PRINTED: 04/20/2023 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_ B MING 85820 03/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 832 SUNSET LAKE BOULEVARD SUNSET LAKE HEALTHCARE AND REHABILITATION VENICE, FL 34292 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 INITIAL COMMENTS N 000 An unannounced relicensure with complaints survey for #2022005477, #2022005651, #2022015152, #2022015392, #2022016349, #2023000937, and #2023001104 was conducted at Sunset Lake Healthcare and Rehabilitation Center, a skilled nursing facility in Venice, Florida. Complaint #2022005477 was substantiated without citation Complaint #2022005651 was substantiated without citation. Complaint #2022015152 was unsubstantiated. Complaint #2022015392 was substantiated without citation. Complaint #2022016349 was substantiated without citation. Complaint #2023000937 was substantiated without citation. Complaint #2023001104 was substantiated without citation. The following is a description of the deficiencies. N 072 59A-4.109(2), FAC; Comprehensive Care Plans N 072 SS=D 59A-4.109 FAC

assessment.

within 7 days after completion of the resident LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(2) The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed

TITLE (X6) DATE Electronically Signed 123

STATE FORM If continuation sheet 1 of 19 VUGP11

Agency fo	or Health Care Adminis	tration				04/20/2023 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SI COMPLE	
		85820	B. WING		C 03/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
SUNSET L	AKE HEALTHCARE AN		SET LAKE BOU FL 34292	ILEVARD		
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N 072	Continued From page	1	N 072		Accessoration	
	Based on record revie and procedure, reside facility failed to develo comprehensive care	olan describing services to the needs of 1 (Resident sidents with an		Preparation and/or execution of the F of Correction does not constitute admission or agreement of the provid the truth of the facts alleged or conclusions set forth in the Statemen Deficiencies. The Plan of Correction prepared and/or executed solely bect it is required by the provisions of Fed and State law.  This plan represents the facility's crecallegation of compliance as of	t of is ause eral	
	note person-centered care measurable objective resident's physical,	d, "A comprehensive		Urologist was contacted for progress notes for resident #73. Care plan for resident #73 was reviewed and revised to include and care.		
	revealed an admissio Diagnoses included h			Care plans were reviewed for residual with an with revision as indicated.		
	and (composite of the Admiss (MDS) assessment wreference date of the Admiss (MDS) assessment wreference date of the Admiss (MDS) assessment wreference date of the Admission of	bbstructed , flow, and he ).  ion Minimum Data Set ith an assessment noted Resident #73 had ( inserted into the ). Diagnoses included a and insufficiency.		3. MDS coordinator and IDT was reeducated regarding components of regulation and development of a comprehensive care plan. New residuil be reviewed upon admission for the presence of an as as current residents that have a new for an if the is deemed clinically appropria care plan will be implemented.	ents he well order	
		was addressed		4. Quality Review of 5 residents on ea	ach	

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On

in the care plan.

at 10:30 a.m., Resident #73 said the

unit will be conducted by ADON/designee to ensure resident with have a comprehensive care plan weekly

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Class III

manner.

care and coordination with ,, to ensure the resident's needs were met.

Maintain the facility premises and equipment and conduct its operations in a safe and sanitary

N 110 400.141(1)(h) FS; 59A-4.122(1) FAC Physical SS=D | Environment - Safe, Clean, Homelike 400.141(1)(h) FS

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N 110

PRINTED: 04/20/2023 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 85820 03/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 832 SUNSET LAKE BOULEVARD SUNSET LAKE HEALTHCARE AND REHABILITATION VENICE, FL 34292 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) N 110 Continued From page 3 N 110 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible This Statute or Rule is not met as evidenced by: Based on observation and staff interviews the 1. Resident #69, the power strip and facility failed to ensure residents receive care and extension cord were removed immediately services safely for 1 Resident (Resident #69) of 5 at the time of survey. The residents observed machine was placed securely on the bedside table. feeding pump was The findings included: plugged into the wall electrical outlet. On at 10:30 a.m., during an observation. 2. Current resident rooms were reviewed Resident #69 was in bed receiving a for use of power strips, extension treatment (turns liquid medication into a mist that and placement of .... machines. Any can be inhaled). Resident #69 also had a identified power strips or extension .... (tube placed directly in the .... were removed upon identification. feeding). Both machines were plugged into a 3. Assigned Clinical staff for resident #69 power strip, connected to a wall outlet and wrapped around the ွ pump. at the time of identification was The .... machine was wedged between the reeducated regarding use of power strips. board of the bed and the mattress. in the LTC setting and extension

Class III

at 3:42 p.m., Registered Nurse Staff Q

confirmed the placement of the .... and the

power strip. Staff Q said the power strip should

not be hanging from the .... pole. Staff

Q said he would notify maintenance and left the

room leaving the .... wedged between the

mattress and the headboard and the power strip

attached to the .... , pole.

placement of ... machines in

resident rooms at the time of survey.

Skilled Nursing facility setting and

placement of ... machines in

educated during orientation.

resident rooms. New employees will be

4. Quality review of 5 resident rooms on each unit for safe, clean, comfortable, and homelike environment will be conducted by the Director of Maintenance / designee

Current facility staff reeducated regarding

the components of this regulation and the

use of power strips, extension .... in the

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

BERTIFICATION NUMBER:

		85820	B. WING		03/09/2023
			DRESS, CITY, ST		
SUNSET	LAKE HEALTHCARE AND	D REHABILITATION 832 SUNS VENICE, I	ET LAKE BOU L 34292	LEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
N 110	Continued From page	4	N 110	weekly for (4) four weeks then every (; two weeks x (2) two months then mon until 100% compliance is achieved for consecutive months. Findings will be reported to the QAPI committee month until the committee determines compliance.	thly 2
N 201 SS=G	Appropriate Health C.  (i) The right to receive health care and prote including social service including social service if available; planned recognized practice is community, and with agency.  This Statute or Rule Based on record revice and procedures, and the facility failed to iminterventions, including prevent avoidable major injuries for 1 (R reviewed with or successful and procedures). The failure to implement or prevent and Resident #74 sustains including with me to a higher level of ca The facility also failed #51, and #97) of 12 re 1.	are a dequate and appropriate citive and support services, exercational activities; and oblitative services coreational activities; and oblitative services consistent plan, with established and tandards within the rules as adopted by the list of the plan, with established and tandards within the rules as adopted by the sis not met as evidenced by: ow, review of the policies staff and family interviews, prement appropriate gadequate supervision toincluding _ related tesident #74) of 3 residents end multiple at the ent appropriate interventions related injuries resulted in ing preventable, alor injury requiring transfer re.  10 to ensure 3 (Resident #73, esidents reviewed for riate health care received	N 201	1. Resident #74 reduction /injury prevention interventions reviewed and revised. 2. Current residents Risk Evaluatis scores were reviewed to determine leu of risk. Residents identified as having for was care planned and interventions implemented. 3. New admissions and residents who sustain a will have a Risk Evaluation completed. These resident will be reviewed in morning meeting to determine risk, with care plan and interventions as indicated. Current nursing staff will be educated on a	ons veil risk

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PRINTED: 04/20/2023 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 85820 03/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 832 SUNSET LAKE BOULEVARD SUNSET LAKE HEALTHCARE AND REHABILITATION VENICE, FL 34292 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 Continued From page 5 N 201 Prevention Program with exam to The findings included: determine competency. New employees will be also educated during orientation. The facility policy . .-Clinical Protocol 4. Quality Review of 5 residents will be ) documented "The physician will conducted by Director of Nursing / help identify individuals with a history of and designee to ensure appropriate risk for falling. Staff will ask the resident and the reduction / injury prevention interventions caregiver about a history of falling. . . The staff are in place weekly for (4) four weeks then and practitioner will review each resident's risk every (2) weeks for (2) months then factors for falling and document in the medical monthly until 100% compliance is record. . . The staff and physician will continue to achieved for 2 consecutive months. collect and evaluate information until either the Findings will be reported to the QAPI cause of the falling is identified, or it is committee monthly until the committee determined that the cause cannot be found or is determines compliance. not correctable. . . Based on preceding assessment the staff and physician will identify 1. Urologist was contacted for pertinent interventions to try to prevent progress notes for resident subsequent . . . and address the risks of #73. Care plan for resident #73 was clinically significant consequences of falling. The reviewed and revised to include staff and the physician will monitor and document ... and ... care. the individual's response to interventions intended to reduce falling or the consequences of falling." 2. Care plans were reviewed for residents with an with revisions Review of the clinical record revealed Resident as indicated. #74 had an admission date of diagnoses including . . . . of the left pubis,

cnso

The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of .

, and

documented Resident #74 required of two persons with transfers and bed mobility. The MDS documented ambulation in the room and corridor did not occur.

The MDS noted Resident #74's ..., . . . skills for daily decision making was moderately

3. MDS coordinator and IDT was reeducated regarding components of this regulation and development of a comprehensive care plan. New residents will be reviewed upon admission for the presence of an as current residents that have a new order for an . If the ..... is deemed clinically appropriate, a care plan will be implemented.

