared with resident #11 into a different room. The CNA said he notified RN Staff S after the first incident<br><br>Resident #29's clinical record was reviewed and revealed he is a [AGE] year-old male with a history of sexually inappropriate behavior. In a progress note the Advanced Practice Registered Nurse (APRN) noted on 6/3/21 at 10:13 a.m., staff requested she evaluate the resident's sexually inappropriate behavior. Staff reports Resident #29 has been approaching the men in the building (staff and residents) and requesting sexual favors. He is redirected by staff when this behavior occurs; He just laughs and leaves the situation.<br><br>On 6/3/21 at 10:44 a.m. the facility's Social Services Director (SSD) noted: today Resident #29's representative was informed about this resident's sexually inappropriate behavior.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 6/8/21 at 6:40 a.m., Licensed Practical Nurse (LPN) Staff G noted Resident #29 entered Resident #62's room during care, The CNA asked the resident to leave the room and the resident responded No. The CNA asked the resident why is he going into Resident #62's room, and he responded I wanna [sic]chew his balls off . Resident #29 was observed previously at 5:24 a.m., and 6:01 a.m., attempting to enter Resident #62's room.<br><br>In an interview on 8/5/21 at 1:29 p.m., the Director of Nursing (DON) said there was no report of the incident involving Resident #29 inappropriately touching Resident #11, and she was not aware this had occurred until the morning of 6/8/21. The Administrator at the time had directed staff to move the resident to a different room on the night of 6/7/21. Resident #29 was sent out to the hospital that same morning.<br><br>The facility's staffing schedule was reviewed and indicated both RN Staff S and CNA Staff O were working on the evening of 6/2/21. CNA Staff O was not on duty 6/3/21.<br><br>In an interview on 8/5/21 at 2:06 p.m., the DON said she had determined the date of the incident occurred on 6/3/21 as that was last day RN Staff S worked. She confirmed she had not interviewed RN staff S regarding the incident. The DON said she was not aware CNA Staff O was not even on duty that day. The DON did not identify and interview all staff members who were on duty 6/2/21 or may have had knowledge of the incident.<br><br>In an interview on 8/5/21 at 3:49 p.m., the Administrator said he did not start until 6/25/21 and was not here at time of incident. He revealed the facility did not follow its abuse policy, did not conduct a thorough investigation, and did not protect Resident #11 from further abuse by allowing the alleged perpetrator to continue to share a room for 5 days. Record review revealed documentation the APRN, and SSD were also aware of the inappropriate sexual contact on 6/3/21 but no indication of any action taken to report the incident or prevent the resident from having further contact with Resident #11. On 6/7/21, Resident #29 was relocated to a different room, but several entries were made by LPN Staff G of resident being seen trying to enter the room of another vulnerable resident's (#62) room. There was no evidence of the resident being on a one-to-one supervision during this time. The Administrator said he would look to see if there was any documentation of this being done.<br><br>In an interview on 8/6/21 at 10:38 a.m., the APRN said on 6/3/21 she was notified by a nurse about the episode with Resident #29 and Resident #11. Was told staff walked into their shared room to give care to Resident #11 and Resident #29 had his hand inside of Resident #11's brief. She said Resident #29 was very mobile in his wheelchair and all over the facility. The APRN said she thinks the episode may have happened the day before, on 6/2/21.<br><br>In an interview on 8/6/21 at 11:06 a.m., the DON said she is now the Risk Manager, but the previous Administrator was the Risk Manager at the time of the incident. The root cause of this incident is a lack of education and understanding as to the seriousness of the issue. She did a disciplinary action with RN Staff S last night until she can further investigate her involvement.<br><br>In an interview on 8/6/21 at 12:50 p.m., the Administrator said he was unable to provide any evidence of Resident #29 being on one-to-one supervision after the incident on 6/3/21 to 6/8/21 when he left the facility.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 8/8/21 the facility submitted an acceptable removal plan. Verified implementation of removal plan through record review of staff Inservice records and staff interviews. Administration was re-educated on investigation of abuse/neglect. Resident #29 was observed on 1:1 observation.