STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964825	**07/25/2018**
NAME OF PROVIDER OR SUPPLIER **SUNSET LAKE VILLAGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1121 JACARANDA BLVD** **VENICE, FL 34292**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced complaint survey for CCR#2018003553 was conducted . . . . . through . . . . . at Sunset Lake Village, an assisted living facility (license #9325) in Venice, Florida.

The complaint contained 2 allegations, both of which were substantiated with deficiencies.

The following is description of the deficiencies.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on resident and staff interviews, and record review, the facility failed to ensure residents' complaints and grievances were documented, investigated, and resolved in a timely manner for 3 (Residents #5, #7, and #8) of 7 residents reviewed.

The findings included:

On , a review of the Resident Bill of Rights documented "every resident shall have the right to present grievances..."

On . . . . . at 1:15 p.m., the Administrator said she is unable to locate her grievance log. She said she has been here a year and they had maybe 2-3 grievance forms completed because the complaints "are answered on the spot." She said if the resident tells the staff about a complaint, it is handled immediately. The Administrator said she was not aware of what the facility's Grievance Policy and Procedure are. She was unable to explain the contents of the policy.

During an interview on . . . . . at 5:30 p.m., Resident Associate ( ) Staff D and Staff E said they handle a resident complaint or grievance on the spot. If they cannot, they tell the wellness director. RAs Staff D and Staff E said they do not know what the facility grievance policy and procedure is or where to find it. They said they do not know anything about a grievance log.

During an interview on at 3:20 p.m., Resident #5 said she does not know they have a grievance process. No one has discussed that with her.

During an interview on . . . . . at 5:05 p.m., Resident #7 said she had no idea how to file a grievance; no one had talked to her about it. The subject had not come up during a Resident Council meeting.

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During an interview on at 5:07 p.m., Resident #8 said she did not know anything about how to file a grievance. No one had spoken to her about it or discussed it in any of their meetings.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and staff and resident interviews, the facility failed to ensure a safe living environment free from noxious insects for 1 (Resident #1) of 8 residents sampled. Resident #1 suffered ant bites that may have contributed to his .

The findings included:

Record review revealed Resident #1 was admitted to the facility on with diagnoses including Parkinson , , Atherosclerotic , and .
The resident was admitted to hospice on with Parkinson , , Abnormal Weight loss, Acute Kidney Failure, Chronic Kidney , and two pressure sores.
The resident on after being found in bed covered in ants.

The District Twelve Medical Examiner report dated listed, "CAUSE OF : Atherosclerotic CONTRIBUTORY: Sequelae of Envenomation/reaction to Red Ant Bites, , , Parkinson's MANNER OF : Accident (Natural causes exacerbated by multiple ant bites). EVIDENCE OF INJURY: Multiple insect bites are noted consistent with red ant bites on the extremities and torso...In summary, a total of approximately 142 [ ] bites are noted. No definitive pustular change is noted. 70 non- bites are also noted."

On a review of the pest control service receipt dated documented, "Customer complaint of over 1,000 ants on a patient." The recommendations included for the facility to fill in any gaps or holes to prevent any pests from entering into the building.

On at 4:30 p.m., the lawn maintenance person said he had heard what happened to Resident #1. While he said he had not noticed any ant mounds against the building, there are a lot where he parked the truck. He stated, "The lot has a massive amount of red ants." He said the lot is just across from Resident #1's window. He said it was possible the red ants came from there.

On at 4:16 p.m., Housekeeper Staff B, assigned to the Memory Unit, explained she had seen live ants on the window sill in (Resident #1's). She said she did not remember when, but

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it was before Resident #1 . She said she would have reported it to maintenance or the administrator. She does not remember which one.

On at 2:00 p.m., observation with the Maintenance Director revealed a large tear in the window screen of Resident #1's .

On at 4:00 p.m., the Maintenance Director said he does not know how the ants got into Resident #1's . He acknowledged there is a large tear in Resident #1's window screen. He stated, "I do not recall any cracks or gaps around the window."

On at 2:00 p.m., the Maintenance Director stated, "because of the pest control's recommendations on when servicing the building, because of what the pest guy found, I did fill a gap in the window seal of that . I did not know the window screen had a hole in it."

On at 4:05 p.m., 11 to 7 shift Resident Associate ( ) Staff A, said on , she saw some ants on the wall near Resident #1's bed (time unknown). She said she did not remove them, and she left them there. She said she told the oncoming staff about them.

On at 8:30 p.m., Resident #1's wife said her husband , , on . She said on at 6:00 a.m., the facility called and told her to come in because Resident #1 was declining. She said she arrived at 6:45 a.m., and he looked like he was in a . She stated, "When I got there, his covers were all the way up to his neck. I laid on the bed, on top of the covers, next to him." She said the hospice nurse came in around 10:00 a.m. She said the hospice nurse asked her to get up because she wanted to check Resident #1's vitals. She stated, "There was another woman there too, the administrator. When the hospice nurse pulled his covers back, he had ants all over him. They were even on his privates, on his penis." They asked me to get up and they moved the bed away from wall. I was at the foot of the bed and I could see all the ants on the floor. There were a lot of them there and they sprayed them with something. When we were looking at him with the ants all over his body, you could see so many marks from the ant bites." She said she was there on the 4th, it was their 46th anniversary, and he was out of bed. She was there on the 5th, and he was up in a wheelchair. Thursday, the 8th was the first time she arrived and he was in bed. She said between 6:45 a.m., when she arrived, and when the hospice nurse came, no one came in and cleaned him or repositioned him.

On at 3:30 p.m., the Hospice Nurse said when she and the hospice aide were in the resident's , they observed "a lot of ants on the wall. They were on the wall near the window and at the head of his bed." She said when they pulled the bed away from the wall to turn and take care of the resident, they observed "ants in his bed, all over him. He had a on his hand and they were in the tear.

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We took off his brief and there were hundreds of ants all in his , over his . We literally had to scoop them off of him." She said his wife was there. The Hospice Nurse said because there were so many ants and what would have been multiple ant bites, when the resident , shortly after finding the ants, she requested his body sent to the Medical Examiner's office for evaluation. She said the Medical Examiner's office accepted the request.

On at 4:50 p.m., the Administrator explained she and the Wellness Director had been in the take care of Resident #1 several times. They observed his wife lying in bed with him, under the covers and she had no complaints of ants. The Administrator said they had repositioned him, having to move the bed away from the wall at 9:45 a.m., and did not observe any ants on the wall or in the bed. She said the Hospice Nurse had gone into the 10:15 a.m. and she followed in shortly after. She said she saw there were "a lot of ants in the bed and on the resident. There were a cluster of them on the wall." She said the window was open. She said when they saw all the ants on the wall, she retrieved a sprayer and sprayed the wall.

On at 2:12 p.m., the Administrator said Staff A found ants on Resident #1 the night before. She cleaned him up and did not notify anyone. She said she never told anyone until today. The Administrator said the told her, she just cleaned him up.

Class II

Photos on file