STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964825	R 09/12/2018
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 revisit survey was conducted on at Sunset Lake Village, an assisted living facility (license #9325) located in Venice, Florida.

This was a follow-up to a complaint survey completed on and done in conjunction with a new complaint survey.

The following is description of the deficiency found at the time of the visit.

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

Based on record review and interview the facility failed to honor resident rights to a safe, comfortable, home-like atmosphere were residents are treated with dignity and respect for 1 (Resident #2) of 3 residents reviewed. This has the potential for residents to feel negative about their life and their living situation.

The findings included:

On at 12:20 p.m., Resident #1 said he is of bowel and . He said on he had a bowel movement and had removed his soiled brief and discarded it into the trash can in the . He then showered and cleaned himself. Shortly after he was on the phone with a worker from the Department of Elderly Affairs. He said he must have had the phone on speaker. Staff A came into his yelled at him and talked to him in a way that made him feel bad about the soiled brief in the trash can. When he return to the phone call the Department of Elderly Affairs worker said she heard the incident and felt he should report it. He said he spoke to the Resident Care Coordinator and she told him staff should not speak to him like that.

Record review of Staff A's personnel file found no documentation of any corrective or disciplinary action being taken related to the incident. The facility's policy says "any community staff member witnessing, suspecting, or having knowledge of /neglect is required to report it immediately to the Executive Director."

On at 1:30 p.m., the Resident Care Coordinator said Resident #1 talked to her about the incident on concerning staff A. She asked him if he wanted to file a report. He did not respond and she did not complete any investigation or follow-up concerning the incident. She did not discuss this incident with staff A. She said she did not report the incident to the Executive Director.

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Class III