<br><br>The immediate actions implemented by the facility according to their Immediate Jeopardy removal plan and verified by the survey team, included the following:<br><br>On 6/7/21 Resident #29 was placed in a room by himself.<br><br>On 6/8/21 Resident #29 was placed on one-to-one supervision and [NAME] Act initiated.<br><br>On 6/8/21 the facility initiated a thorough investigation, interviewed all interview able residents for any concern regarding any unwanted sexual advances.<br><br>On 6/8/21 a full skin assessment was completed on Resident #11.<br><br>On 6/8/21 Resident #11 was assessed by the APRN, no evidence of injuries noted.<br><br>On 6/8/21 interview with Resident #68 was conducted. Resident showed no fear or anxiety towards interviewer. Mood unchanged and thorough investigation conducted. Interviewed all interviewable residents for any concerns regarding any unwanted sexual advances. No concerns noted.<br><br>On 6/10/21 Resident #29 returned to the facility and was placed on every 30 minutes monitoring and placed in a private room.<br><br>On 6/12/21 Resident #29 was placed on one-to-one supervision.<br><br>On 7/14/21 The Abuse, Neglect and Exploitation / Reporting Alleged Violations policies were reviewed during Monthly Quality Assurance and Performance Improvement (QAPI) meeting.<br><br>On 7/22/21 Resident #29 moved to a different room related to positive cases in the building and remained on one-to-one monitoring.<br><br>On 8/5/21 Resident #29 was placed in a room by himself and placed on one-to-one supervision.<br><br>On 8/7/21 Residents #29, #11 and #68 were evaluated by psychiatry services.<br><br>The psychiatrist conducted a psychological evaluation of Resident #29 and medications: Estradiol (female hormone) dosage increased. No concerns noted for Resident #11 and #68.<br><br>The Interdisciplinary Team (IDT) reviewed and revised Resident #29's care plan to better identify patterns in resident's behavior and implement interventions. Care Plan revisions and interventions communicated to front line staff caring for resident.<br><br>On 8/7/21 The Interdisciplinary Team reviewed residents with behaviors that could result in any abuse behaviors. They were identified and care plans personalized to reflect residents' preferences and the Kardex updated to assist with redirection to prevent other residents from suffering further physical abuse, sexual abuse, or any type of abuse.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 8/6/21, Federal Immediate report for abuse was filed to the Agency for Resident #11, Adult Protective Services was notified.<br><br>On 8/6/21, a facility investigation was initiated by the Administrator in conjunction with the Director of Nurses. The IDT team has concluded the root cause analysis of this concern was lack of education related to identifying abuse, neglect policy and procedures including compliance with reporting allegations of Abuse/Neglect/Exploitation.<br><br>On 8/6/21, the facility initiated a Quality Monitor audit review for current residents residing in the facility with a Brief Interview of Mental Status (BIMS) of 9 or above, interviewing and assessing for potential abuse.<br><br>On 8/6/21, the facility initiated a Quality Monitor audit to review non-interview able residents by interviewing staff and resident families.<br><br>The Administrator, DON, designee will complete a Quality Monitor to identify any resident with sexual behaviors with likelihood to result in physical and sexual abuse.<br><br>On 8/6/21 and 8/7/2021 re-education initiated for Facility Staff by Administrator, DON, and Designee on:<br><br>Abuse, neglect, exploitation with emphasis on abuse prevention and reporting investigation. In the event of any future resident-to-resident sexual abuse, the perpetrating resident will immediately be placed on one-to-one supervision until physician, and psych evaluation can be completed and reviewed by IDT.<br><br>Outcomes of these evaluations will result in one-to-one supervision or the initiation of discharge planning to a facility with a focus on behavior management.<br><br>Abuse/Neglect/Exploitation and Reporting allegations posters were placed at each nursing station, employee breakrooms, and by the time clock. Targeted Ad Hoc education completed to attain and maintain compliance.<br><br>On 8/6/21, the Regional Director of Operations re-educated the Administrator and Director of Nursing as it relates to Federal Regulation F 610, Investigating, preventing and correction of alleged violations.