STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105761	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Lake Healthcare and Rehabilitation Center	832 Sunset Lake Boulevard Venice, FL 34292

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51818 Based on record review, review of facility's policy and procedure, resident, resident representative and staff interviews, the facility failed to develop and communicate a resident centered baseline care plan to meet the needs of 1 (Residents #273) of 3 newly admitted residents reviewed. The findings included: Review of the facility's policy for Baseline Care Plan revised December 2016 revealed, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission . The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan . The resident and their representative will be provided a summary of the baseline care plan on the 21st day that includes but is not limited to the initial goals of the resident, a summary of the resident's medications, any services and treatments to be administered and any updated information based on the details of the comprehensive care plan, as necessary . Review of the clinical record for Resident #273 revealed an admitted [DATE] with history of a recent fall, adjustment disorder, type 2 diabetes, and congestive heart failure. The Admission Nursing Comprehensive Evaluation dated 4/12/25 noted Resident #273's cognition was intact with a Brief Interview for Mental Status score of 15. The evaluation noted the Resident's skin was intact and no conditions noted upon this exam. Review of the baseline care plan dated 4/12/25 revealed the nurse entered No for the question, Do I have a current wound? On 4/13/25 at 11:35 a.m., during an interview, Resident #273 stated, It seemed like they really weren't prepared for me when I got here. They didn't know I needed a diabetic meal; I had to inform them. Also, some of my medications were not available, but they are catching up now. There has been no itinerary or timeline for what I need to expect while I am here . you know, like when I can get out of bed, or what the plan is now that I am here. On 4/14/25 at 2:00 p.m., Resident #273's family member was observed approaching Licensed Practical Nurse (LPN) Staff L and asking, What are you doing for the wounds on his feet? (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/25 at 2:15 p.m., during an interview LPN Staff L stated, (Resident #273)'s sister asked me if I've seen his feet. She said that they look horrendous. I have not, the nurse practitioner would do that. Review of the clinical progress notes revealed a wound care nurse skin assessment dated [DATE] at 3:39 p. m. which noted Resident #273 had a dressing to his coccyx and bilateral heels. The wound care nurse removed the hospital dressings to assess skin and found redness excoriation to coccyx, the right heel had a DTI (Deep Tissue Injury), the left heel had blanchable redness. Treatments were completed and ordered by the wound care nurse. On 4/14/25 at 2:52 p.m., during an interview, MDS nurse LPN Staff N was asked what type of wound care interventions that Resident #273 had been receiving. LPN Staff N reviewed the baseline care plan for Resident #273 and stated, He does not have a wound. On 4/15/25 at 8:02 a.m., a Late Entry Admission note for 4/12 documented, Patient refused head to toe assessment and removal of hospital protective dressings. Visual skin check done at best of ability due to refusal. On 4/15/25 at 9:30 a.m., during an interview, LPN Staff F verified that she had admitted Resident #273 on 4/12/25. LPN Staff F said she recalled that, He had a very long commute, over two hours to get here, so when he arrived, he did not want me to assess the skin under his dressings. So, I didn't. On 4/15/25 at 10:40 a.m., during an interview, the DON confirmed that the facility process was that staff was not to document on wounds if they aren't able to see them. When asked whether it was accurate for the nurse to document The resident has no wounds on the baseline care plan, the DON stated, there is nowhere to write a comment, this form is all check boxes where would they even put that? When asked if the resident's baseline care plan is resident specific, she said that he should have been care planned for wounds.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51818 Based on observation, record review, review of facility's policies and procedures, resident, resident representative and staff interviews, the facility failed to provide care and services to meet the needs for Activities of Daily Living (ADL) for 2 (Residents #275 and #276) of 5 residents reviewed for assistance with ADL. The findings included: Review of the facility policy titled, Activities of Daily Living (ADLs), supporting, last revised on March 2018 revealed, Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, including hygiene (bathing, dressing, grooming, and oral care). Review of the clinical record for Resident #276 revealed an admitted [DATE]. Diagnoses included cerebral infarction (stroke), hemiplegia (paralysis) on her left side, aphasia (language disorder affecting speech), and muscle weakness. Clinical record review revealed Resident #276 sustained a fall at the facility on 4/9/25, on the day of admission. Review of the Admission Minimum Data Set (MDS) assessment with a target date of 4/12/25 revealed Resident #276's cognition was severely impaired with a Brief Interview for Mental Status score of 07. Resident #276 required substantial/maximal assistance with personal hygiene. On 4/13/25 at 12:45 p.m., during a dining observation, Resident #276 was observed in bed with her eyes closed leaning to her left side. There was a lunch tray set up in front of her. Certified Nursing Assistant (CNA) Staff I was observed attempting to spoon feed the Resident. CNA Staff I was shaking Resident #276 and calling her name, stimulating her enough to open her mouth. Resident #276's mouth was partially opened with food falling onto the bedding and her black and white floral blouse, leaving a stain. CNA Staff I was observed using the bedding to wipe the food from the resident's mouth. On 4/13/25 at 12:50 p.m., CNA Staff U was observed entering Resident #276's room. CNA Staff U addressed CNA Staff I and said, If she is asleep, you shouldn't be feeding her, she's not eating the food. Staff I then wiped the resident's mouth and removed the tray without changing the bedding or the black and white floral blouse. On 4/13/25 at 2:50 p.m., Resident #276 was observed asleep in bed leaning to her left side. She was wearing the stained black and white floral blouse. On 4/14/25 at 10:15 a.m., Resident #276 was observed asleep in bed leaning to the left side. She was wearing the same black and white floral blouse from 4/13/25 with food stains. