

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RAINBOW MANOR, INC.

**2075 RAINBOW DRIVE
CLEARWATER, FL 33765**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the _____ are enrolled in the national retained print _____ notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic _____ submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; _____; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the employment status of employees within the background clearinghouse employee roster, within ten-business days of termination of employment, for three former	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ814	Continued From page 1 employees (Staff B, C, and D) of three sampled former employees (photographic evidence obtained). Findings Included: A review of the facility's background screening employee roster, conducted on _____, there were five current employees listed on the facility's background screening roster which included the Administrator and Staff A, B, C, and D. Staff B was hired on _____. Staff C was hired on _____. Staff D was hired on _____. There were no termination dates for Staff B, C, and D. During an interview with the Administrator, conducted on _____ at 09:30am, the Administrator stated that he had Staff A were the only employees at the facility. At 02:55pm, the Administrator agreed that the facility's employee roster was not up to date. The Administrator stated that Staff B, C, and D no longer worked at the facility and had not worked there for a long time. The Administrator was unable to provide Staff B, C, and D's termination dates. Unclassified	CZ814			
CZ815	408.809(1)(_____); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2022	
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ815	Continued From page 2 considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, _____ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or _____ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All _____ must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf.	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ815	Continued From page 3 (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2022	
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ815	Continued From page 4 (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or _____ with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2022	
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ815	Continued From page 5 apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ815	Continued From page 6 authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining _____ pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any _____ person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ815	Continued From page 7 otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed.	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ815	Continued From page 8 (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or _____ for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was _____, regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employees had an eligible level 2 background screening every five years for one employee (Administrator) of two sampled employees. Findings Included: A record review for the Administrator, conducted on _____, revealed that the Administrator had an eligible level 2 background screening dated _____ which was greater than five years ago. The Administrator was the Owner since _____ (photographic evidence obtained). During an interview with the Administrator, conducted on _____ at 02:55pm, the Administrator agreed that his level 2 background screening had expired on _____. The Administrator was unable to provide evidence that	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2022
---	--	---	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RAINBOW MANOR, INC.

**2075 RAINBOW DRIVE
CLEARWATER, FL 33765**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ815	Continued From page 9 he had an eligible background screening. Unclassified	CZ815		
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's _____ to the Federal Bureau of Investigation for a national criminal history record check unless the person's _____ are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the _____ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit _____ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the _____ to the Federal Bureau of Investigation for a national criminal history record check. The _____ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program.	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ816	Continued From page 10 The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required	CZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ816	Continued From page 11 Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106 , and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml . This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal . (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with	CZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ816	Continued From page 12 the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a signed affidavit or attestation of compliance every five years as required with Background Screening requirements in Chapter 435 Florida Statute for two employees (Administrator and Staff A) of two sampled employees. Findings Included: A record review for the Administrator, conducted on _____, revealed that the Administrator had a signed Attestation of Compliance dated _____, which was greater than five years ago. The Administrator was also the Owner since _____. A record review for Staff A, conducted on _____, revealed that Staff A did not have a signed Attestation of Compliance in the employee's record. Staff A was the Assistant Administrator since _____. During an interview with the Administrator, conducted on _____ at 02:55pm, the Administrator agreed that his Attestation of Compliance was signed greater than five years ago and that Staff A did not have a signed Attestation of Compliance in the employee's record. Unclassified	CZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
CZ830 CZ830 SS=C	Continued From page 13 408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory	CZ830 CZ830			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
CZ830	Continued From page 14 justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections	CZ830			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ830	Continued From page 15 indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide revisions to their comprehensive emergency management plan (CEMP) within thirty days of request by the local emergency management office. Furthermore, the facility failed to maintain testing and maintenance records for their alternate portable power source. Findings Included: During an attempt to review the testing and maintenance records for the facility's alternate power source, conducted on . . . at 09:45am and 02:25pm, no documents were provided. A review of the most recent CEMP approval document, conducted on . . . , revealed that the last approved CEMP document provided was dated During an interview with the local emergency management Representative, conducted on . . . at 11:42am, the facility submitted their plan without all required documents in The Representative stated that the local emergency management office requested the	CZ830			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