<br><br>On 8/6/21, an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review a Performance Improvement Plan (PIP) inclusive of Abuse, Neglect and Exploitation (ANE). The Medical Director was also Involved in the QAPI review.<br><br>On 8/7/21 an Ad-Hoc QAPI meeting was held to review any concerns identified on the quality monitoring tools along with any PIP inclusive of ANE.<br><br>Abuse, Neglect and Exploitation, Reporting Alleged Violations policies have been reviewed by the committee. The committee also updated the Facility assessment.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ad-Hoc Quality Assurance meetings will be held after Morning Meeting to review the PIP and Quality Monitoring.<br><br>Facility Staff will not be permitted to work until education completed. Newly hired staff members will receive<br><br>education and training during the orientation period upon hire, by the Director of Nursing or designee.<br><br>30599 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>33250<br><br>Based on observation, record review, and staff interview, the facility failed to provide appropriate services and interventions for the management of contractures for 1 (Resident #62) of 1 resident sampled with a limitation in range of motion (ROM). This has the potential to cause pain and worsening of the contracture.<br><br>The findings included:<br><br>A review of the policy provided by the facility for Restorative Nursing Programs, copyright 2020, states it is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Residents as identified during the comprehensive assessment process will receive services from restorative aides when they are assessed as having a need for restorative nursing services. These services may include; passive or active ROM, and splint or brace assistance. Residents may receive restorative nursing when restorative needs arise during the course of a longer-term stay, or upon discharge from therapy. The Restorative Nurse is responsible for maintaining a current list of residents who require restorative nursing services; and for ensuring that all elements of each resident's program are implemented.<br><br>Observation on 8/2/21 at 11:05 a.m., revealed Resident #62's left, and right hands were closed in a fist. Resident #62 was not able to respond to attempt to interview.<br><br>On 8/4/21 at 8:20 a.m., Resident #62 was observed to have rolled up wash cloths in both hands.<br><br>A review of the clinical record for Resident #62 revealed an annual Minimum Data Set 3.0 assessment completed on 6/29/21. The comprehensive clinical assessment documented Resident #62 had impairment on both sides for functional limitation in ROM and totally dependent on staff for bed mobility.<br><br>A review of Occupational Therapy (OT) recommendations dated 11/8/20 documented Resident #62 had a contracture of his upper extremities involving both wrists. The OT established a restorative nursing program and trained staff to apply resting hand splints to both hands in the evening and remove in the morning to facilitate a more relaxed position of both upper extremities to decrease risk of skin breakdown and further contracture.<br><br>A review of Resident #62's restorative program revealed on 11/9/20, the Restorative Nurse set up a program for bilateral resting hand splints to be applied for up to 8 hours daily to decrease risk of further contracture, and at risk for skin breakdown at bilateral palms. A restorative nursing program progress note dated 12/3/20 noted bilateral passive ROM and splint placement continues, tolerating very well. On 12/7/20, the restorative Nurse noted the resident was discharged to the hospital and would be re-evaluated upon his return.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident#62's current care plan dated 11/9/20, identified the problem of resident requires a restorative nursing program for splint care related to bilateral upper extremity contractures. The goal revised on 5/14/21, was for the resident to maintain current level of function. Interventions were to complete restorative program as written, and restorative nurse to evaluate monthly. Under the problem of Restorative ROM, the resident was to receive gentle ROM to arms and legs 3 times a week<br><br>A review of the Certified Nursing Assistant (CNA) task list was reviewed and there was no documentation of any ROM being done. The CNA Kardex (communicates important information on the resident) did not identify the resident had contractures, was to wear resting hand splints, or receive passive ROM to upper and lower extremities.