4. Quality Review of 5 residents on each

unit will be conducted by ADON/designee

to ensure resident with VUGP11 If continuation sheet 6 of 19

	or Health Care Adminis				PRINTED: 04/20/202: FORM APPROVE	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		85820	B. WING		C 03/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, ST	ATE, ZIP CODE		
SUNSET L	AKE HEALTHCARE AN	DEHARII ITATION	ISET LAKE BOU FL 34292	ILEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
N 201	Continued From page	6	N 201		Andrew and a second	
	Resident #74 was at injury related to and poor safety awar minimize the risk of The interventions incl assistance with ambu appropriate ware call light within reach, request assistance presented, report responsible party as i	eness. The goal was to and related injury, uded provided on liation, observe for use of and assist as needed, keep educate/remind resident to ior to ambulation/fransfers to physician and needed, , , as indicated.		have a comprehensive care plan weel for (4) four weeks then every (2) two weeks the monthly 100% compliance is achieved for 2 consecutive months. Findings will be reported to the QAPI committee month until the committee determines compliance.  1. Resident #51 was offered a shower trimmed at the time of survers. It immed at the time of survers are the compliance of the compliance.  2. Review of current resident bathing preferences and frequency completed revisions as indicated.  3. Current Nursing staff reeducated	until and ay. with	
	for communication be about a patient's cone "Resident was sitting to put shoes on when forward hitting her wheelchair."	on side of bed leaning over she lost her balance falling		regarding components of this regulation bathing preferences, providing resider showers and completion of bathing documentation. New employees will be deducated during orientation.  4. Quality Review of 5 residents on ea	e ch nd	

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bed.

nondisplaced

observed on floor in room. The care plan was

updated with the intervention staff education to ensure resident has her shoes on when out of

On ...... the nursing progress note documented Resident #74 was found on the floor getting out of her room using a walker. The resident was sent

to the local Emergency Room (ER) for evaluation.

obtained in the ER and documented a new acute

of the right greater

A CT (Computerized , , ) scan was

then (2) two times weekly for (2) months then monthly until 100% compliance is

1. Resident #97 \_\_\_ was applied at the

2. Review of current residents with

to ensure ... applied per physician

time of survey.

order.

achieved for 2 consecutive months.

Findings will be reported to the QAPI committee monthly until the committee determines compliance.

Agency fr	or Health Care Adminis	tration				0: 04/20/2023 1 APPROVED
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE S COMPLI	
		85820	B. WING		03/0	9/2023
	ROVIDER OR SUPPLIER	REHARII ITATION 832 SUN	DDRESS, CITY, ST. SET LAKE BOU			
		VENICE,	FL 34292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPS DEFICIENCY)	BE	(X5) COMPLETE DATE
N 201	Continued From page	7	N 201			
	facility on with the	., Resident #74 was sitting on the side of the leal. There was one floor the bed, no floor mat on		3. Current nursing staff reeducated regarding the components of this regulation and applying per physician order and documentation of completion. New employees will be educated during orientation.  4. Review of 5 residents with ceach unit to ensure application per physician order will be conducted by 4 ADON / designee weekly for (4) week then (2) times weekly for (2) months thought in 100% compliance is achieved for 2 consecutive months. Findings will be reported to the QAPI committee monthly until the committee determines compliance.	on the ss, hen	
	and her, for She said and	and came to this facility her mother had a _ on her right _ but had no ent #74's daughter said she				

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side of the bed.

had concerns with her mother's safety due to sun-downing and said ..., reported today that her mother was not able to stand or ambulate and was unable to do tasks. She said she had asked the facility to place another floor mat on the left

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С 85820 B. WING \_\_\_\_ 03/09/2023

NAME OF PROVIDER OR SUDDI ION

		CE, FL 34292		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
N 201	Continued From page 8	N 201		
	On			dende had not he had n
	The POA said her mother had sun-downing related to and will pack her things at night wanting to go home. She said the nurse called her to report the but was not able to tell her how the _ occurred.			and
	Onat 9:11 a.m., Staff Q said he tries to keep a close on Resident #74. She is assisted with transfers and tolleting and is on the left related to the , she wants to leave the facility. We educate her to use the call light, but she has The staff just keep a close on her, it is not documented, it ya not keep my med cart outside of her room when I'm doing medications.			
	On at 9:01 a.m., the Director of Rehab said Resident #74 was planning to discharge home before her on . She said, we had the meeting with the family before discharge to provide education and to ensure they were able to provide the care for her at home. We are working on transfer training and balance with Resident #74 was able to ambulate with supervision and transfer, she was			
	amousae win supervision and transser's, she was doing very well. She required supervision because of her loss, she required constant verbal cues. The Director of Rehab said Resident #74 was not safe to ambulate or transfer unassisted. Resident #74 had a 2 days before the planned discharge and now she has declined significantly and is			nessos de la companya

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

A BUILDING:

B 58820

B WING

COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PATE TAKE BOULEVARD VENICE, F. 34292    PATE   SUMMANY STATEMENT OF DEFICIENCES   120   PROVIDERS PLAN OF CORRECTION   150   PROPERTY   150   PROVIDERS PLAN OF CORRECTION   150   PROVIDERS PLAN OF	NAME OF PI		ADDRESS, CITY, STATE					
PREFIX TAG  N 201  Continued From page 9 increased since the and we recommended the rurse get an of the right was no material to the care plan. The Director of Rhab said right now Resident #74 had the first she was working with ry and educate the resident and ye recommended the resident #74 had the first she was working with ry and educate the resident and ye in page. But to take her home. On admission we had her as a high risk, and we recommended call lights and floor mats, and she was receiving. The first here was a 110-45 p.m., leaning over to put shoes on and forward hitting her on the wheelchair arm. The DON said we reviewed the the very next day, and the intervention was to encourage shoes when out of bed, if no shoes are on then, nonskid socks. A low bed was on at 12-30 a.m., she was found on floor with walker, trying to go to the bathroom and prompted was not, the floor was down, she had no socks on, the floor may be here.  Tag  RECOLLATORY OR USE CIDENTATION TAG  N 201  N	SUNSET LAKE HEALTHCARE AND REHABILITATION VENICE, FL 34292							
increased since the and we recommended the nurse get an of the right The was obtained on but did not show any new She said all are reviewed daily in the morning interdisciplinary team meeting and any new interventions are put on the care plan. The Director of Rehab said right now Resident #74 needs 24/7 supervision for safety and cues. She is not safe to ambulate or transfer on her own.  On at 11:18 a.m., the Director of Nursing (DON) said after Resident #74 had the first she was working with The DON said we try and educate the resident and put interventions in place, but she is getting up no matter what. She packs her things daily and she has a guard on. We are meeting with family today to take her home. They want to take her home. On admission we had her as a high fisk, and we recommended call lights and floor mats, and she was receiving The first here was at 10:45 p.m., leaning over to put shoes on and forward hitting her on the wheelchair arm. The DON said we reviewed the the one was the provided on the care plan.  The second was on at 12:30 a.m., she was found on floor with walker, trying to go to the bathroom and prompted was initiated before and after meals, upon rising and bettime. The lith of was on at 4:12 in the p.m., she had no socks on, the floor mats and on, she	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE			
and she was sitting on noor mat. A new intervention for nonskid socks was added to the		Continued From page 9 increased, since the and we recommended the nurse get an of the right. The was obtained on but did not show any new She said all are reviewed daily in the morning interdisciplinary team meeting and any new interventions are put on the care plan. The Director of Rehab said right now Resident #74 needs 247 supervision for safety and cues. She is not safe to ambulate or transfer on her own.  On at 11.18 a.m., the Director of Nursing (DON) said after Resident #74 had the first she was working with The DON said we try and educate the resident and put interventions in place, but she is getting up no matter what. She packs her things daily and she has a guard on. We are meeting with family today to take her home. They want to take her home. On admission we had her as a high risk, and we recommended call lights and floor mats, and she was receiving  The first here was and floor mats, and she was receiving and the intervention was to encourage shoes when out of bed, if no shoes are on then, nonskid socks. A low bed was initiated but not updated on the care plan.  The second was on at 12.30 a.m., she was found on floor with walker, trying to go to the bathroom and prompted was initiated before and after meetis, upon rising and bedtime.  The third was on at 41.21 in the p.m., she had no socks on, the floor mat A new and she was stitting on floor mat. A new			UNE			

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STATE FORM FORM VUGP11 If continuation sheet, 10 of 19

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

LIDENTIFICATION NUMBER:
B. WING

B. WING

B. WING

COMMETCE

COMMET

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUNSET I	SUNSET LAKE HEALTHCARE AND REHABILITATION 832 SUNSET LAKE BOULEVARD VENICE, FL 34292						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
N 201	Continued From page 10  was bad, she came to us as a high risk, and she was packing her things everyday wanting to leave and we placed a guard on her at admission. The DON said the resident was a high score for elopement risk on admission. She is redirected but forgets what we say to her.  I know she is walking. Her did not have any susues. The resident can get out of bed by herself, she is not safe. The DON said the facility had a falling star program, where the staff bring residents at risk for in to do activities, but this is not occurring daily. It depends on staffing. Resident #74 needs (one-to-one) supervision, but we have no staff to provide the supervision.  On at 2:03 p.m., Certified Nursing Assistant (CNA) Staff P said Resident #74 required assistance with transfers and toileting and uses a walker but is not safe to ambulate on her own. The CNA said the resident was a risk, and she was instructed to an on her more often.	N 201					
	2. The facility's policy titled, "Care Plans, Comprehensive Person-Centered" revised noted, "A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, and functional needs is developed and implemented for each resident"  Review of the clinical record for Resident #73 revealed an admission date of Diagnoses included history of and (obstructed flow, and						

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PRINTED: 04/20/2023 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 85820 03/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 832 SUNSET LAKE BOULEVARD SUNSET LAKE HEALTHCARE AND REHABILITATION VENICE, FL 34292 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 Continued From page 11 N 201 ... up of ... into the .....). Review of the Admission Minimum Data Set (MDS) assessment with an assessment reference date of ..... noted Resident #73 had - ( inserted into the ..... to drain .....). Diagnoses included a , . . . , and insufficiency. The Care Area Assessment summary noted Resident #73 . . . . was addressed in the care plan. at 10:30 a.m., Resident #73 said the was inserted at the hospital. He said he was seeing a urologist in the community for treatments. The care plan initiated on ..... noted to

observe the skin surrounding the for signs of . . . . . . . The care plan updated on noted to observe

cloudiness, odor, . . . and quantity; report abnormal findings to physician.

