STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910431	C 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANGERINE COVE OF BROOKSVILLE	**307 HOWELL AVENUE BROOKSVILLE, FL 34601**

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

0000 - Initial Comments

On , , , 2018 an Extended Congregate Care monitoring survey in conjunction with a Complaint # 2018001253 was conducted at Tangerine Cove Assisted Living Facility, License number 7622. Deficient practice was identified during survey.

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the facility failed to ensure that a resident's pain medication prescription was filled in a timely manner for 1 (#5) of 5 sampled residents.

Findings:

In an interview on at 3:10PM, Resident #5 said she hasn't had any pain medication since yesterday. She said the nurse told her she was out of medication and it had been ordered.

Record review of the Resident's Medication Administration (MAR) revealed that the resident's last dose of pain medication was on at 8:00AM.

Record review of physician's orders dated , 2018 revealed an order for 1 tablet by mouth every six hours as needed for pain.

In an interview on at 3:47PM, the Director of Nursing said the facility is responsible for calling the pharmacy to reorder the resident's medication. She confirmed that the resident has been out of medications since yesterday and that her last dose was at 8:00AM on that day.

Class III

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

Based on observation and interview, the facility failed to maintain an environment that is safe and free of hazards.

Findings:

During an initial tour of the dining at 9:00 AM, the dining was noted to have missing floor tiles and holes in the concrete in the area where residents were eating. The area had

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not been secured to prevent residents from accessing the area. The floor also had linoleum that was not secured to the floor and was curled at the edges.

During an observation on at 12:30 PM, residents were observed in the dining at the tables. One resident was observed sitting next to the area with the missing tiles, and another resident was observed sitting at another table with her walker next to her. The walker was resting in a hole in the floor. (Pictures attached)

In an interview on at 12:36 PM, the administrator confirmed that the missing tiles and linoleum is a safety hazard to the residents, and that the dining area should be roped off to prevent residents from accessing the area, but she doesn't know why it has not been done. She said the maintenance man would rope off the construction area to prevent the residents from gaining access.

In an interview on at 3:00 PM, Resident #1 said it's a dangerous area in the dining because she has seen two resident trip over the curled linoleum.

Class III