<br><br>On 8/4/21 at 10:58 a.m., during an interview, the facility's Rehab Director said Resident #62 received therapy to work on pain management for spasms and positioning. A Restorative Nursing program had been set up on 11/8/20 for bilateral hand splints. She was not aware of any changes being made to the program.<br><br>On 8/4/21 at 11:17 a.m., during an interview, Registered Nurse (RN) Staff V said she used to see Resident #62 wearing splints but hasn't in quite a while. Sometimes staff put a cloth in his hands to try to keep him from digging into his palm with his fingernails. The residents' room was searched by the Rehab Director and RN Staff V. There was no evidence of any splints in the resident's room.<br><br>On 8/4/21 at 11:20 a.m., during an interview with CNA Staff W and CNA Staff X, both said they had not seen any splints for Resident #62, just the washcloths in his hands.<br><br>On 8/4/21 at 11:28 a.m., in an interview, RN Staff T said she took over as Restorative Nurse in February 2021 and did not have Resident #62 on any restorative program. Staff T reviewed her restorative book and confirmed Resident #62 had been added in November 2020, but program had stopped on 12/4/20 due to the resident going out to the hospital. The resident returned on 12/9/20 but the program was never restarted. Staff T said she has no further documentation of his splints.<br><br>On 8/4/21 at 12:10 p.m. during an interview with the Director of Nursing (DON) regarding Resident #62's restorative program for bilateral splints was stopped when he went out to the hospital and not restarted upon his return. The DON confirmed the restorative program for splinting is on the resident's current care plan, but not on the CNA Kardex or task list, and there was no documentation of ROM being done or splints being applied. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33250<br><br>Based on observation, and staff interview the facility failed to maintain the kitchen and food storage rooms in a clean and sanitary manner that is in good repair by not having clean surfaces in food preparation and storage areas, and not maintaining can goods and prepackaged food in a manner to prevent potential contamination.<br><br>The findings included:<br><br>1. On [DATE] at 7:30 a.m. and [DATE] at 8:30 a.m., during tours of the kitchen, the following was observed:<br><br>The door inside the kitchen was heavily soiled; the walk-in refrigerator floor was soiled with debris; the corner of wall next to walk-in was damaged, soiled, and stained; food was being stored on rusted metal carts; and inside of door and handle of the walk-in refrigerator was heavily coated with rust;<br><br>The side of the reach-in cooler was rusted and soiled; the steam table had rusted wheels; the metal leg of the oven was soiled with grease along leg onto floor.<br><br>Rusted screens to vents in ceilings throughout the kitchen; the door to the dining room was soiled, stained, and rusted; the vents were coated with dust; and a three-inch by two-inch hole was observed in the wall above the thermostat with accumulated dust around the opening.<br><br>The dish room had carts with rusted wheels and detached ceiling tiles.<br><br>The exit door had a gap along bottom with one inch opening to the outside.<br><br>The janitor closet had detached rusted metal vent hanging in the ceiling and the floor was soiled.<br><br>2. On [DATE] at 8:30 a.m., the facility's emergency food storage area was observed; the room was heavily soiled with broken ceiling tile allowing 12 inches by 3 inches gap into ceiling above; the rack holding the boxes of food was heavily rusted; and the door frame had heavy accumulation of dust. The food was observed and several boxes appeared to be damaged: four of 12 cans of cranberry juice were dented along top seal; a bag of powdered milk received on [DATE] had extensive water damage and was brown along bottom, label read packaged on [DATE] and expires on [DATE] (over 2 years old); a can of chicken and dumplings was dented along the top seal.<br><br>On [DATE] at 8:30 a.m., The Dietary Manager (DM) and Facility's Registered Dietitian (RD) confirmed the stock should be rotated more frequently to prevent losing quality and would be removing the expired/damaged items from potential use. The DM acknowledged the room was not being maintained in a sanitary manner. The RD and DM both confirmed the cans with damage along the top or side seam can damage the seam and allow bacteria to enter the can. Dented cans had potential for contamination of the food inside.