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/14/25 at 2:13 p.m., CNA Staff G and CNA Staff V were observed providing incontinence care to Resident #276. Resident #276 was lying in bed, leaning to her left side, wearing the black and white floral blouse with the food stains. CNA Staff G stated, I believe she had another bowel movement, this the second one today. CNA Staff G pulled the positioning pad from behind the resident's back and removed it. Multiple small particles of food like debris fell to the floor. CNA Staff G then shook the pad out and placed it back on the bed and tucked it under the resident. CNA Staff G removed the resident's incontinent brief, soiled with feces. She rolled the soiled brief and placed it in the bed next to Resident #276's head and said, I don't see a trashcan. CNAs Staff G and Staff V completed the incontinent care, placed the resident on her left side and left the room. They did not change the linen on the bed. On 4/14/25 at 2:20 p.m., in an interview, CNA Staff V and CNA Staff G were asked about the care needs and preferences of various residents in their assignment. CNA Staff G said that they didn't know any of the residents because they usually worked in another unit. On 4/14/25 at 4:30 p.m., Resident #276 was observed lying in bed on her left side. She was still wearing the black and white floral blouse with food stains. On 4/15/25 at 7:55 a.m., in an interview CNA Staff G was asked about changing the clothing of the residents in her assignment, in the past two days. She stated, I don't know whether these residents are being changed because I don't usually work in this hallway, I can only hope that today is not as crazy as yesterday, it was so crazy yesterday. 2. Review of the clinical record for Resident #275 revealed an admitted [DATE]. Diagnoses included dementia, pneumonia, fracture of the spine and atrial fibrillation (irregular, rapid heart rate). Review of the BIMS interview dated 4/15/25 revealed Resident #275 scored 4.0 indicating severe cognitive impairment. On 4/13/25 at 10:33 a.m., in an interview Resident #275's daughter and Power of Attorney (POA) stated, My dad has dementia, if they don't check him they won't know he needs to be changed, because he won't just ask or tell anyone. Today, I arrived at 10:00 a.m. and his diaper was completely soaked. I don't think it has been changed, so I changed it and put it in the bathroom trash. I tried to put a clean diaper on him but it got stuck and has been like that for past 30 minutes. I've used his call light multiple times. They (facility staff) just keep coming in to ask what we need and shut the light off. At least three people have been by, and they have all said they will be back. No one has helped with the diaper that is stuck on him. Resident #275 was observed lying in bed during the interview. An improperly placed incontinent brief was observed pulled to mid-thigh and wedged beneath the resident. The resident's bathroom had a foul odor. Resident #275's daughter showed an incontinent brief, saturated with urine. The daughter activated the call light. CNA Staff W entered the room and asked the resident's daughter if anyone had come by to help her. The daughter replied, No. CNA Staff W said, Are you saying the other CNA who came in here never came back in to help you? (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The daughter said No and showed CNA Staff W that she attempted to place a clean brief on Resident #275. Review of therapy notes revealed that Resident #275 was screened on 4/10/25. The resident was safe for transfers with assistance, using sit to stand (mechanical lift) from the bed, moderate assistance using rolling walker or sit to stand mechanical lift steady. Review of the documentation for toileting assistance showed that the CNA caring for the resident during the 11:00 p.m., to 7:00 a.m., shift entered that the resident was independent with toileting, no physical help or setup was provided, and continent on the previous shift at 10:59 p.m. The record lacked documentation he had received incontinence care. Review of the care plan created on 4/13/25 showed that Resident #275 was identified to have a self-care deficit and required hands-on assistance for dressing, grooming and bathing. Observations on 4/13/25 at 12:00 p.m., 4/13/25 at 3:30 p.m., 4/14/25 at 11:00 a.m., while working with Physical Therapy (PT), and on 4/15/25 at 8:00 a.m., revealed Resident #275 wearing a light-blue, three buttons collared shirt. Record Review of the CNA documentation for support provided with dressing revealed on 4/13/25 at 10:59 p. m., placed a check mark indicating, No setup or physical help from staff was provided. On 4/15/25 at 7:55 a.m., during an interview, CNA Staff G who had been assigned to Resident #275 on 4/13/25 and 4/14/25 was asked if she changed the resident's clothing or bedding the prior day. CNA Staff G stated, I don't know these residents because I don't usually work in this hallway, I can only hope that today is not as crazy as yesterday, it was so crazy yesterday. On 4/15/25 at 8:00 a.m., Resident #275 was observed wearing the light blue collared three button shirt. In an interview, Resident #275 said he did not recall if his clothes have been changed since he arrived at the facility. On 4/15/25 at 8:05 a.m., in an interview CNA Staff K was asked if she knew whether Resident #275 has had his clothing changed. CNA Staff K stated, I only know this resident from today, he just moved to this hallway.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of the clinical record, review of the facility policy and procedures and resident and staff interviews, the facility failed to ensure they provided an ongoing program to support the residents in their choice of activities which are designed to meet the resident's interests and support the resident's physical, mental, and psychosocial well-being for 2 (Residents #29 and #48) of 3 reviewed for involvement in the activity programs. The findings included: Review of the facility policy Activity Programs revised August 2006 revealed, Activity programs designed to meet the needs of each resident are available on a daily basis . Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. 