CZ830	Continued From page 16 additional documents on _____ and on _____ , the facility submitted their emergency plan without the requested documents. The Representative stated that the facility continued without a approved CEMP. During an interview with the Administrator, conducted on _____ at 02:56pm, the Administrator stated that there were no testing and maintenance records for the facility alternate power source. The Administrator agreed that the facility had not submitted the requested documents to the local emergency management office. Class III	CZ830			
CZ841 SS=D	408.823() FS In-person Visitation (1) This section applies to _____ centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part _____ of chapter 400, intermediate care facilities for the _____ licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include control and education policies for visitors; screening, personal protective equipment, and other _____ control protocols for visitors; permissible length of visits and numbers of	CZ841			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2022	
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ841	Continued From page 17 visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any _____ or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor. (b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and providers may not require an essential caregiver to provide such care. (c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects: 1. End-of-life situations. 2. A resident, client, or patient who was living with family before being admitted to the provider 's care is struggling with the change in environment and lack of in-person family support. 3. The resident, client, or patient is making one or more major medical decisions. 4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently _____.	CZ841		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ841	Continued From page 18 5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver. 6. A resident, client, or patient who used to talk and interact with others is seldom speaking. 7. For hospitals, childbirth, including labor and delivery. 8. patients. (d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures. (e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request. (f) Within 24 hours after establishing the policies and procedures required under this section, providers must make such policies and procedures easily accessible from the homepage of their websites. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a visitation policy and procedures for visitors within thirty days of the effective date of the act under part 1 of chapter 429, Florida Statute. Findings Included: During an attempt to review the facility's visitation policy and procedures, conducted on _____, a visitation policy and procedures dated _____	CZ841			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ841	Continued From page 19 for a sister facility was provided. There was no visitation policy and procedures provided for the facility. The visitation policy and procedures stated that there were no visitors permitted in the facility (photographic evidence obtained). The visitation policy and procedures did not include the following: The allowance of in-person visits in all of the following circumstances: -End-of-life situations -A resident, client, or patient who was living with family before being admitted to the provider's care is struggling with the change in environment and lack of in-person family support -The resident, client, or patient is making one or more major medical decisions -A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently -A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver -A resident, client, or patient who used to talk and interact with others is seldom speaking. -The length of the visits and numbers of visitors which allow for consensual physical contact between residents and the visitors -The control and education policies for visitors for screening, personal protective equipment, and other control protocols for visitors -The designation of a person responsible for ensuring that staff adhere to the policies and procedures During an interview with the Administrator, conducted on at 02:15pm, the	CZ841			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ841	Continued From page 20 Administrator agreed that the visitation policy and procedures was for a closed sister facility and not for the facility. The Administrator stated that there was no other visitation policy and procedures since Class III	CZ841		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RAINBOW MANOR, INC.

**2075 RAINBOW DRIVE
CLEARWATER, FL 33765**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A biennial survey, a limited nursing services, and a generator monitoring were conducted at Rainbow Manor on . Deficiencies were identified at the time of survey.	A 000		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.	A 054		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 054	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed document refusals or missed doses of medications and failed to update medication observation records (MORs) immediately at the time medications were offered to nine Residents (#1, #2, #3, #4, #5, #6, #7, #8, and #9) of nine sampled residents that required assistance with self-administration of medications. Findings included: During an attempt to observe the medication pass, conducted on _____ at 10:20am, there were no medications provided to residents. Further observation through 03:00pm, there was no staff that provided medications to residents. A MORs review for Resident #1, conducted on _____, revealed that Resident #1 had medications that were not documented as given which included: - _____ 25mg was not documented as given from _____ through _____ at 02:00pm - _____ 10mg was not documented as given from _____ at 08:00pm through _____ at 08:00pm A MORs review for Resident #2, conducted on _____, revealed that Resident #2 had medications that were documented as given and the time had not yet occurred which included: - _____ 12% was documented as given on _____ at 08:00pm. - _____ 20mg was documented as given on _____ at 08:00pm	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 054	Continued From page 2 A MORs review for Resident #3, conducted on _____, revealed that Resident #3 had medications that were documented as given and the time and dates had not yet occurred which included: - _____ 1mg and _____ 100mg were documented as given for _____ at 08:00pm and _____ at 08:00am and 08:00pm A MORs review for Resident #4, conducted on _____, revealed that Resident #4 had medications that were documented as given and the time and dates had not yet occurred which included: - _____ 100mg was documented as given on _____ at 12:00pm and 08:00pm and on _____ at 08:00am, 12:00pm, and 08:00pm A MORs review for Resident #5, conducted on _____, revealed that Resident #5 had medications that were not documented as given which included: - _____ 325mg, _____ 75mg, _____ 10mg, _____ 5mg, _____ 15mg, 500mcg, and _____ D3 were not documented as given from _____ through _____ at 08:00am - _____ 40mg was not documented as given from _____ through _____ at 08:00pm - _____ FlexTouch Pen and _____ level check were not documented as given from _____ through _____ at 08:00pm - _____ 1000mg was not documented as given from _____ through _____ at 08:00am and 05:00pm A MORs review for Resident #6, conducted on _____	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RAINBOW MANOR, INC.