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 3. On [DATE] at 9:00 a.m., the food storage area in the main kitchen was again observed along with the RD and five of the nine cans of diced green chilies stored on the shelf were damaged along the top of the can in the area of the seam; The RD removed the items from storage and potential use.<br><br>4. On [DATE] at 9:17 a.m., a tour of the kitchen was conducted with the DM. All above concerns were again identified. The DM acknowledged the rusted areas were uncleanable surfaces and may need to be replaced. He said the dust in ceiling vents was to be cleaned by maintenance. He acknowledged the rusted vents and ceiling supports needed to be replaced.<br><br>**photographic evidence obtained** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>33250<br><br>Based on record review and staff interviews, the facility's Administration failed to use resources effectively to ensure the facility's abuse policy and procedures was implemented to prevent, report, protect, and investigate sexual abuse for vulnerable residents (#11, #62, and #68,)<br><br>Residents #11, #62, and #68 have severe cognitive impairment.<br><br>Applying the reasonable person concept, Resident #11 would likely suffer serious psychosocial harm, not yet realized, because he was not able to consent to sexual activity which diminished his self-worth and self-respect. Survivors of sexual abuse may develop depression, anxiety, post-traumatic stress, personality disruptions, attachment issues and addiction. There is a chance of passing sexually transmitted infections during unprotected sexual activities, which can lead to further health complications and death.<br><br>The failure of the Administration to implement their abuse policies created a likelihood that put Resident #11 at risk for further potential sexual abuse, as well as other vulnerable residents at risk for abuse.<br><br>The noncompliance resulted in Immediate Jeopardy starting on 6/3/21.<br><br>The Administrator was notified of the Immediate Jeopardy on 8/6/21 at 7:27 p.m. and provided the IJ template.<br><br>After the facility submitted an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed on 8/8/21 at 6:30 p.m., and the scope and severity were reduced to D.<br><br>The findings included:<br><br>Cross Reference to F600, F607, F609, and F610.<br><br>Review of the Administrator job description dated April 2020 stated in the Summary section the Administrator was to lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents.<br><br>Review of The Director of Nursing job description, signed on 2/19/21, stated in the Summary section to manage the overall operations of the Nursing Department in accordance with Company policies, standards of nursing practices and governmental regulations so as to maintain excellent care of all residents' needs.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility's Abuse, Neglect, and Exploitation policy and procedure with a reviewed/revised date of 7/14/21, defines Sexual Abuse as non-consensual sexual contact of any type with a resident. An immediate investigation is warranted when suspicion or reports of abuse, neglect or exploitation occur. Under section VI. Protection of Resident- the facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include: responding immediately to protect the alleged victim and integrity of the investigation; Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increased supervision of the alleged victim and residents; and room or staffing changes, if necessary to protect the resident(s) from the alleged perpetrator.<br><br>In an interview on 8/3/21 at 9:30 a.m., Resident #11's family member said she was informed a couple of months ago that her husband's roommate (Resident # 29) was found by a Certified Nursing Assistant (CNA) to have his hands down her husband's pants. She said they told her his roommate was moved out of his room into another room and the facility was going to investigate the incident.<br><br>On 8/4/21, the facility's abuse investigation and federal immediate report was reviewed. On 6/8/21 the facility reported during the evening after dinner (no date) a CNA Staff O saw Resident #29 in his room at the foot of his roommate's bed (#11). The CNA observed resident #29 with his hand in the top part of the resident's brief.<br><br>CNA Staff O's written statement dated 6/8/21 was reviewed. The CNA noted at approximately 9:35 p.m., he observed Resident #29 in the dining room facing Resident #68. He heard Resident #68 say put it away. At that time, he observed Resident #29 had his penis out and said to Resident #68, You want it and Resident #68 began to curse at Resident #29. He then took Resident #29 to the unit and informed the nurse what he observed. Staff O noted there was another incident that occurred before the weekend during the evening, after dinner. He saw Resident #29 in his room with his hand inside of Resident #11's brief. His statement noted he informed Registered Nurse (RN) Staff S at the time of the incident.