1. Review of the clinical record revealed Resident #29 had an admitted [DATE]. Diagnoses included major depressive disorder. The Annual Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 6/30/24 documented the importance of the following activities for Resident #29: How important is it to you to have your family or a close friend involved in a discussion about your care? Very Important. How important is it to you to be able to use the phone in private? Very Important. How important is it to you to listen to music you like? Very Important. How important is it to you to do things with groups of people? Very Important. How important is it to you to do your favorite activities? Very Important. How important is it to you to participate in religious services or practices? Very Important. The MDS noted Resident #29's cognitive skills for daily decision making were moderately impaired. The care plan initiated 10/5/22 and revised on 1/18/24 noted the resident was at risk for decreased social interaction/ activity participation. Activity preferences include: Church Service, Music Performance, ice cream/cookie socials, Wii games, trivia, and Bingo participates in group activities of preference, requires assistance to and from activities. The care plan interventions included to provide assistance with television programs of choice as needed, Provide monthly activity calendar in room, invite to daily group programs and provide assistance to group location as needed, encourage social interactions with staff and peers. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/13/25 at 11:49 a.m., 1:30 p.m., and 3:23 p.m., Resident #29 was observed in his room in bed with no music or television on. Review of the activity calendar for 4/13/25 revealed: 9:30 a.m.: 1-1 visits. 10:45 a.m.: Magic moves exercise. 1:30 p.m.: Palm Sunday Church Service. 2:30 p.m.: Bingo. On 4/14/25 at 11:33 a.m., Resident #29 was observed in bed with no television on and no music. The activity calendar for 4/14/25 revealed: 11:15 a.m.: AM trivia/mind games. On 4/15/25 at 8:47 a.m., and 4:22 p.m., Resident #29 was observed in bed. In an interview Resident #29 said no one comes to ask him if he would like to participate in activities or to get him out of bed. The activity Calendar for 4/15/25 specified: 9:00 a.m.: Our Lady of Lourdes. 3:00 p.m.: Men's sport club. On 4/16/25 at 9:31 a.m., Resident #29 was observed in bed. In an interview he said he likes to go out to activities when the staff take him. He said he loves music and religious activities. While reviewing the facility Daily Chronicle with Resident #29, he said he would love to go outside and listen to the music. Resident #29 repeated, I love music. On 4/16/25 at 10:30 a.m., live musical entertainment was observed in the facility courtyard. On 4/16/25 at 11:36 a.m., Resident #29 was observed in bed. In an interview, he said no one had offered to take him outside to listen to the music. Review of the Activities Provided log from 3/18/25 through 4/12/25 revealed Resident #29 attended Pastoral Visit/Religious on 3/18/25. He received nine conversation visits and three sensory activities. On 4/15/25 at 9:09 a.m., in an interview the Activity Director said Resident #29 comes to some activities, he enjoys music and church activities. He likes ice-cream socials and has a lot of community support. She tries to involve him as much as she can, it depends on how he is feeling. The Activity Director said all the activity participation notes are documented in the computer. She said Resident #29 was a pastor at his church and some church members do come to visit him. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/15/25 at 9:15 a.m., in an interview Activity Aide Staff J said he provides room visits two times a week for 10 to 15 minutes. 2. Review of the clinical record revealed Resident #48's diagnoses included senile degeneration of the brain. Resident #48 received hospice services. The clinical record noted Resident #48's primary language was Polish. Review of the Significant Change MDS with a target date of 3/3/25 noted Resident #48's cognitive skills for daily decision making were severely impaired. The MDS documented the importance of the following activities for resident #48: How important is it to you to listen to music you like? Very Important. How important is it to you to do your favorite activities? Very Important. How important is it to you to go outside to get fresh air when the weather is good? Very Important. How important is it to you to participate in religious services or practices? Very Important. The care plan initiated on 3/9/22 and revised 2/25/25 revealed Resident #48 was at risk for decreased social interaction/ activity participation. Activity Preferences included live entertainment, sing a longs, all things music, prefers in room activities, prefers to stay in room and does not pursue independent activities, requires cues and assist during activities, requires assistance to and from activities The care plan interventions included: Determine which individual activities resident prefers and provide any related materials as needed. Provide assist with television programs of choice as needed. Provide monthly activity calendar in room. Encourage social interactions with staff and peers. Activities staff to provide in room [ROOM NUMBER]:1 visits. On 4/13/25 at 10:29 a.m., Resident #48 was observed sleeping in her room. The activity Calendar for 4/13/25 noted: 9:30 a.m.: Room visits. 10:45 a.m.: Magic Moves Exercise. On 4/13/25 at 11:30 a.m., Resident #48 was observed out of bed sitting in her wheelchair. The resident did not respond when spoken to and made no eye contact. The television was off. The activity calendar for 4/13/25 at 11:15 a.m., noted: Mind Games/Trivia. On 4/15/25 at 9:27 a.m., Resident #48 was observed in her room in bed. She was awake and looking up at the ceiling. The television was not on. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/15/25 at 9:00 a.m., in an interview the Activity Director said Resident #48 only speaks Polish. Her family updated her television to play in Polish only. She said Resident #48 loves music so whenever they have music, she brings her. The Activity Director said they do the best they can with her. They put music on the television for her and she receives room visits two times a week. On 4/16/25 at 10:20 a.m., Resident #48 was observed in her room seated in her wheelchair. She was alert but did not speak. Activity Aide Staff J was observed assisting residents to the outside courtyard for live musical entertainment scheduled for 10:30 a.m. On 4/16/25 at 11:22 a.m., Resident #48 was observed sitting in her room. The television was off. The musical activity program was still in progress in the courtyard. Review of the activity documentation from 3/18/25 through 4/13/25 revealed Resident #48 attended eight religious activity programs and had four conversation visits. The log for the number of minutes spent providing 1:1 activity to Resident #48 for 3/18/25 through 4/13/25 revealed Resident #48 received one minute of 1:1 activity on 3/25/25, 4/3/25, 4/5/25 and 4/15/25 and two minutes of 1:1 activity on 4/1/25. The documentation revealed Resident #48 attended no group activities in the last 30 days.