The care plan did not provide instructions for the ..... care, including frequency of cleaning insertion site, and monitoring for obstruction. , at 9:30 a.m., the Director of Nursing (DON) said Resident #73's daughter takes him to ... clinical treatments but did not provide the facility with documents from the clinic. She said the resident's daughter dropped off a soap to clean the area before treatment but she did not have any information related to the outside treatments the resident was receiving. On .... at 11:25 a.m., the DON verified the lack of a specific individualized care plan

for sediment.

PRINTED: 04/20/2023 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: c B MING 85820 03/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 832 SUNSET LAKE BOULEVARD SUNSET LAKE HEALTHCARE AND REHABILITATION VENICE, FL 34292 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 Continued From page 12 N 201 .... care and coordination with ... to ensure the resident's needs were met. 3. The facility policy titled Activities of Daily Living (ADLs), Supporting revised . . . , stated Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out necessary ADLs. Residents who cannot carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Review of the clinical record revealed Resident #51 was admitted to the facility on The Quarterly Minimum Data Set (MDS) assessment with an assessment reference date documented Resident #51's cognition was intact. The resident was totally dependent on one person physical assistance for bathing. Resident #51 did not have any behaviors and did not reject care. The plan of care initiated on documented Resident #51 had a self-care. with \_\_\_, grooming, and bathing related to the diagnosis of . . . . with

, / , (, , of one side of the body). The goal is for the resident to have a neat appearance daily. Interventions included to gather and set up supplies for care, provide

noted Resident #51 was scheduled on Mondays, Wednesdays and Fridays for a bath, The flow sheets specified Resident #51 preferred

-on assistance with and bathing, and staff to . . . . residents'

needs with ADLS. The ADL flow sheets for

showers.

,, grooming.

STATE FORM VUGP11 caso If continuation sheet 13 of 19

PRINTED: 04/20/2023 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 85820 03/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 832 SUNSET LAKE BOULEVARD SUNSET LAKE HEALTHCARE AND REHABILITATION VENICE, FL 34292 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 | Continued From page 13 N 201 at 9:41 a.m., Resident #51 stated his shower days are during the day on Mondays. Wednesdays, and Fridays. He said, "I generally only get showered once a week but really preferred three times a week." Resident #51 also stated he needed help to trim the \_\_\_\_ on his left The ADL flow sheets for documented Resident #51 received four of 13 scheduled showers in ,, six of 12 scheduled showers in \_\_\_\_, and two of the four scheduled showers through There was no documentation the resident refused the showers. On ... at 9:13 a.m., and ..... at 10:45 a.m., Resident #51 again said he wanted to shower more than once a week. On ...... at 1:35 p.m., Certified Nursing Assistant (CNA) Staff U stated if a resident

refusing care.

week

refused care, then the process is to let the nurse know. She said she did not recall resident #51

On ....... at 2:07 p.m., Unit Manager Staff Nurse L. reviewed the ADL flow sheets and verified Resident #51 wanted to have three showers weekly and only received only one shower a

4. Review of the clinical record revealed Resident #97 had an admission date of

diagnoses including . . . . and . . . . . . . or , , ) of the left side.

The Quarterly Minimum Data Set (MDS)

with

STATE FORM caso VUGP11 If continuation sheet 14 of 19 Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С 85820 B. WING \_\_\_\_ 03/09/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUNSET L	SUNSET LAKE HEALTHCARE AND REHABILITATION 832 SUNSET LAKE BOULEVARD VENICE, FL 34292					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
N 201	Continued From page 14	N 201				
	assessment (standardized tool that measures health status in nursing home residents) with an assessment reference date of documented Resident #97 was dependent on staff for and had functional limitations of range of motion in upper and lower extremities.			recordant contrata de contrata		
	The MDS noted Resident #97's skills for daily decision making were intact. The physician's order dated documented apply left in the morning and remove at bedtime as tolerated.			outed the state of		
	The Certified Nursing Assistant (CNA) resident care Kardex (provides instructions for care) documented to apply the left in the morning and remove at bedtime and or as tolerated. Monitor skin integrity when applying and removing.			eurotaetaetaetaetaetaetaetaetaetaetaetaetaet		
	On at 2:35 p.m., observed a on the wheelchair seat, across from the bed. Resident #97 said she had a and is not able to move her left side. She said staff is supposed to apply the to her left but they do not consistently apply the			an parameter de la companion d		
	Review of the CNA documentation for revealed no documentation on the day shift on and the was applied.					
	The documentation showed not applicable on					
	The evening shift showed no documentation of application or removal on application or removal on and and the documentation showed not applicable on					

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STATE FORM 6550 VUGP11 If continuation sheet 15 of 19

PRINTED: 04/20/2023 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING 85820 03/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 832 SUNSET LAKE BOULEVARD SUNSET LAKE HEALTHCARE AND REHABILITATION VENICE, FL 34292 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 | Continued From page 15 N 201 Review of the CNA documentation for . . . revealed no documentation on the day shift and not applicable on ...... The evening shift showed no documentation of ., application or removal on ..... and not applicable on . . , and On ...... at 1:51 p.m., CNA Staff P said she did not apply the , to Resident #97's left She said the . . . , . . applies the . , . . . for the residents. at 2:00 p.m., the \_\_\_\_, Director said the CNAs are responsible to apply the ... to Resident #97's left , the instructions are posted on the inside of the resident's closet door. On ..... at 2:08 p.m., the Rehab Director provided a copy of a restorative nursing ... program initiated on ....... The program documented " to wear , daily to left upper extremity incidence of ........ On ....... at 2:56 p.m., the Director of Nursing said she did not have restorative staff and the CNAs were responsible to apply ... for

AHCA Form 3020-0001

Class II

SS=D | , . . . . .

residents not on \_\_\_\_, caseload.

N 917 400.147(8), FS Report , Neglect, &

chapters 39 and 415.

(8) ....., neglect, or . , . . . must be reported to the agency as required by 42 C.F.R. s. 483.13(c) and to the department as required by

STATE FORM case VUGP11 If continuation sheet 16 of 19

N 917

Agency fo	or Health Care Adminis	tration				0: 04/20/2023 1 APPROVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLE	
1401211	7 00/1120/10/1	IDENTIFICATION TO THE STATE OF	A. BUILDING:			
		85820	B. WING		03/0	9/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
SUNSET L	AKE HEALTHCARE AND	REHABILITATION	SET LAKE BOU FL 34292	LEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 917	Continued From page	16	N 917			
	Based on records rev facility policies the report of an unwitness report of an unwitness report of an unwitness with the service of facility policies of the service of facility policies of the service of service of service of service of service of the service of service of the service of service of the se	by titled, "Incident Report delines," dated		1. Resident #16 no longer resides at t facility. An Immediate report was completed and submitted on 2. Review of resident for the past thirty days conducted with faderal reporting completed if indicated. 3. Director of Nursing was reeducated regarding components of this regulation investigation and federal reporting period of the past of t	i (30) i pn, of for or (2) tive	
	. and . related in	Resident #16 was at risk for jury related to generalized valance, unsteady gait. The				

AHCA Form 3020-0001

resident required staff assistance with transfers and ambulation. Resident #16 was impulsive, attempts transfers, has poor safety awareness. The goal was to minimize risk of related injuries with staff intervention.

STATE FORM FORM VUGP11 If continuation sheet 17 of 19

PRINTED: 04/20/2023 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 85820 03/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 832 SUNSET LAKE BOULEVARD SUNSET LAKE HEALTHCARE AND REHABILITATION VENICE, FL 34292 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 917 | Continued From page 17 N 917 Records documented resident had an unwitnessed at the facility on resultina in transfer to the hospital for a higher level of The hospital clinical record dated documented a to right pubis, , requiring admission to the hospital. .... at 3:08 p.m., Licensed Practical Nurse (LPN) Staff M, caring for Resident #16 on ..... said there was no one in the room with Resident #16 when she . Since the resident was complaining of . . in her ., she was sent to the hospital. The hospital contacted the facility and told them it was a \_\_\_\_\_, and she informed the physician. at 3:14 p.m., LPN Unit Manager Staff N. also confirmed Resident #16 had an which resulted in a unwitnessed on and hospitalization. LPN Staff N said she completed the notifications of the event to the Director of Nursing (DON). She said the Director of Nursing (DON) or her supervisor would decide

On

if a report needed to be filed.

