STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953352	06/07/2017
NAME OF PROVIDER OR SUPPLIER **DIXIE OAK MANOR, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6410 OLD DIXIE HWY** **VERO BEACH, FL 32967**	

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

0000 - Initial Comments

On , a Change of Ownership survey was conducted at Dixie Oak Manor LLC, license #8502. The facility had deficiencies identified at the time of the survey.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observations, interviews and record review, the facility failed to ensure required Interdisciplinary Care Plans ( ) were in place for 1 of 1 sampled Residents (#1) receiving hospice services at the facility.

The findings included:

Resident #1 was admitted to the facility on . A Hospice Certification dated documented she began receiving end-of-life hospice services. On at 3:15 PM, she was observed in bed in her , she was tired and spoke softly and slowly. Further review of her records revealed a which did not adequately reflect the resident's individual and specific needs. It did not adequately identify services to be provided by hospice staff, and did not adequately identify services to be provided by assisted living facility staff. Also, there was no Hospice Care Plan available for review.

This was discussed with the facility's Manager on at 1:02 PM, she stated she would contact the hospice agency for more information. At 5:00 PM, the Manager confirmed there was no other related documentation available for review at this time.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observations, interviews and record review, the facility failed to ensure unlicensed staff members followed the required standards for assisting residents with self-administration of medications, for 1 of 1 observed staff members (Staff D).

The findings included:

Assistance with self-administration of medications conducted by Staff D, a Certified Nurse Aide and Medication Technician, was observed on beginning at 8:55 AM. Staff D was observed to provide medications to Residents #2 and #7. During the process, Staff D was observed to present the residents with their medications without stating either the name of the medications or what medical

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condition the medications were for.

This was discussed with Staff D and the facility's Manager on at 10:02 AM.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observations, interviews and record review, the facility failed to ensure unlicensed staff updated Medication Observation Records (MOR) with the effectiveness of "as needed" pain medications and did not ensure accuracy for MOR entries for 1 of 2 sampled Residents (#1).

The findings included:

Assistance with self-administration of medications conducted by Staff D, a Certified Nurse Aide and Medication Technician, was observed on beginning at 8:55 AM. Review of Resident #1's MOR revealed an entry, " 20 [milligrams], take 1 tablet every day as needed for leg ". In an interview conducted at 11:01 AM, Staff D was asked and stated this order was added to the resident's 2017 MOR in error. She presented the resident's 2017 MOR which did not include this order. At 11:10 AM, Staff D stated she checked and there were no medications on site for this order.

This was discussed and acknowledged by the facility's Manager on at 12:22 PM. She was asked and stated staff should have caught this and updated the MOR upon receipt.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on observation, interviews and record review, the facility failed to ensure staff members who provide direct care to residents, received required training for 1 of 3 sampled Staff (D).

The findings included:

Personnel record review conducted with the facility's Manager present, revealed the following concerns:

Staff A was hired on and works as a Caregiver and Medication Technician. Review of her personnel records revealed no documentation showing she received the required 1 hour of training in

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reporting adverse and major incidents, , neglect and , , and 3 hours activities of daily living and resident behaviors.

This was discussed with the facility's Manager on at 4:45 PM. She confirmed Staff A provides direct care to the residents. She further stated there was no other related documentation available for review at this time.

Class III

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

Based on observations and interviews, the facility failed to maintain toilets and resident devices in good repair, for 3 of 8 sampled resident (#2, #4 and #10) (photographic evidence obtained).

The findings included:

A tour of the facility was conducted on at 9:20 AM. The following concerns were observed:

1. In resident , the toilet was not functioning properly, it emitted a loud whining noise and the water in the basin was continuously running.

2. In resident , the rear metal bar on the over toilet commode was deteriorated with rust-colored matter.

3. In resident , the toilet seat was excessively worn, exposing the inner material is two places.

4. During medication system review, the facility's only pill cutter was observed excessively soiled with debris build-up.

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on record review and interviews, the facility failed to include provisions consistent with regulations in resident contracts, for 2 of 2 sampled Residents (#1 and #5). This is evidence in the facility failure to ensure that the contracts had a 30 day termination provision for the resident with respect to the resident terminating his/her residency contract.

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The findings included:

Review of Residency and Care agreements (resident contract) for Resident #1 and #5 was conducted on [redacted] at 1:57 PM with the facility's Manager present. Page 6, Item 17. Termination of Agreement and Residency disclosed, "A. Withdrawal: You may withdraw from this facility forty-five days after you have written our administrator of you decision to withdraw."

These concerns were discussed with and acknowledged by the Manager at the time of review.

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