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, clinical record review, staff and resident interview, the facility failed to provide the appropriate care and services to prevent a decline in range of motion for 1(Resident #55) of 3 residents reviewed with a limitation in range of motion (ROM). The findings included: Review of the undated facility Policy and Procedure titled, Splints and Braces, revealed, Residents of the facility who wear splint or braces shall be monitored periodically assessed by OT (Occupational Therapy) and or PT (Physical Therapy) department. Splints and braces are usually fabricated and provided by Occupational Therapists and or Physical Therapists to treat temporary conditions of muscle weakness, joint limitations, pain and swelling. On occasion the splints and braces may be required for long term use to prevent contracture or to stabilize joints. Review of the clinical record revealed Resident #55 was a [AGE] year-old female admitted on [DATE] with diagnoses including left hand contracture, hemiplegia (paralysis of one side of the body), hemiparesis (muscle weakness or partial loss on one side of the body) and stiffness of the left knee. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 3/12/25 dated 3/12/25 revealed Resident #55 had limitations on one side of the upper and lower body and was dependent for care. Review of the physician's orders revealed: An order with a revision date of 12/9/24 to, Apply (brand name) knee extension splint to left knee. The order specified for the splint to be on after breakfast and remove before supper. Staff was to monitor skin integrity when applying and removing. An order dated 1/21/25 to, Apply Left resting hand splint to Left hand. The order specified for the splint to be on after morning care and off at evening meal. Staff was to monitor skin integrity when applying and removing the splint. Review of the Therapy Screen completed on 3/21/25 revealed therapy was required for reduced/ improved left knee flexion contracture. On 4/13/25 at 10:19 a.m., Resident #55 was observed in her room in bed. She had her left arm and hand sticking out of the covers with her hand in a tight fist. Resident #55 was not wearing a splint to her left hand or a rolled washcloth. In an interview, when asked if she was able to move her hand, Resident #55 replied No. On 4/13/25 at 11:55 a.m., and 1:58 p.m., Resident #55 was observed in the same position in bed. She was not wearing a splint to her left hand or an extension splint to her left knee. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/25 at 8:57 a.m., Resident #55 was observed in bed. The call light was on the floor and out of her reach. There was a splint on her left hand, but it was not properly applied. The hand roll that goes into the palm to open the hand was positioned at the wrist. Resident #55 was not wearing an extension splint to her left knee. Photographic evidence obtained. On 4/15/25 at 12:00 p.m., Resident #55 was observed in her room, sitting in her wheelchair. She was not wearing an extension splint to her left knee. The left-hand splint was not applied correctly, and the large palm roll was placed under her wrist. On 4/15/25 at 12:06 p.m., in an interview Licensed Practical Nurse (LPN) Staff R said she did not know if Resident #55 should have a leg brace on but she did have a splint on her arm. LPN Staff R said she was busy and did not have time to check the resident's chart to see if there was an order for a leg splint. Review of the Certified Nursing Assistant (CNA) Kardex (Provides instructions for care) revealed instructions to apply the splint to the left-hand splint and the knee extension splint to the left knee. On 4/15/25 at 8:22 a.m., Resident #55 was observed in her room in her wheelchair. The left hand splint was placed under her wrist and she was not wearing the left knee extension splint. On 4/15/25 at 9:51 a.m., Resident #55's left hand splint was observed with the Director of Therapy. In an interview, the Director of Therapy confirmed the left hand splint was not applied correctly. The Director of Therapy was observed massaging the resident's left hand. In an interview she said Resident #55 had a stroke and increased tone to the hand/fingers. She explained tone was the muscles tightening. The Director of Therapy demonstrated the splint should be applied with the roll in the palm of the hand and a separate part for the thumb. She said the thumb had more movement with decreased tone and this helped to keep the thumb from going into the palm. The Director of Therapy said the staff are instructed on how to apply each device. She said, We meet with them, we demonstrate the device and have them demonstrate how to put the device on. She said they also place the device instructions on the inside of the closet door with photos but confirmed there were no instructions for Resident #55. On 4/15/25 at 10:22 a.m., in an interview CNA Staff O said sometimes the CNA applies the splints and sometimes the nurse applies it. Staff O said, Therapy showed us how to put it on, so I know how to do it. On 4/15/25 at 12:29 p.m., in an interview CNA Staff T said Resident #55 required total care and he did not know about a leg splint. On 4/15/25 at 12:38 p.m., in an interview Unit Manager Licensed Practical Nurse (LPN) Staff S said she did not know about a knee splint for Resident #55 and thought it was discontinued. Unit Manager LPN Staff S reviewed the physician orders and confirmed Resident #55 had a current physician order for an extension splint to the left knee. (continued on next page)