On at 3:20 p.m., the DON said she did not think Resident #16's unwitnessed resulting in a .... needed to be reported since they had interventions in place for prevention. at 4:25 p.m., the Administrator confirmed Resident #16 sustained an unwitnessed and

hospitalization. He said it was not a reportable event based on the facility policy since the resident had interventions in place and the was out of the facility control.

and required

at 6:35 p.m., the Administrator he filed

Agency f	or Health Care Adminis	tration					: 04/20/2023 1 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE S COMPL	ETED
		85820		B. WING		03/0	9/2023
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SUNSET I	AKE HEALTHCARE AND	REHABILITATION	832 SUNSE VENICE, FL	T LAKE BOUI . 34292	LEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 917	Continued From page	18		N 917			
	a Federal Day 1 report Agency for Resident # resulting in	rt with the State Survey #16's unwitnessed					
	Class III						

AHCA Form 3020-0001

		D HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDI	NG.		Ι.	С
		105761	B. WING _				09/2023
NAME OF PI	ROVIDER OR SUPPLIER			- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
			1		832 SUNSET LAKE BOULEVARD		
SUNSET	AKE HEALTHCARE AND	REHABILITATION CENTER		,	VENICE, FL 34292		
(X4) ID		ATEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE		
(AG REGULATOR CALESC IDENTIFY INTO INFORMATION) (AG		DEFICIENCY)					
F 000	INITIAL COMMENTS		F (	000			
	An unappounced rec	ertification with complaints					
	survey for #20220054						
		015392, #2022016349.					
	#2023000937, and #2	2023001104 was conducted					
	through	at Sunset Lake Healthcare					
		enter, a skilled nursing					
	facility in Venice, Flor	ida.					
	Complaint #20220054	177 was substantiated					
	without citation.						
		651 was substantiated					
	without citation.	152 was unsubstantiated.					
		392 was substantiated					
	without citation.						
	Complaint #20220163	349 was substantiated					
	without citation.						
		937 was substantiated					
	without citation.	04 was substantiated					
	without citation.	104 was substantiated					
	Current Laire Healthan	are and Rehabilitation					
		are and Renabilitation liance with Code of Federal					
		Part 483, Subparts B-F,					
		g-Term Care Facilities.					
	The following is a des	crintion of the					
	noncompliance.	onprom or the					
F 584	Safe/Clean/Comfortal	ble/Homelike Environment	F.	584	1		
SS≖D	CFR(s): 483.10(i)(1)-	(7)					
	§483.10(i) Safe Envir	onment.					
	The resident has a rig						
		elike environment, including					
	but not limited to rece						
	supports for daily living	ig safely.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

/2023

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.

DEPART	VIENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		LETED
		105761	B. WING			1	09/2023
NAME OF PE	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE		
	* VE UE 41 TUO 4 DE 4 N	D DELLADU ITATION OFFITED		8	32 SUNSET LAKE BOULEVARD		
SUNSELL	ISET LAKE HEALTHCARE AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES			v	'ENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	e 1	F!	584			
	homelike environmen use his or her person possible. (i) This includes ensur receive care and serv physical layout of the independence and do (ii) The facility shall e	clean, comfortable, and the allowing the resident to all belongings to the extent uring that the resident can rices safely and that the facility maximizes resident ones not pose a safety risk, vercise reasonable care for resident's property from loss					
		eeping and maintenance o maintain a sanitary, orderly, ior;					
	§483.10(i)(3) Clean b in good condition;	ed and bath linens that are					
	§483.10(i)(4) Private resident room, as spe	closet space in each ecified in §483.90 (e)(2)( );					
	§483.10(i)(5) Adequa levels in all areas;	ite and comfortable lighting					
	levels. Facilities initia	table and safe temperature ily certified after , a temperature range of 71 to					
	sound levels. This REQUIREMENT by:	maintenance of comfortable  is not met as evidenced					
		n and staff interviews the e a safe environment for for			Preparation and/or execution of the P of Correction does not constitute	ian	

1 Resident (Resident #69) of 5 residents

admission or agreement of the provider of

### DEPARTMENT OF HEALTH AND HUMAN SERVICES C

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &			PRINTED: 04/20/2023 FORM APPROVED OMB NO: 0938-0391
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED

NA SL

		105761	B. WING			03/09/2023
AME OF P	ROVIDER OR SUPPLIER		<del>                                     </del>	STREET ADDRESS, CITY, STATE		33/09/2023
oone or r	CONDEN ON OUT DEN		- 1	832 SUNSET LAKE BOULEVA		
SUNSET L	AKE HEALTHCARE AND	REHABILITATION CENTER		VENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE IGIENCY)	(X5) COMPLETION DATE
F 584	Resident #69 was in treatment (turns liquic can be inhaled). Resignation (tube placed of feeding). Both machin power strip, connecte wrapped around the The machin board of the bed on at 3:42 p.m. confirmed the placem power strip. Staff Got be hangling from to de hangling from to Q said he would notify from leaving the	m., during an observation, bed receiving a limedication into a mist that dent #69 also had a directly in the for ses were plugged into a d to a wall cuttet andpump.  e was wedged between the land the mattress.  ., Registered Nurse Staff Q ent of the and the aid the power strip should hepole. Staff maintenance and left the wedged between the shoard and the power strip	FS	the truth of the facts a conclusions set fortusions set of the Deficiencies. The Pla prepared and/or exec it is required by the pr and State law.  This plan represents allegation of complian  1. Resident #69, the pextension cord were rat the time of survey, machine was placed to bedside table. plugged into the wall of or use of power strip and placement of Any identified power strip and placement of Any identified power.	in the Statement of in of Correction is uted solely because ovisions of Federal control of the facility's credible ice as of	
				Quality review of 5     each unit for safe, cle		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/20/2023

		ID HUMAN SERVICES					APPROVED
		MEDICAID SERVICES					0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	1	LETED
		105761	B. WING			1	09/2023
NAME OF PE	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
CUNCET	AVE HEALTHCADE AND	REHABILITATION CENTER		8	32 SUNSET LAKE BOULEVARD		
SUNSE! L	ARE REALITICARE ANI	REMADILITATION CENTER		٧	/ENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	3	1	584	homelike environment will be conducte by the Director of Maintenance / desig weekly for (4) four weeks then every diversers of two weeks x (2) two months then montuntil 100% compliance is achieved for consecutive months. Findings will be reported to the QAPI committee monthuntil the committee determines compliance.	nee 2) thly 2	
F609 SS=D	must: §483.12(c)(1) Ensure involvingneg  mistreatment, includis source and misapnus are reported immedia hours after the allegat serious bodily injury, the events that cause and do not res the administrator of to filicials (including to adult protective service)	ii)(A)(B)(c)(1)(4) se to allegations of or mistreatment, the facility that all alleged violations ect, or ginipries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to se facility and to other he State Survey Agency and ses where state law provides eterm care facilities) in a law through established	F	609			
	investigations to the a designated represent	idministrator or his or her ative and to other officials in a law, including to the State					

Survey Agency, within 5 working days of the

Facility ID: 85820

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	LETED
		105761	B. WING		1	09/2023
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER	8	TREET ADDRESS, CITY, STATE, ZIP CODE 32 SUNSET LAKE BOULEVARD ENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	incident, and if the all appropriate corrective This REQUIREMENT by: Based on records re of facility policies the report of an unwitnes requiring ho: # 16) of 4 reviewed f The findings included	eged violation is verified a action must be taken. It is not met as evidenced view, interviews, and review facility failed to file a federal sed which resulted in a spitalization for 1 (Resident or reporting requirements. :	F 609	Resident #16 no longer resides at facility. An Immediate report was completed and submitted on      Review of resident for the par (30) thirty days conducted with federal reporting completed if indicated.      Director of Nursing was reeducate regarding components of this regulation.	st	

and investigation Guidelines." dately injected which stated, "Guidelines: All ... injeries of which stated, "Guidelines: All ... injeries of unknown origin ... Leading to harm or injury to a visitor or resident occurring in the facility or on the facility properly will be documented and investigated and recorded on the incident report. Procedure: The facility shall initiate an investigation and notify federal, state, and local authorities as required. The findings of the investigation ... will be reported as required by Federal and State law ... The facility Risk Manager is responsible for ensuring the timely and accurate reporting and for recording reporting as appropriate . ."

Review of clinical records for Resident #16 documented resident originally admitted to facility ..., and readmitted on ..... with diagnosis of of right pubis (bones that form the

The care plan noted Resident #16 was at risk for and related injury related to generalized balance, unsteady gait. The resident required staff assistance with transfers and ambulation. Resident #16 was impulsive,

- Director of Nursing was reeducated regarding components of this regulation, investigation and federal reporting of neglect, and mistreatment.
- 4. Quality Review of 5 resident investigations will be conducted by Director of Nursing idesignee weekly for (4) four weeks then every (2) weeks for (2) months then monthly until 100% compliance is achieved for 2 consecutive months. Findings will be reported to the QAPI committee monthly until the committee determines compliance.

Facility ID: 85820

### PRINTED: 04/20/2023 DEPARTMENT OF HEALTH AND HUMAN SERVICES. FORM APPROVED ST

CENTERS FOR MEDICARE & MEDICAID SERVICES OF						
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
	105761	B. WING	С			
	100701		03/09/2023			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 832 SUNSET LAKE BOULEVARD SUNSET LAKE HEALTHCARE AND REHABILITATION CENTER VENICE, FL 34292 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 609 Continued From page 5 F 609 attempts transfers, has poor safety awareness. The goal was to minimize risk of related injuries with staff intervention. Records documented resident had an unwitnessed at the facility on resulting in transfer to the hospital for a higher level of The hospital clinical record dated documented a to right pubis. . .... , requiring admission to the hospital. On ...... at 3:08 p.m., Licensed Practical Nurse (LPN) Staff M, caring for Resident #16 on said there was no one in the room with Resident #16 when she . . Since the resident was complaining of ... in her ... she was sent to the hospital. The hospital contacted the facility and told them it was a \_ . . . , and she informed the physician. at 3:14 p.m., LPN Unit Manager Staff N. also confirmed Resident #16 had an unwitnessed on which resulted in a and hospitalization. LPN Staff N said she completed the notifications of the event to the Director of Nursing (DON). She said the Director of Nursing (DON) or her supervisor would decide

if a report needed to be filed.