**2075 RAINBOW DRIVE
CLEARWATER, FL 33765**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 3 , revealed that Resident #6 had medication that were documented as given and the time had not yet occurred which included: - 7.5mg was documented as given on at 08:00pm A MORs review for Resident #7, conducted on , revealed that Resident #7 had medications that were documented as given and the time and dates had not yet occurred which included: - 5mg was documented as given on at 08:00pm and at 08:00pm A MORs review for Resident #8, conducted on , revealed that Resident #8 had medications that were not documented as given which included: - 25mg and 20MeQ was not documented as given from at 08:00am through at 08:00am A MORs review for Resident #9, conducted on , revealed that Resident #9 had medication that were not documented as given which included: - 250mg was not documented as given from through at 08:00am and 08:00pm - 100mg was not documented as given from through at 08:00pm - level checks were not documented as given from through at 08:00am and 05:00pm - 100mg was not documented as given	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 054	Continued From page 4 from _____ through _____ at 08:00am During an interview with the Administrator, conducted on _____ at 10:20am, the Administrator stated that no residents receive medications in the afternoon and that all residents received their medications at 08:00am and 08:00pm every day. At 02:58pm, the Administrator stated that Resident #1 refuses his 02:00pm 25mg dose every day. The Administrator agreed that Resident #1's refusals were not documented on the resident's MORs. The Administrator stated that he signed Residents #2, #3, #4, #6, and #7 MORs early so that he did not forget to sign them. The Administrator agreed that Residents #1, #5, #8, and #9 had medications that were not documented as given. The Administrator stated that he knew that medications were supposed to be signed at the time they were offered to residents. Class III	A 054			
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container:	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2022	
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 056	Continued From page 5 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 056	Continued From page 6 observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide prescribed medications	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 056	Continued From page 7 as ordered from residents' health care providers and failed to notify the residents' health care providers that residents did not receive their medications as prescribed for four Residents (#1, #4, #5, and #9) of four sampled residents that required assistance with self-administration of medications. Findings Included: During an attempt to observe the medication pass, conducted on _____ at 10:20am, there were no medications provided to residents. Further observation through 03:00pm, there was no staff that provided medications to residents. A review of medication observation records (MORs) for Resident #1, conducted on _____, revealed that Resident #1 had an order for _____ 25mg take one tablet by _____ three times every day at 08:00am, 02:00pm, and 08:00pm. Resident #1's _____ was not documented as given from _____ through _____ at 02:00pm. There was no order found to discontinue Resident #1's prescribed _____ at 02:00pm. A review of MORs for Resident #4, conducted on _____, revealed that Resident #4 had an order for _____ 100mg take one capsule by _____ three times every day at 08:00am, 12:00pm, and 08:00pm. There was no order found to discontinue Resident #4's prescribed 12:00pm _____. A review of MORs for Resident #5, conducted on _____, revealed that Resident #5 had an order for _____ FlexTouch Pen _____ inject 50	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2022	
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 056	Continued From page 8 units , every day at 08:00pm. The medication was not documented as given from through , Resident #5 had an order for level checks every day at 08:00am, 12:00pm, and 08:00pm that were not documented as obtained from through . There was no order found to discontinue Resident #5's prescribed or level checks. A review of MORs for Resident #9, conducted on , revealed that Resident #9 had an order for level checks every day at 08:00am and 05:00pm that were not documented as obtained from through . There was no order found to discontinue Resident #9's level checks. During an interview with the Administrator, conducted on at 10:20am, the Administrator stated that none of the residents received their medications in the afternoon and all residents received their medications at 08:00am and 08:00pm. At 02:58pm, the Administrator stated that he gives Resident #4 one dose of in the morning at 08:00am and he gave the 