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	105761	A. Building B. Wing	04/16/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 12:46 p.m., in an interview the Director of Therapy said Resident #55 was receiving physical therapy. They have tried to apply the leg splint, but the resident would cry. She said, The therapist will not change the order until the resident is discharged from therapy. I thought the brace was discontinued in the past, I don't know why it is a current order, but we would not change it until the resident has completed treatment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, interview, and record review, the facility failed to ensure a safe environment and provide adequate supervision to prevent multiple falls for 1(Resident #65) of 3 residents reviewed for accident. The findings included: Review of the facility policy on Safety and Supervision of Residents revised July 2017, our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Page 1, Individualized, Resident Centered Approach to Safety: #3 The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision . Systems Approach to Safety, continued on page 2: #2 Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs . #3 The type and frequency of resident supervision may vary among residents over time for the same resident . resident supervision may need to be increased . if there is a change in the resident's condition. Resident Risks and Environmental Hazards include . Falls . Review of Resident #65's medical record revealed hospitalization from [DATE] through 7/21/24 for multiple falls at home following a craniotomy (surgical procedure removing part of the skull to reveal the brain) in May 2024. The resident was re-hospitalized from 9/8/24 through 9/10/24 for multiple falls at home and the brother can no longer care for the resident at home. On 9/11/25 the resident was admitted to the facility and on 9/12/25 the facility initiated a fall care plan to minimize fall related injuries. The medical record revealed Resident #65 continued to have multiple unwitnessed falls while residing in the facility from 11/22/24 to the present. On 11/22/24 the resident had an unwitnessed fall trying to get to the bathroom. The resident fell to the floor and hit her head. On 11/25/24 the resident had a witnessed fall while ambulating with the walker in the hallway. Resident lost balance and fell hitting elbows and head. On 11/29/24 the resident lost balance, fell to the floor and sustained skin tears to both arms. The facility intervention was to remind the resident to use the call light for assistance when needed. On 12/5/24 the resident was found on the floor after toileting herself and sustained a skin tear. The resident did not use the call bell for assistance. The facility intervention included to place a call don't fall sign on the resident's wall to remind the resident to call for staff if she needed to use the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/24, Resident #65 had 2 falls. The first fall was 9:20 a.m., unwitnessed in the bathroom. The resident tried to get off the toilet to the wheelchair and lost balance. The 2nd fall occurred when the resident went to the vending machine. No one knew the resident left the unit. The facility intervention included scheduling a neurology appointment. On 12/31/24, the roommate called the nurses' station after the resident fell out of the wheelchair onto the floor. The resident said she lost balance reaching for something. The facility intervention included obtaining a urine specimen. On 1/1/25 Resident #65 fell trying to get into the wheelchair. The resident did not request assistance and sustained a skin tear to the lower right leg. The facility intervention included moving the resident closer to the nurses' station. On 1/7/25 Resident #65 had an unwitnessed fall in the bedroom. The facility intervention was to obtain a CT scan and/or MRI of the head and spine and a gradual dose reduction of the anti-anxiety medication. On 1/29/25 the roommate reported that Resident #65 fell in the bedroom on 1/28/25. The resident sustained a dark purple bruise on the right flank area and was complaining of right hip pain. An X-ray and medication review were ordered. On 3/5/25 Resident #65 had an unwitnessed fall and hit her head on the dresser. The facility intervention was giving the resident a scoop mattress and rescheduling neurology appointment for 4/1/25. On 3/9/25 Resident #65 had an unwitnessed fall in the bedroom. The roommate called because the resident was on the floor. The resident said she was cleaning up spilled coffee and fell . The intervention added to make sure all necessary items were in reach at all times. On 3/18/25 the resident had an unwitnessed fall leaning forward and losing balance. The new intervention was nonskid socks as the resident allows. On 3/29/25, the resident fell out of bed onto the floor. The roommate reported Resident #65 slid out of bed and put herself back in bed. The facility intervention was to obtain labs to rule out medical reasoning for the fall. Review of the fall log provided to the team revealed Resident #65 had 14 falls from 11/22/24 to 4/13/25. Review of the care planning interventions to prevent injury from falls included: remind the resident to lock the wheelchair; offer toileting during rounds and as needed; medication review; call light in reach and educate resident to use call light; remove unsafe footwear; remove hall pass, not safe to walk independently; urine for culture and sensitivity; call don't fall sign; needed items in reach; scoop mattress; safety reminders; keep environment free of clutter in the walkways; keep bed in low position; report falls to the physician as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were no interventions to increase supervision for Resident #65. For 3 days from 4/13/24 through 4/15/24, Resident #65 was observed in a bedroom, which was located at a remote end of the hallway and farthest away from the nursing station (approximately 40 feet away from the nursing station and staff visibility). Resident #65 ate the meals in the room, did not engage in therapy sessions, was not offered supervised time outdoors, and did not participate in group activities. The resident was in the room with the roommate and did not receive visitors. On 4/13/25 at 10:43 a.m. observed Resident #65 in the bedroom in the corner at the end of the hallway approximately 40 feet away from the nurse's station. There were no staff in the room or hallway at the time. The resident was sitting in the wheelchair. There were scrapes and bruises on both arms. There was a bloody dressing on the right elbow. There was a broken fan lying on the floor behind the wheelchair. Resident #65 said she tripped over the fan a few months ago and it fell over. No one ever cleaned it up. On 4/13/25 at 3:31 p.m., observed Resident #65 in bed, eyes closed, body close to the left edge