<br><br>In an interview on 8/5/21 at 2:36 p.m., CNA Staff O said there were 2 incidents involving Resident #29. The first was when he found him at bedside of roommate Resident #11 with his hands down the front of Resident #11's brief. The next incident occurred about a week later when he came through the dining room and Resident #29 was exposing his penis to Resident #68. Right after this incident, Resident #29 was moved out of the room he shared with resident #11 into a different room. The CNA said he notified RN Staff S after the first incident.<br><br>The facility's staffing schedule was reviewed and indicated both RN Staff S and CNA Staff O were working on the evening of 6/2/21.<br><br>Resident #11's clinical record revealed a diagnosis of Lewy Bodies Dementia, Cerebral Infarction with resulting paralysis, aphasia (loss of ability to express speech), and total dependence on staff for all activities of daily living (ADL's). There was no documentation of the resident having been examined for any evidence of physical or psychological harm until 6/8/21, 6 days after the incident occurred. The resident was not interviewable. On 8/6/21 at 5:15 p.m., a second interview was conducted with Resident #11's wife. She stated her husband would feel violated if he was able to express how he felt about the incident with Resident #29.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #68's clinical record revealed a diagnosis of Cerebral Infarction with partial paralysis, dementia, major depression, cognitive communication deficit, severe cognitive impairment, and required extensive assistance with most ADL's. On 8/5/21 at 11:10 a.m. Resident #68 was interviewed, and he denied any incident occurred with Resident #29.<br><br>Resident #29's clinical record was reviewed and revealed a history of sexually inappropriate behavior. In a progress note the Advanced Practice Registered Nurse (APRN) noted on 6/3/21 at 10:13 a.m., staff requested she evaluate the resident's sexually inappropriate behavior. Staff reports Resident #29 has been approaching the men in the building (staff and residents) and requesting sexual favors. He is redirected when this behavior occurs by staff; He just laughs and leaves the situation.<br><br>On 6/3/21 at 10:44 a.m. the facility's Social Services Director (SSD) noted: today Resident #29's representative was informed about this resident's sexually inappropriate behavior.<br><br>On 6/8/21 at 6:40 a.m., Licensed Practical Nurse (LPN) Staff G noted Resident #29 entered Resident #62's room during care, The CNA asked the resident to leave the room and the resident responded No . The CNA asked the resident why is he going into Resident #62's room, and he responded I wanna [sic] chew his balls off . Resident #29 was observed previously at 5:24 a.m., and 6:01 a.m., attempting to enter Resident #62's room.<br><br>Resident #62's clinical record revealed a diagnosis of traumatic brain injury, persistent vegetative state, non-verbal, and total dependence on staff. The resident was noted to be unable to state or express needs. Resident #62 was observed to be in a private room and in bed all days of survey. The resident was did not respond to attempts to be interviewed on 8/2/21.<br><br>In an interview on 8/5/21 at 1:29 p.m., the Director of Nursing (DON) said there was no report of the incident involving Resident #29 inappropriately touching Resident #11, and she was not aware this had occurred until the morning of 6/8/21. The Administrator at the time had directed staff to move the resident to a different room on the night of 6/7/21. Resident #29 was sent out to the hospital that morning and one-to-one supervision was started upon his return.<br><br>In an interview on 8/5/21 at 3:49 p.m., the Administrator said he did not start employment until 6/25/21 and was not here at time of incident. He revealed the facility did not follow its abuse policy, did not conduct a thorough investigation, and did not protect Resident #11 from further abuse by allowing the alleged perpetrator to continue to share a room for 5 days. Record review revealed documentation the APRN, and SSD were also aware of the inappropriate sexual contact on 6/3/21 but no indication of any action taken to report the incident or prevent the resident from having further contact with Resident #11. On 6/7/21, Resident #29 was relocated to a different room, but several entries were made by LPN Staff G of resident being seen trying to enter the room of another vulnerable resident's (#62) room. There was no evidence of the resident being on one-to-one supervision during this time. The Administrator said he would look to see if there was any documentation of this being done.