On ...... at 3:20 p.m., the DON said she did not think Resident #16's unwitnessed resulting in a .... needed to be reported since they had interventions in place for prevention.

On at 4:25 p.m., the Administrator confirmed Resident #16 sustained an unwitnessed and and required hospitalization. He said it was not a reportable

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/20/2023 MAPPROVED O: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		105761	B. WING		0:	C 3/09/2023
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 332 SUNSET LAKE BOULEVARD VENICE, FL. 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	was out of the facility On at 6:35 p.n a Federal Day 1 repo Agency for Resident:	acility policy since the ventions in place and the control.  ., the Administrator he filed rt with the State Survey	F 609			
F 656 SS=D	CFR(s): 483.21(b)(1)  §483.21(b)(1) The fat implement a compref care plan for each resident rights set for \$483.10(c)(3), that in objectives and timeframedical, nursing, and needs that are identif assessment. The con describe the following (i) The services that or maintain the reside physical, mental, and required under \$483.21(ii) Any services that in the resident of the following that the following the following the following the following that the following (iii) Any services that in the following that the following the following that the following t	ensive Care Plans cility must develop and tensive person-centered ident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's imental and, ied in the comprehensive nprehensive care plan must j tre to be furnished to attain int's highest practicable well-being as 24. §483.25 or \$483.40; and would otherwise be required 25 or \$483.40 but are not saident's exercise of rights ting the right to refuse 1.10(c)(6). ervices or specialized the nursing facility will	F 656			

rationale in the resident's medical record. ( )In consultation with the resident and the

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AN			PRINTED: 04/20/2023 FORM APPROVED DMB NO. 0938-0391
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	105761	B. WING	C

AND POW OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	·	COMPLETED		
					С	
		105761	B. WING		03/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			- 1	832 SUNSET LAKE BOULEVARD		
SUNSET L	AKE HEALTHCARE AND	REHABILITATION CENTER		VENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIATE OF T		
F 656	future discharge. Faci whether the resident's community was asses local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, ir requirements set forth section. §483.21(b)(3) The sei	tive(s)- als for admission and iference and potential for litties must document desire to return to the ssed and any referrals to s and/or other appropriate	F 65			
	(iii) Be culturally-comp. This REQUIREMENT by: Based on record revi and procedure, reside facility failed to develo comprehensive care; be furnished to meet it #73) of 2 sampled res.  The findings included The facility's policy titl Comprehensive Personcentered care measurable objective resident's physical, needs is developed a resident"	plan describing services to the needs of 1 (Resident idents with an		1. Urologist was contacted for progress notes for resider #73. Care plan for resident #73 was reviewed and revised to include and care.  2. Care plans were reviewed for reside with an with revision as indicated.  3. MDS coordinator and IDT was reeducated regarding components of the regulation and development of a comprehensive care plan. New resider will be reviewed upon admission for the presence of an as was current residents that have a new or for an If the is deemed clinically appropriate, a care plan will be	ents ns nis nts e e e vell rder	

### PRINTED: 04/20/2023 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		105761	B. WING		03/0	; 19/2023
NAME OF PE	ROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNSET L	AKE HEALTHCARE AN	D REHABILITATION CENTER	1	332 SUNSET LAKE BOULEVARD VENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 658	revealed an admission Diagnoses included hand and up of into	n date of	F 656	implemented.  4. Quality Review of 5 residents on ea unit will be conducted by ADON/destigr to ensure resident with have a comprehensive care plan week for (4) four weeks then every (2) two weeks x (2) two months them monthly to	nee	

, and insufficiency. The Care Area Assessment summary noted . , ... was addressed Resident #73 in the care plan.

reference date of .... noted Resident #73 had

an ( inserted into the

to drain .....). Diagnoses included a

at 10:30 a.m., Resident #73 said the , .... was inserted at the hospital. He said he was seeing a urologist in the community for treatments.

The care plan initiated on ..... noted to observe the skin surrounding the for signs of ...... . The care plan updated on noted to observe for sediment, cloudiness, odor, . . . and quantity; report abnormal findings to physician.

The care plan did not provide instructions for the care, including frequency of cleaning insertion site, and monitoring for obstruction.

. at 9:30 a.m., the Director of Nursing (DON) said Resident #73's daughter takes him to ... clinical treatments but did not provide the facility with documents from the clinic. She said the resident's daughter dropped off a soap to clean the area before treatment but she did not

100% compliance is achieved for 2

until the committee determines compliance.

consecutive months. Findings will be

reported to the QAPI committee monthly

		ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDI	NG _		1	
		105761	B. WING			1	C (09/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	DOILULU
			1	83	2 SUNSET LAKE BOULEVARD		
SUNSET	AKE HEALTHCARE AND	REHABILITATION CENTER		VE	ENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	have any information treatments the reside  On at 11:25 a. lack of a specific indiv	related to the outside nt was receiving. m., the DON verified the ridualized care plan care and coordination with	F	356			
F 657 SS=D	Care Plan Timing and		F	557			
	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not lim (includes but includes a limit includes a	rehensive care plan must days after completion of seesament. erdisciplinary team, that ited to- sician.  with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s), be included in a resident's participation of the resident resentative is determined development of the staff or professionals in ined by the resident's needs e resident. seed by the interdisciplinary sement, including both the					

This REQUIREMENT is not met as evidenced

		ID HUMAN SERVICES				FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			ON	AB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X:	B) DATE SURVEY COMPLETED
		105761	B. WING _			C 03/09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
				832 SUNSET LAKE BOULEVARD		
SUNSET	AKE HEALTHCARE AN	D REHABILITATION CENTER		VENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERÊNCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 657	Continued From page		F 6			
	and procedure, staff a facility failed to ensur resident participation	iew, review of facility's policy and resident interviews, the e timely revision, and in care plan to meet the #39) of 5 residents reviewed		Resident #39 had a car held on inviting both and the resident representation. The care plan was revised accordingly.     An audit was completed.	oth the residen ative (son). and updated	
	The findings included			residents last MDS dates. dates and revisions dates we to ensure compliance with the Timing and Revision require	Care plan vere matched Care Plan	
	Planning-interdiscipling			Non-compliant findings wer		
	, sta	ted the facility 's care		by setting up individual care	e plan	
	planning team is resp	onsible for the development		conferences and ensuring of	care plan	
		omprehensive care plan for prehensive care plan is		revisions were completed a	s appropriate.	
	completion of the res- resident, resident fam- representative are en- the development and care plan. The care p	sident within 7 days of ident assessment. The ility, and/or legal couraged to participate in revision of the resident 's lan must be updated when or readmitted to the facility		<ol> <li>MDS staff has been edu to monthly care plan calend generated by the MDS Coo on MDS quarterly schedule reviews will be conducted to the quarterly schedule.</li> </ol>	lar will be rdinator based . Care plan	
	from a hospital stay,	and at least quarterly, in equired quarterly MDS		New admissions will be add catendar to complete comp plan conferences by invitati 21-30 days of the admission	rehensive care on within	•
	admitted to the facility Review of the Minimu, assessments reveale had an unplanned dis hospital. Resident #3 A Quarterly I completed on	m Data Set (MDS)		4. Five day a week audits be completed by the MDS (conjunction with the Interdis of care plan time frames an dates. Five day a week au completed x 2 months and complance is achieved for consecutively. Audits will b the CAPI Committee month	x 1 month will Coordinator in sciplinary Tean id revision dits will be until 100 % 4 weeks re presented to	•

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILD	MG.		١.,	С
		105761	B. WING			1	09/2023
NAME OF PR	ROVIDER OR SUPPLIER		_	-	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNSET	AKE HEALTHCARE AND	D REHABILITATION CENTER			332 SUNSET LAKE BOULEVARD		
00,10272	AND HEAD HOARE AND	A REFERENCE FOR SERVICE		_ '	VENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
					DEFICIENCY)		
F 657	Continued From page	. 11	-	657			
1 007	was reviewed and rev		"	00/			
	documented care cor						
	There was no docume	entation the care plan was					
		by the interdisciplinary team as readmitted from the					
	hospital on	as readmitted from the					
	On at 2:29 p.m	n., resident # 39 's son					
		e first care conference when					
		has not been contacted					
		nference since that time. m., the Social Service					
		he could not find any care					
		s for Resident #39 since could not locate any care					
		notes for the resident. She					
	said she did not recal	l holding a care plan					
		ating with Resident #39					
	regarding a care plan	conference.					
		n., Minimum data set					
		aff D said Resident #39 re plan conference within					
		S updates on					
	, and						
	On at 3:00 p.m	., the Regional Consultant					
	said the only docume	ntation available was from					
E 077	the conference held of		-				
F 677 SS=D	CFR(s): 483.24(a)(2)	or Dependent Residents		677			
		ent who is unable to carry					
		iving receives the necessary					
	personal and oral hyg	good nutrition, grooming, and piene:					
		is not met as evidenced					

		ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105761	B. WING		C 03/09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			1	32 SUNSET LAKE BOULEVARD	
SUNSET	AKE HEALTHCARE ANI	D REHABILITATION CENTER	١,	/ENICE, FL 34292	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 677	Continued From page by:	e 12 n. record review, staff, and	F 677	1.Resident #51 was offered a showe	rand
	resident interview, the	e facility failed to provide the for showers for 1 (Resident		trimmed at the time of surv	
	#51) of 2 sampled de for Activities of Daily	pendent residents reviewed Living (ADL).		<ol> <li>Review of current resident bathing preferences and frequency completed with revisions as indicated.</li> </ol>	1
	The findings included	:		Current Nursing staff reeducated	
	(ADLs), Supporting re	d Activities of Daily Living evised stated		regarding components of this regulation bathing preferences, providing resident	
	and services as appro	vided with care, treatment,		showers and completion of bathing documentation. New employees will be	_
		carry out necessary ADLs.		educated during orientation.	e
		t carry out activities of daily		educated during orientation.	
		vill receive the services		4.Quality Review of 5 residents on ea	ch
		good nutrition, grooming,		unit will be conducted by DON / design	
	and personal and ora			for completion of bathing preference a documentation weekly for (4) four weekly	and
		record revealed Resident		then (2) two times weekly for (2) month	
		the facility on		then monthly until 100% compliance i	š
	The Quarterly Minimu			achieved for 2 consecutive months.	
		issessment reference date		Findings will be reported to the QAPI	
		ted Resident #51's cognition ent was totally dependent on		committee monthly until the committee determines compliance.	9
		assistance for bathing.		determines compilance.	
		have any behaviors and did			
	not reject care.				
	The plan of care initia	ited on			
		t #51 had a self-care			
		ng, and bathing related to			
		with ( , , of one side of			
		for the resident to have a			
		y. Interventions included to oplies for care, provide			
	on assistance				
		f to , residents'			

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES					O. 0938-0391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		B. WING			C 03/09/2023		
NAME OF PROVIDER OR SUPPLIER			_	STR	EET ADDRESS, CITY, STATE, ZIP CODE	, ,	
SUNSET L	AKE HEALTHCARE ANI	REHABILITATION CENTER			SUNSET LAKE BOULEVARD NICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	SUMMANY STATEMENT OF DEFICIENCISS (EACH DEFICIENCY MANS THE PRECEDED BY PILL RECULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13 needs with ADLS.  The ADL flow sheets for		F	677			
		n., Unit Manager Staff Nurse low sheets and verified					

Resident #51 wanted to have three showers weekly and only received only one shower a

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED		
CENTERS FOR MEDICARE & MEDICARID SERVICES  (XT) PROVIDERSUPPLIENCIA  (XT) PROVIDERSUPPLIENCIA  IDENTIFICATION NUMBER:  105761		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		B. WING		C 03/09/2023				
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 832 SUNSET LAKE BOULEVARD VENICE, FL 34292	ÞΕ			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLETION HE APPROPRIATE DATE			
F 677	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 14 week.  Increase/Prevent Decrease in ROM/Mobility		F 6:	77 98	oplied at the			
	limited range of motion.  The findings included Review of the clinical #97 had an admission diagnoses including	: record revealed Resident		to ensure applied per p order.  3. Current nursing staff reedu- regarding the components of regulation and applying physician order and documer completion. New employees educated during orientation.	icated this per ntation of			

## PRINTED: 04/20/2023 DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEFACTORE OF TREASMENT SECONDED					
CENTERS FOR MEDICARE & MEDICAID SERVICES					
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NO PLAN OF CORRECTION LIBERTY OF THE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
	С				
105761 B. WING	03/09/2023				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					

		105761	B. WING		C 03/09/2023		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00,00,2020		
SUNSET LAKE HEALTHCARE AND REHABILITATION CENTER			- 1	832 SUNSET LAKE BOULEVARD VENICE, FL 34292			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERÊNCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 688	The Quarterly Minimu assessment (standars health status in nursir assessment reference documented Residen staff for and ange of motion in up; The MDS noted Resid daily decision making The physician's order apply left at bedtime as tolerate apply left at bedtime as tolerate and the standard to the stan	m Data Set (MDS) fized tool that measures g for home residents) with an date of g for mere sidents of the sidents of the sident of had functional limitations of oper and lower extremities. Sent #97's skills for were intact. dated documented in the morning and remove d.  Assistant (CNA) resident instructions for care) the left in the at bedtime and or as integrity when applying in the sident in the standard or as in the standard or one of the standard or	F 68&	4. Review of 5 residents with on each unit to ensure application per physician order will be conducted by the ADON / designee weekly for (4) weeks, then (2) times weekly for (2) months ther monthly until 100% compliance is achieved for 2 consecutive months. Findings will be reported to the QAPI committee monthly until the committee determines compliance.			

Facility ID: 85820

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTI	MENT OF REALTH AN	NO HUMAN SERVICES				FORM	# APPROVED			
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		105761	B. WING _			1	C 09/2023			
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
CHNCETI	AVE HEATTHCARE AND	D REHABILITATION CENTER		832 SUNSET LAKE BOULEVARD						
SUNSELL	ARE HEALI HUARE AND	J REMADILITATION CENTER		VENICE, FL 34292						
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE			
F 688	The documentation si	showed not applicable on , , , , , , , , , , , , , , , , , ,	F	688						
	and not application or reapplicable on , on application or reapplicable on , on	owed no documentation of emoval on and not , , and . n., CNA Staff P said she did								
	Resident #97's left posted on the inside of On	sible to apply the to the instructions are of the resident's closet door.  n., the Rehab Director restorative nursing The program ear daily to left upper								
F 689 SS=G	On at 2:56 p.m said she did not have CNAs were responsib residents not on	n., the Director of Nursing e restorative staff and the ble to apply ., for , , caseload. tards/Supervision/Devices	Ff	689						

# PRINTED: 04/20/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & I	MEDICAID SERVICES			OMB NO.	0938-039	
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE		
				С		
	105761	B. WING		03/09	/2023	
VAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	DELIABILITATION OFFITER		832 SUNSET LAKE BOULEVARD			
SUNSET LAKE HEALTHCARE AND REHABILITATION CENTER			VENICE, FL 34292			
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	

PREEIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 689 | Continued From page 17 F 689 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced Based on record review, review of the policies. 1. Resident #74 reduction /injury and procedures, and staff and family interviews. prevention interventions reviewed and the facility failed to implement appropriate revised. interventions, including adequate supervision to prevent avoidable , including related 2 Current residents Risk Evaluations major injuries for 1 (Resident #74) of 3 residents scores were reviewed to determine level reviewed who sustained multiple of risk. Residents identified as having risk for . . . was care planned and The failure to implement appropriate interventions interventions implemented. and related injuries resulted in Resident #74 sustaining preventable 3. New admissions and residents who with major injury requiring transfer sustain a ... will have a Rick to a higher level of care. Evaluation completed. These residents will be reviewed in morning meeting to The findings included: determine risk, with care plan and interventions as indicated. Current The facility policy -Clinical Protocol (revised nursing staff will be educated on a ) documented "The physician will help identify Prevention Program with exam to individuals with a history of and risk for falling. determine competency. New employees Staff will ask the resident and the caregiver about will be also educated during orientation. a history of falling. . . The staff and practitioner will review each resident's risk factors for falling 4. Quality Review of 5 residents will be and document in the medical record. . . The staff conducted by Director of Nursing / and physician will continue to collect and evaluate designee to ensure appropriate information until either the cause of the falling is reduction / injury prevention interventions

identified, or it is determined that the cause cannot be found or is not correctable. . . Based on preceding assessment the staff and physician will identify pertinent interventions to try to prevent subsequent . . and address the risks of clinically significant consequences of falling. The staff and the physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling."

are in place weekly for (4) four weeks then every (2) weeks for (2) months then monthly until 100% compliance is achieved for 2 consecutive months. Findings will be reported to the QAPI committee monthly until the committee determines compliance.

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		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	COM	E SURVEY PLETED
		105761	B. WING			1	C /09/2023
NAME OF PR	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
				١ ا	332 SUNSET LAKE BOULEVARD		
SUNSELL	ARE HEALTHCARE ANI	D REHABILITATION CENTER		١	VENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From page	e 18	F	689			
	Review of the clinical #74 had an admission diagnoses including and	of the left pubis,					
	health status in nursin assessment reference documented Residen	ment tool that measures ng home residents) with an e date of t #74 required					
		sons with transfers and bed ocumented ambulation in the not occur.					
	The MDS noted Residaily decision making	was moderately					
	Resident #74 was at injury related to and poor safety awar	balance, unsteady gait, eness. The goal was to and related injury.					
	appropriate ware call light within reach.						
		dated documented a					
		Communication Form (a tool stween health care team dition) documented					

"Resident was sitting on side of bed leaning over

		MEDICAID SERVICES					. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105761	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 03/09/2023		
NAME OF PE	ROVIDER OR SUPPLIER		_	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/1	39,2023
SUNSET LAKE HEALTHCARE AND REHABILITATION CENTER				1	32 SUNSET LAKE BOULEVARD (ENICE, FL. 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE  REGULATORY OR LSC (DENTIFYING INFORMATION) TAI			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERÊNCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	to put shoes on when forward hitting her wheelchair."  The care plan docum observed on floor in r updated with the inter	she lost her balance falling		689			

On ...... the nursing progress note documented Resident #74 was found on the floor getting out of her room using a walker. The resident was sent to the local Emergency Room (ER) for evaluation.