and right knee hanging over the bed unsupported. There was 1 fall mat propped up against the wall. The broken fan was still on the floor next to the bed and had not been removed. There were no side rails in the up position on either side of the bed. There was no sign on the wall instructing the resident to call don't fall. On 4/14/25 at 11:55 a.m., observed the resident's room. The broken fan remained in the room beside the bed where the resident slept. No one had removed the potential tripping hazard. On 4/15/25 at 1:10 p.m., observed the resident's room and the broken fan still on the floor near the bed. No staff were in the room or the hall area at the time. Resident #65 said she came to the facility because she was falling at home, and her brother couldn't take care of her. She said she has a bad memory; can't remember last fall. She pressed the call bell, and it took staff 12 minutes to answer the light. The CNA took the resident to the bathroom and then helped her to bed. The CNA did not pull the side rail up; did not place the fall mat on the floor. Just left the room. There was no sign on the wall to remind the resident to call don't fall. On 4/15/25 at 1:38 p.m., 1:58 p.m., and 3:40 p.m. observed Resident #65 from the hallway laying in the bed. There was no staff in the room and none in the hallway near the room. The one fall mat in the room, was propped up against the wall and not in use. The broken fan was still on the floor on the right side of the bed. The side rails were not raised on either side of the bed to prevent the resident from falling out of bed. On 4/15/25 1:45 p.m., during an interview with the Therapy Director, she said she was aware of the frequent falls. She said it is balance related and the resident was confused and not with it. On 4/15/25 at 3:31 p.m. Certified Nursing Assistant (CNA) Staff BB said Resident #65 can use the call bell. She said one day Resident #65 tried to stand in front of the wheelchair and fell . She said she tries to answer the call bells quick. On 4/15/25 at 3:42 p.m., during interview with CNA Staff O said if they are a fall risk you answer the call bell quickly. She said the resident does not use the call bell and tries to do things by herself. She said an intervention for safety could be fall mats and check on the resident every now and then. She said one-to-one supervision could be used for a resident who falls a lot. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/15/25 at 4:10 p.m., the Minimum Data Set Coordinator (MDS) Licensed Practical Nurse Staff CC said they are aware of the falls, but it is a sticky situation. The resident tries to do things herself and they don't want to take away the independence. The MDS LPN said the resident is not listed for frequent checks. She is still going to fall, but there have been no major injuries. The MDS nurse LPN said the room is not close to the nurses' station, but it used to be. The MDS RN said the resident goes to the bathroom a lot of times herself. On 4/15/25 at 4:48 p.m., Resident #65's roommate said the resident just falls. The roommate said the resident can be sitting in the wheelchair and will lean over to reach for something and falls. The roommate said Resident #65 fell on the fan a few weeks ago. On 4/15/25 at 4:59 p.m., Resident #65's room was observed. The Director of Nursing (DON) was present during the observation. The DON noticed the broken fan that was lying on the floor next to the bed. The DON said the fan is an accident hazard because the resident could trip on it and fall. She said it should have been recognized by staff as an accident hazard and removed. The DON said the side rail should be raised on the resident's left side, but it was not. The DON said the fall mat should be down on the left side of the bed instead of up against the wall while the resident was in the bed. The DON said the room should have the call don't fall sign but it was missing. The DON said they tried interventions to reduce the falls, but the resident is non-compliant and does not ask for assistance. The DON said the resident was moved due to remodeling and is far from the nursing station. She said she would move the resident in the morning so she would be closer to the nursing station. On 4/16/25 at 9:34 a.m., during an interview with CNA staff G she said they moved the resident to the new room this morning. She said the staff did not tell her why they moved the resident. She said she is not assigned to the resident today, but she is familiar with her. She said she usually stays in the bedroom; does not go out of room for dining or activities. On 4/16/25 at 9:34 a.m. Resident #65 said they moved her room this morning. She said after they deliver the food, staff usually go away, and you don't see them anymore. She said she usually just stays in her room and does not go outdoors or to the group activities. On 4/16/25 at 1:54 p.m., the DON reviewed each fall one by one since 11/22/24 and the interventions used to prevent future injuries and falls. The DON said the resident forgets to use the call bell and is non-compliant with education. The DON confirmed the interventions have not worked to prevent the Resident's falls and she keeps having them. The DON said they stopped incident reporting for Resident #65's falls. The DON said there were no interventions for increased supervision, and it was just this morning did they move the resident's room closer to the nurses' station, for more frequent monitoring.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41155 Based on observation, review of facility policy and procedure and staff and resident interviews, the facility failed to ensure sufficient nursing staff to meet residents' needs for 4 (Residents #9, #17, #29, #37) of 34 sampled residents. The findings included: The facility policy Staffing documented Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with the resident care plans. 