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 8/6/21 at 10:38 a.m., the APRN said on 6/3/21 she was notified by a nurse about the episode with Resident #29 and Resident #11. Was told staff walked into their shared room to give care to Resident #11 and Resident #29 had his hand inside of Resident #11's brief. She said Resident #29 was very mobile in his wheelchair and all over the facility. The APRN said she thinks the episode may have happened the day before, on 6/2/21. She did not realize he was still in the room with Resident #11 as she usually saw him outside of the room.<br><br>In an interview on 8/6/21 at 12:27 p.m., the SSD said she was informed through nursing team that someone had seen Resident #29 with his hand in Resident #11's brief. She wrote the note on 6/3/21 after she heard of it. The SSD said they also discussed it in morning meeting and were putting Resident #29 on one-to-one supervision. All the department heads including the Administrator were in the meeting. The Administrator and DON were to do the reporting to the state agency and assumed this was taken care of. She did notify the family of Resident #29. The SSD said they talked about a room change, and the one-to-one supervision was to be 24 hours a day. She was told about the incident involving Resident #68 and did talk to him about it on 6/8/21. She said the resident was offended by the incident and said Resident #29 was nasty. The SSD could not explain how that would occur if Resident #29 was on one-to-one supervision.<br><br>In an interview on 8/6/21 at 12:50 p.m., the Administrator said he was unable to provide any evidence of Resident #29 being on one-to-one supervision from 6/3 to 6/8/21 and upon his return from 6/10 to 6/12/21. The facility provided evidence of some monitoring for the evening of 6/12/21 but lacked consistent documentation for the evening and night shifts when the resident was more likely to exhibit these behaviors.<br><br>The immediate actions implemented by the facility according to their Immediate Jeopardy removal plan and verified by the survey team, included the following:<br><br>On 8/6/21 education was completed by the Regional with the Administrator and Director of Nursing on their job descriptions.<br><br>Beginning 8/6/21, the Administrator will hold Quality Assurance/Performance Improvement meetings daily until removal of immediacy is achieved. The facility will then move to weekly until compliance has been determined.<br><br>On 8/6/21, the Regional educated the Administrator and the Director of Nursing on the components<br><br>of regulations:<br><br>F600 Free from Abuse and Neglect;<br><br>F609 Reporting of Abuse and Neglect;<br><br>F610 Investigation of Abuse and Neglect;<br><br>F607 Operationalize Policy and Procedure to protect;<br><br>F835 Administration.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105407 | A. Building<br>B. Wing | 08/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Siesta Key Health and Rehabilitation Center | 4602 Northgate Court<br>Sarasota, FL 34234 |

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 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Targeted Ad Hoc education completed as indicated to attain and maintain compliance.<br><br>The facility Administrator/designee and the Director of Nursing/designee will conduct a daily Monitoring of quality monitoring related to abuse and reporting of alleged violations until removal of immediacy.<br><br>The facility will then move to weekly then monthly to ensure compliance maintained.<br><br>The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines compliance has been met and recommends moving to monthly monitoring by the Regional Director of Clinical Operations when completing their<br><br>systems review.<br><br>The Regional Director of Operations and or Regional Resource Nurse to perform quality Monitoring during visits for compliance with F 600, F609, F610, F607 and F 835.<br><br>On 8/7/21, an Ad hoc Quality Assurance Performance Improvement (QAPI) Meeting was convened to review the removal plan as written.<br><br>An Ad-Hoc Quality Assurance meetings to be held after Morning Meeting to review Plan of Correction (PIP) and Quality Monitoring. |