A CT (Computerized , , ) scan was obtained in the ER and documented a new acute nondisplaced of the right greater . . . . ( , ). Resident #74 returned to the with conservative measures for facility on the ......

The care plan was updated on ..... with the intervention "staff to assist resident with toileting upon arising, before and after and at bedtime."

On ...... at 8:49 a.m., in an interview registered Nurse Staff Q said Resident #74 had another last night and was found on the floor next to bed. He said Resident #74 had sun-downing (a state of ...... occurring in the late afternoon and lasting into the night) behaviors starting around 4:00 p.m., each night and said staff are monitoring her.

at 9:24 a.m., Resident #74 was On observed in her room sitting on the side of the bed eating morning meal. There was one floor mat on the left side of the bed, no floor mat on

DEPARTMENT OF HEALTH AND HUMAN SERVICES					
CENTERS FOR MEDICARE & MEDICAID SERVICES C					
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
			С		
	105761	B. WING	03/09/2023		

ST ۵ħ STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 832 SUNSET LAKE BOULEVARD SUNSET LAKE HEALTHCARE AND REHABILITATION CENTER VENICE, FL 34292 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 689 Continued From page 20 F 689 the right side. Resident #74 had ...... to the right , , and cheek and said she had home and .... her , ... and had ..... since her admission to the facility and ..... at 12:43 p.m., in an interview Resident #74 daughter said her mother had a at home and ..... her , ... and came to this facility for . . . . She said her mother had a on and her right but had no surgical repair. Resident #74's daughter said she had concerns with her mother's safety due to sun-downing and said \_\_\_\_ reported today that her mother was not able to stand or ambulate and was unable to do tasks. She said she had asked the facility to place another floor mat on the left side of the bed. at 8:25 a.m. Resident #74's Power of Attorney (POA) was at her bedside and said her mother had another last night and is now complaining of increased right . . . . down to The POA said her mother had sun-downing related to . . . and will pack her things at night wanting to go home. She said the nurse called her to report the . but was not able to tell her how the occurred at 9:11 a.m., Staff Q said he tries to keep a close ... on Resident #74. She is

assisted with transfers and toileting and is . . . . . . on the left . , related to the , . She has sun downing and tries to get out, she wants to leave the facility. We educate her to use the call light, but she has The staff just keep a close ... on her, it is not

DEPARTMENT OF REALTH AN	ID HUMAN SERVICES		FORM APPROVE
CENTERS FOR MEDICARE & I	MEDICAID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
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		105761	B. WING			l	09/2023
NAME OF PROVIDER OR SUPPLIER SUNSET LAKE HEALTHCARE AND REHABILITATION CENTER				STREET ADDRESS. CITY, STATE, ZIP CODE 832 SUNSET LAKE BOULEVARD VENICE, FL 34292			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	documented. I try and of her room when I'm asid Resident #74 wa home before her or the meeting with the forovide deducation and to provide the care for working on transfer unassisted. R days before the plann has declined signification on the left increased, since transfer unassisted. R days before the plann has declined signification on the left increased, since transfer unassisted. R days before the plann as declined signification on the left increased, since transfer on the reviewed daily in the reviewed daily in the reviewed daily in the reviewed daily in the ransfer on her own.  On at 11:18 a.r. (DON) said after Resiste was working with try and educate the re in place, but she is ge She packs her things.	keep my med cart outside doing medications, the Director of Rehab is planning to discharge in . She said, we had amily before discharge to to ensure they were able her at home. We are uning and balance with seident # 74 was able to sion and transfer, she was equired supervision loss, she required supervision safe to ambulate or esident #74 had a 2 ed discharge and now she ritly and is . She has been reporting he and we se get an of the right aimed on but did not .She said all are norming interdisciplinary rinew interventions are put Director of Rehab said right dis 24/7 supervision for is not safe to ambulate or The DON said we sident and put interventions the supervision for the process of the said was supported to the said said from the process of the said said from the said from the said said said the said said said said said said said said	F	689			

take her home. They want to take her home. On

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPS	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	MING	ı	COMP	LETED
		105761	B. WING				09/2023
NAME OF PE	ROVIDER OR SUPPLIER			П	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	00,2020
				1	832 SUNSET LAKE BOULEVARD		
SUNSET L	AKE HEALTHCARE AND	D REHABILITATION CENTER		1	VENICE, FL 34292		
				_			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION
PREFIX TAG		LSC (DENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
F 689	Continued From page	22	-	68	٥		
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,	r as a high risk, and we		uo.	9		
		hts and floor mats, and she					
	was receiving ,						
	The first here was	at 10:45 p.m., noes on and forward					
		wheelchair arm. The DON					
		the very next day, and					
		to encourage shoes when s are on then, nonskid					
		s are on then, nonskid s initiated but not updated on					
	the care plan.	i initiated but not operated on					
	The second was o	on at 12:30 a.m., she					
		th walker, trying to go to the					
	bathroom and prompt						
		is, upon rising and bedtime.					
	The third was on	at 4:12 in the p.m.,					
		the floor mat was down,					
	and she was sitting of						
		id socks was added to the					
	care plan.	nu socks was auded to the					
		ot cause of Resident #74's					
	was bad	, she came to us as a high					
		packing her things everyday					
	wanting to leave and						
		The DON said the resident					
	was a high score for e						
		firected but forgets what we					
	say to her.						
		. Her did not have					
		sues. The resident can get					
		she is not safe. The DON					
	said the facility had a	falling star program, where					
		nts at risk for in to do					
	activities, but this is n						
	depends on staffing.						
		sion, but we have no staff to					
	provide the super						

On ..... at 2:03 p.m., Certified Nursing

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	J: 04/20/2023 MAPPROVED D: 0938-0391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLERICLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING		(X3) DATE COMP	SURVEY			
		105761	B. WING		I	09/2023
NAME OF P	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE		
SUNSET L	AKE HEALTHCARE AND	REHABILITATION CENTER		32 SUNSET LAKE BOULEVARD /ENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	and uses a walker bu her own. The CNA sa risk, and she was inst more often.	P said Resident #74  ith transfers and toileting t is not safe to ambulate on id the resident was a  ructed to an _, _ on her	F 689			
F 692 SS=D	CFR(s): 483.25(g)(1)  \$483.25(g) Assisted r (Includes naso- both, endosc fluids). Basec comprehensive asses ensure that a residen  \$483.25(g)(1) Maintai of nutritional status, s desirable body balance, unless the r demonstrates that th preferences indicate  \$483.25(g)(2) is offer maintain proper hydr  \$483.25(g)(3) is offer there is a nutritional p provider orders a ther This REQUIREMENT by: Based on observatio	(3) nutrition and hydration, and tubes, and opic, and opic, and to na resident's sisment, the facility must be the susual body or range and electrolyte sident's clinical condition is is not possible or resident atherwise; ed sufficient fluid intake to tition and health; ed a therapeutic diet when roblem and the health care	F 692	1. Resident #16 no longer resides at t facility.	he	
	failed to ensure effect			Current resident reviewed fi	or	

loss for 1 (Resident #16) of 5 residents reviewed for nutrition.

Joss.

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DEPARTMENT OF HEALTH AN				FORM APPROVED
CENTERS FOR MEDICARE &				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
	105761	B. WING		C 03/09/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
		- 1	832 SUNSET LAKE BOULEVARD	
SUNSET LAKE HEALTHCARE ANI	D REHABILITATION CENTER		VENICE, FL 34292	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 692 Continued From page		F 6	3. A revision to the	
which slated, "I will strive to prevent, undesirable Jo Assessment 1. Then resident on a concern noted at this measured monthly th recorded in each Indi Any assessment who for confirmation. If the will immediately notify Dietitian will respond Dietitian will review the 15th of the month to 1 trends over time. Nee evaluated by the trea the criteria for "signiff been met. 6. The thre unplanned and undes based on the following service of the criteria for "signiff been met. 6. The thre unplanned and undes based on the following service of the criteria for "signiff been met. 6. The thre unplanned and undes based on the following." Joss significant b. 3 month 7.5% greater than 7.5% greater than 7.5% greater than 7.5% for the criteria for "signiff beevere."	by titled."  ryention" revised  he multidisciplinary team monitor, and intervene for ss for our residents.  ursing staff will measure dmission, if no point, will be ereafter. 2. will be vidual's medical record. 3. % or more since the last till be retaken the next day s is verified, nursing y the diettian. 4. The upon notification. 5. The se unit Record by the ollow individual stative trends will be ment team whether or not cant" change has sshold for significant sired loss will be g criteria. 4. I month- 5% t; greater than 5% is severe.  loss is significant; severe. c. 6 month- 10% ant; greater than 10% is		and Intervention Policy was made includeupon admission at thereafter for the next 3 weeks for of four weeks. The and \( V) Exception Report will be generate the Electronic Medical Record were the DON or designee to screen for significant loss. Any reside identified will be reviewed during it weekly Standard of Care meeting follow up. Current Nursing staff reeducated regarding components regulation and obtaining, entering communicating resident \( N) employees will be educated during orientation.  4. Quality review of 5 residents on unit for loss will be conduct Director of Nursing / designee wee (4) four weeks then every (2) week (2) months then monthly until 100 compliance is achieved for 2 consmonths. Findings will be reported to APAI committee monthly until the committee determines compliance	nd a total fitted a t