1. On 4/13/25 at 12:24 p.m., in an interview Resident #9 said it takes a while before someone comes to answer the call light. She said it depends on who is working, some staff are good, and some are not. They say they don't have the staff so what can you do? 2. On 4/13/25 at 9:53 a.m., in an interview Resident #17 said sometimes he waits an hour or more for someone to answer his call light. He said the staff tell him they are shorthanded and they don't have enough people to care for us. I was left on the bed pan for over an hour one day a week or so ago. I was on there for a long time and my legs and my bottom started to go numb, it was cutting off my circulation. I have told the nurse, they just say someone didn't come in today, so we are shorthanded. There are some good ones that work here, others are loafers, they see the light on and walk past it. The nurse managers change so quickly here, you tell one and then there is a new one. 3. On 4/15/25 at 8:43 a.m., Resident #17 said the call response depends on the day. He said this week there are so many people here, I don't know why, it could be because you are here. Last night was not good and I waited more than 20 minutes for assistance. I called my son and he said to call him back if someone didn't come and he would call the facility. 4. On 4/13/25 at 11:44 a.m., Resident #29 said it takes a long time for staff to answer his call light, more than 15 minutes to 30 minutes. He had a urinal on his bedside table 1/4 full. He said he did not like to have it there, but the staff had not come to empty it. Photographic evidence obtained. 5. On 4/13/25 at 12:09 p.m., Resident #37 said she must wait sometimes for 30 minutes or more before the staff answer the call light. It used to be worse on the night shift, now it doesn't matter. They tell me they are short-staffed, but I can't get out of bed without a lift so when I need something, I need it. Sometimes I lay here wet in urine for a while. On 4/15/25 at 11:01 a.m., in an interview certified nursing assistant (CNA) Staff O said call lights should be answered as soon as you see they are on. On 4/15/25 at 12:03 p.m., in an interview CNA Staff T said the call lights should be answered in 3 to 5 minutes or as soon as possible. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/25 at 8:44 a.m., in an interview the Director of Nursing (DON) said we staff based on census and acuity. I have been doing the staffing on and off since February we, never go under the 97%, never below 1. 0 hours or nurses and never below 2.0 hours for CNA's. We do use the therapy hours, and the Therapy Director provides the minutes for all therapy staff. If I go over the required numbers, I'm ok with that. Residents want 1-1 attention it is different here when they come from the hospital. The expectation is 1-1 and we can't provide that. We have an on-call phone to ensure the building is staffed. I will replace the call offs; the unit managers will come in or I will. We do staff competencies electronically and in person. The DON said the call light expectation is it will be answered within 5 minutes or less. Everyone can answer the call light from housekeeping to administration. We do call light audits, and we do Ambassador rounds daily. Each member of the management team has a group of rooms. We review the audits daily in morning meetings. I have done education on call light response time. We have had no agency since I started here. I have an on-going performance improvement plan for call lights, and we review it monthly. I have seen improvement in the last 5 months in the response time. I have a rotation of myself, the assistant director of nursing and the Risk Manager all take turns to supervise. I have a weekend supervisor on the weekends. We have a staffing phone where I can text everyone of open shifts and I have a group of staff I can count on to pick up extra shifts. Review of the call bell competencies, 28 staff competencies were reviewed, dated 4/9/25. The DON said all staff including all departments completed the training and competencies. On 4/16/25 at 9:00 a.m., the Human Resource Director said we check the licenses, do the background screenings and make calls if needed. Staff are provided education in orientation and are not permitted to hit the floor until they have received and completed the education and competencies. On 4/16/25 at 9:10 a.m., the Director of Nursing provided the Call light Customer Service Ambassador rounds for review. The Administrator walked in the room, took the forms and said the forms contained information that the survey team was not permitted to have access to.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51818 Based on observation, and staff interviews, the facility to follow proper sanitation and food handling practices in accordance with professional standards for food service safety. The findings included: On 4/13/25 at 9:35 a.m., during a kitchen observation, Dietary Staff B was observed removing a cut glove (glove to prevent injury during food prep) from his back pocket and putting it on his right hand to prepare raw vegetables for lunch. Dietary Staff B was not observed performing hand hygiene or sanitize the glove before using it. In an interview, Dietary Staff B was asked how long he has been using the glove. He stated, I've been using it as long as I've worked here, for a year. When asked how he makes sure the glove is clean before using it, he demonstrated by putting one pump of hand sanitizer on the palm of the glove while he was wearing it. On 4/13/25 at 12:00 p.m., during a kitchen observation, Dietary Aide Staff C was observed washing his hands in the 3-compartment sink for less than 10 seconds. On 4/13/25 at 12:11 p.m., during a kitchen observation, Dietary Staff B performed hand hygiene for less than 10 seconds in the handwashing sink. On 4/13/25 at 12:15 during an observation of the garbage process, Dietary Staff C returned from garbage detail and washed his hands 3-compartment sink for dishwashing, On 4/14/25 at 8:35 a.m., Dietary Staff, AA was observed to perform hand hygiene for only 10 seconds. In an interview, when asked how long handwashing should be performed, he stated, 10 seconds. On 4/14/25 at 8:37 a.m., in an interview, Culinary Manager Staff A said handwashing should be performed for 30 seconds. On 4/15/25 at 8:30 a.m., in an interview, Culinary Manager Staff A stated, The mesh glove is an issue, and (Dietary Staff B) should definitely not be using hand sanitizer on the cut glove and then cutting vegetables with it because hand sanitizer is not an approved handwashing agent in the kitchen. He received facility specific training when he was hired because he came from another facility's kitchen but there will be education going out. Staff should be using the handwashing sink and not the 3-compartment sink for hand hygiene, I will educate the staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, record review, resident and staff interviews, the facility failed to ensure staff followed infection prevention interventions when entering the room of 1 (Resident #1) of 1 resident observed on enhanced barrier precautions and failed to change the dressing as ordered to prevent catheter related infections for 2 (Residents #69 and #173) of 2 residents reviewed with Peripherally Inserted Central Catheters. The findings included: Review of the Policy for Midline and PICC(peripherally inserted central catheter) line dressing changes Revised 4/2016 stated Change midline/PICC line catheter dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way. Review of Resident #173's medical record revealed admission to the facility on [DATE]. Diagnoses included osteomyelitis (bone infection) of the vertebra. Review of the Medication Administration Record (MAR) revealed an order for Daptomycin (antibiotic) 500 milligram (mg) Intravenous (IV) Solution to be administered twice a day from 4/9/25 through 5/12/25. A second antibiotic, Cefepime 2 grams IV, was ordered twice a day from 4/9/25 through 5/12/25. Review of the Medication Administration Record (MAR) April 2024 revealed an order dated 4/9/25 to change cover dressing to the right upper extremity PICC every day shift every Thursday. The MAR revealed the nurse documented the cover dressing was changed on Thursday, 4/10/25. On 4/14/25 at 9:58 a.m., during interview and observation of Resident #173 in the bedroom, the right arm PICC line cover dressing was dated 4/2/24. The dressing edges were raised and not intact on one side. Resident #173 was awake and oriented to person, place, and situation. In an interview Resident #173 said the hospital put the cover dressing over the PICC line on 4/2/25. No one at the facility changed the cover dressing since she has been at the facility. She said the nurses were administering the antibiotics twice a day through the PICC line. Photographic evidence obtained. On 4/14/25 at 10:52 a.m., Registered Nurse Staff E went to the room and verified the PICC line cover dressing was outdated and had not been changed as the nurse documented on 4/10/25. On 4/16/25 at 10:33 am., during interview with RN Staff P she said on 4/10/25 she documented on the MAR that she had changed the PICC line cover dressing, but she had not. On 4/16/25 at 2:57 p.m., during an interview with the Director of Nursing she said the policy is to change the PICC line dressings every 5-7 days to prevent catheter-related infections. She said she does not expect the nurse to sign off a task before it has been completed. 51818 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105761	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Lake Healthcare and Rehabilitation Center	832 Sunset Lake Boulevard Venice, FL 34292

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record for Resident #69 revealed an admitted [DATE]. Resident #69 had a PICC in his right arm for antibiotic infusion for an antibiotic resistant bacterial infection. Diagnoses included sepsis, methicillin staphylococcal aureus (MRSA), and altered mental status. On 4/13/25 at 10:00 a.m. Resident #69 was observed with right upper arm PICC with a dressing that was covered by mesh covering, an intravenous infusion was running into the PICC at that time. On 4/14/25 at 10:35 a.m., observation of Resident #69 with right upper arm PICC dressing visible and dated 3/18/25. Record review showed that Resident #69 has physician orders for daily antibiotic intravenous infusions. Record review of nursing orders showed that Resident #69 was to receive weekly PICC dressing changes. The medical record for Resident #69 lacked documentation of dressing changes being performed by the facility. On 4/14/25 at 12:22 p.m., during an interview with Unit Manager Registered Nurse (RN) Staff E, she stated, It is the Unit Manager's responsibility to change the dressing. I just started here. I can't tell when it was last changed because there is no documentation. It was brought to my attention, so I just changed his (Resident #69) and placed a date on the dressing of 4/14/25. I just decided over the weekend that my plan is to do all (PICC) dressing changes on the same day to eliminate confusion. Photographic Evidence obtained 52199 Review of the facilities Enhanced barrier precautions (EBP) policy stated: 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: Dressing; Bathing/showering; Changing linens; Changing briefs or assisting with toileting; Device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and Wound care (any skin opening requiring a dressing). Review of Resident #1's clinical medical record revealed she was admitted to the facility on [DATE] with a most recent admitted [DATE] with diagnosis of unstageable pressure ulcer to the sacral region, a primary diagnosis of multiple sclerosis with paraplegia, neurogenic bladder managed by an indwelling suprapubic catheter, and chronic pressure ulcers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Treatment Administration Record (TAR) revealed an active physician ' s order dated 1/9/2025 for Isolation: Enhanced Barrier Precautions - Suprapubic catheter/Wound care every shift. The order was signed by the physician and noted as ongoing. Resident #1 has a suprapubic catheter and multiple chronic wounds, including an unstageable pressure ulcer of the sacral region. On 4/14/25 at 9:27 a.m. Staff K, Certified Nursing Assistant (CNA) was observed entering Resident #1 's room to assist with toileting, dressing and transfer to wheelchair. An EBP sign was posted on the resident 's door. Staff K, CNA was observed wearing gloves but failed to don a gown as required. PPE (Personal Protective Equipment) supplies were located in a centralized location down the hall and not directly outside the resident's room. When care was completed for Resident #1 Staff K, CNA confirmed she did not wear a gown as required and said she was aware of the EBP signage and protocol, stating, I should have worn a gown. On 4/14/25 at 9:57 a.m. Staff L, Licensed Practical Nurse (LPN) was observed providing care for Resident #1 without the required PPE. When care was completed she confirmed that she had assisted CNA Staff K in providing care for Resident #1 by assisting in transferring the resident from her bed to a wheelchair using a Hoyer lift. Staff L acknowledged that full PPE, including gowns and gloves, is required for EBP precautions, and admitted she had failed to wear a gown and should have. On 4/16/25 at 10:30 a.m. during an interview, the DON said that staff should have donned PPE while providing care. She said staff were last educated on EBP in January and should know better but later acknowledged that the current PPE supply location may be a barrier to compliance and agreed to implement changes to PPE access and hand hygiene station availability.