DEPARTMENT OF REALTH AND HUMAN SERVICES					
ENTERS FOR MEDICARE & MEDICAID SERVICES					
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NING	(X3) DATE SURVEY COMPLETED		
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105761	B. WING		03/09/2023		
VAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			

		105761	B. WING _			C 03/09/2023	
NAME OF PROVIDER OR SUPPLIER SUNSET LAKE HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS 832 SUNSET LAN VENICE, FL 34		,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRI DEFICIENCY)		TION
F 692	on and most a fater a 7-day hospitalia documented on The resident documented in record with repeat measuring a severe months. On Seview of Annual Nut completed 11/ 17/22 on ta risk for Nutritional Risk Evaluater 7 days at the hospitalia of the severe months. On The care plan initiated documented reduction of the severe has been based on Seview of Annual Nutrition of the severe has been based on Seview of Colora of o	Imission date to facility was ecent admission zation.  In was did not have a did not have a did not have a so for two were and of the second o	F6	92			

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OMB	NO.	0938-039	91

CENTERS FOR MEDICARE & MEDICAID SERVICES						IO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		105761	B. WING			C 3/09/2023	
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 0 832 SUNSET LAKE BOULEVARD VENICE, FL 34292		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 692	monitoring process a said are don residents have order was a list in the nurse once a week. She wri and tells the nurse with the computer. Said st Resident #16 had a none of the said state of the said said state of the said stat	VA) Staff B about the facility. CNA Staff B about the facility. CNA Staff B monthly except some for once a week. Said there is for once a week. Said there is station of who is	F6S	12			

Facility ID: 85820

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DEFAILI	WENT OF HEALTHAN	ID HOMMIN SERVICES				FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		105761	B. WING _			ı	09/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				8	32 SUNSET LAKE BOULEVARD		
SUNSET L	AKE HEALTHCARE ANI	D REHABILITATION CENTER		٧	ENICE, FL 34292		
(X4) ID		ATEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFE	X	(EACH CORRECTIVE ACTION SHOULD E		COMPLETION
TAG	REGULATURY OR	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	NIE.	61.110
F 692	Continued From page	27	F.	692			
			1 ''	J.			
		ty. RD said she was not					
		enyone for loss.					
		cility does have					
	meetings and particip		İ				
		if I am invited." RD asked to					
	review clinical record						
		id not have a done					
	and	saying, "I					
	don't know why she v						
		" RD confirmed severe					
		ted saying, "I don't have an					
		ither. It would be a good					
		tor of nursing." RD said she					
	does a nutritional rea						
		cility. RD said she looks for					
		if it is not available, she uses					
		available in the record.					
	Confirmed she used to						
		sion assessment completed					
		sident #16. Asked about					
	documentedlo						
		am aware of it. I was not					
		aware." RD confirmed no					
		D was unaware of the					
		, "I will have to look thru the					
	whole charts again to	determine interventions."					
	On at 12:26 n	m intensioused Disaster of					
	Nursing (DON) about	m., interviewed Director of					
		Resident #16 loss. naware that resident had lost					
		an should have picked up on					
		ve meetings on					
		nave been inconsistent."					
		te meeting minutes					
		confirmed the physician					
		ntacted and informed of the					
	loss for Reside	ent #16. The DON said the					

process is to weigh, if needed reweigh and if a

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/20/2023 M APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105761	B. WING			1	C 09/2023
NAME OF PE	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
OUNIOET!	* WE THO * DE * * **	DELIANDI ITATION OFFITER		8	32 SUNSET LAKE BOULEVARD		
SUNSELL	ARE HEALTHCARE AND	REHABILITATION CENTER		١	/ENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page	. 20	_	coo	4		
F 082	Continued From page		F	692			
	dietician and docume	n contact physician, contact nt.					
F 700 SS≃E	Director who confirm Jess experienc Medical Director said notified and expected discuss, as part of the meeting, additional in Bedrails CFR(s): 483.25(n)(1)- \$483.25(n) Bed Rails The facility must atter alternatives prior to in a bed or side rail is us correct installation, us	to be notified so they could interdisciplinary team terventions.	F	700			
	entrapment from bed §483.25(n)(2) Review bed rails with the resi representative and of to installation.	the resident for risk of rails prior to installation. the risks and benefits of dent or resident tain informed consent prior that the bed's dimensions					
	are appropriate for the	e resident's size and					
	§483.25(n)(4) Follow recommendations and and maintaining bed if	d specifications for installing					

by:

This REQUIREMENT is not met as evidenced

Based on observations, interviews, records

1. Resident #28 no longer resides at the

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 04/20/2023 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3	(X3) DATE COMP	SURVEY PLETED
		105761	B. WING		1	C 09/2023
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS. CITY, STATE, ZIP CODE 832 SUNSET LAKE BOULEVARD VENICE, FL 34292		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE	
F 700	review, and facility pc to review the risks an attempt alternative in (side rail) installation resident/representativ #74, and #28) of 4 re rails.  The findings included Review of the facility Side rails, revised "Purpose: The purporensure the safe use consolity and to p as unless n resident's medical sys Guidelines: 7. Docum Guidelines: 7. Docum	olicy review the facility failed to benefits of bed rails or to terventions prior to bed rail with the reformation for the drail with the refor 4 residents, (#1, #66, sidents reviewed for bed which stated, see of these guidelines are to fiside rails as resident rohibit the use of side rails accessary to treat a	F 74	facility. Resident #1, #66 and #74 be and alternate intervention evaluation: were completed.  2. All current residents were evaluat bedrails and alternate interventions.  3. Prior to initiation and installation obedrail, the rehab team will evaluate attempt alternative measures first. If and Current Nursing staff were reeducated regarding components of regulation and bedrail with alternate intervention evaluation. New employ will be educated during orientation.  4. Quality Review of 5 residents on a unit for bedrail and alternative evalua will be completed by ADOM desione	ed for  f a and DT this ees	

ensure the safe use of side rails as resident mobility... and to prohibit the use of side rails as unless necessary to treat a resident's medical symptoms. General Guidelines: 7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails .... Consent for side rail use will be obtained from the resident or side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks....While the resident or family (representative) may request a , the facility is responsible for evaluating the appropriateness of that request."

bed with 01/8th raised side rails in place on bed. On the facility provided a consent signed and dated .... by resident #1.

Review of clinical records for Resident #66

Facility ID: 85820

Event ID: VUGP11

weekly for (4) four weeks then every (2)

weeks for (2) months then monthly until

reported to the QAPI committee monthly

100% compliance is achieved for 2

until the committee determines

compliance.

consecutive months. Findings will be

PRINTED: 04/20/2023 FORM APPROVED

		AD HOMAN OLIVIOLO				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
AND DI AN OF CORRECTION DENTIFICATION NUMBER			(X2) MUL' A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105761	B. WING			03/	09/ <b>2023</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CUNCET	AVE HEALTHCADE AND	D DELIABILITATION CENTED			832 SUNSET LAKE BOULEVARD		
SUNSELL	ARE HEALTHCARE AND	D REHABILITATION CENTER		١	VENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 700	and a co The consent resident request for i documented alterative the clinical record. On at 11:30 a. Resident #66 was ob raised 1/3rd side rails On at 3:30 p.m Assistant (CNA) Staff rails unless the patier of the consent rails of the confirmer residents for the use of the comment of the comment rails of the consent rails of the consent rails of the consent rails of the consultant rails of the consulta	il Evaluation completed on nisent signed by resident on form documented "per initiating side rails. No e measures were present in m	F	700			

Facility ID: 85820

PRINTED: 04/20/2023

		ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPL(ER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	1	PLETED
		105761	B. WING			1	C /09/2023
NAME OF P	ROVIDER OR SUPPLIER		_		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
	ARE HEALTHOADE AN	D DELLA DIL ITATIONI GENTED			832 SUNSET LAKE BOULEVARD		
SUNSELL	ARE HEALTHCARE AN	D REHABILITATION CENTER			VENICE, FL 34292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 700	Continued From page	e 31	F	700	0		
	#28 had an admissio diagnoses including and of upper The Admission Minim (standardized assess health status in rursi) assessment reference documented Resider Ambor Ambo	end of left num Data Set (MDS) ment tool that measures ng home residents) with an e date of t #28 required limited mobility. dent #28's skills for					
	observed in bed with both sides of the bed	n., Resident #28 was grab bars (side rails) on in the raised position. e did not request the grab em.					-
	#74 had an admissio diagnoses including and The Admission Minim (standardized assess	of right our Data Set (MDS) ment tool that measures on home residents) with an					

documented Resident #74 required extensive

	105761	B. WING	03/09/2023
			С
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
CENTERS FOR MEDICARE & I	MEDICAID SERVICES		OMB NO. 0938-039
DELINITIMENT OF MERCHINAN	D HOMAN OLIVIOLO		FORM APPROVE

	ME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
F700 Continued From page 32 F700 assistance of two persons with transfers and bed mobility.  The MDS noted Resident #69's skills for daily decision making was moderately  The clinical record showed no documentation of a side rail evaluation or alternate interventions attempted prior to the use of the grab bars.  On at 9:24 a.m., Resident #74 was observed in her room sitting on the side of the bed with grab bars on both sides of the bed with grab bars on tooth sides of the bed in raised position.  On at 11:50 a.m., the Director of Nursing said the grab bars were not considered side rails	UNSET I	AKE HEALTHCARE AND REHABILITATION CENTER	1				
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