12:00pm dose at 08:00pm. The Administrator was unable to provide an order that changed the directions of use for Resident #4's . The Administrator stated that Resident #1 refused his 02:00pm every day. The Administrator agreed that the refusals were not documented on Resident #1's MORs. The Administrator stated that he no longer offers Resident #1's to the resident. The Administrator was unable to provide an order that changed the directions of use for	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 056	Continued From page 9 Resident #1's . The Administrator stated that he does not provide Resident #5's or checks the resident's levels as prescribed. The Administrator stated that the and checks were no longer ordered for Resident #5 and the resident's pharmacy kept adding the orders to the resident's MORs. The Administrator was unable to provide an order that discontinued the and level checks for Resident #5. The Administrator stated that he does not obtain Resident #9's level checks and that the resident no longer had the checks ordered. The Administrator was unable to provide an order that discontinued the level checks for Resident #9. The Administrator was unable to provide evidence that Residents #1, #4, #5, and #9's primary care providers were notified that they were not receiving their medications as prescribed. Class III	A 056			
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 078	Continued From page 10 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 078	Continued From page 11 staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain evidence from a health care provider that employees were negative for () annually as required for two employees (Administrator and Staff A) of two sampled employees. Findings Included: A record review for the Administrator, conducted on , revealed that the Administrator had a negative obtained from a health care provider on and . There was no evidence that the Administrator obtained a negative from a health care provider in the years 2019, 2021, or 2022. The Administrator was also the Owner since . A record review for Staff A, conducted on , revealed that Staff A had a negative obtained from a health care provider on and . There was no evidence that Staff A obtained a negative from a health care	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 078	Continued From page 12 provider in the years 2019, 2021, or 2022. Staff A was also the Assistant Administrator since During an interview with the Administrator, conducted on _____ at 02:55pm, the Administrator agreed that he and Staff A did not obtain a negative _____ from a health care provider annually as required. Class III	A 078		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 16-25 212 26-35 253 36-45 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 079	Continued From page 13 beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and () and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 079	Continued From page 14 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 079	Continued From page 15 agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 079	Continued From page 16 services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to maintain the required staffing levels to provide supervision to meet residents' needs for nine residents admitted to the facility. Findings Included: During observations, conducted on from 09:45am through 03:00pm, the Administrator did not provide Residents #1, #4, and #5 with medications. There were no scheduled activities offered to residents. The office area was disorganized and cluttered with paperwork, binders, unfiled documents, and piles of mail on a large table from current and former residents. Resident #1's bed was not made, and the room needed some light housekeeping which included dusting. Resident #2's room had dust accumulation. Resident #3's bed was not made. There was dust accumulation throughout the facility on counter, baseboards, and windowsills. During an interview with Resident #1, conducted on at 10:15am, Resident #1 stated that he watches television but there were no group activities in the facility. Resident #1 stated that the Administrator does not clean but Staff A does. During an interview with Resident #2, conducted on at 10:20am, Resident #2 stated that she like to read and write but that the facility	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 079	Continued From page 17 did not provide group activities. Resident #2 stated that the Administrator does not clean but Staff A does. During an interview with Resident #4, conducted on _____ at 10:40am, Resident #4 stated that the facility did not offer group activities. During an interview with Resident #3, conducted on _____ at 10:36am, Resident #3 stated that he watches television and uses his in-room work out bench but the facility did not offer group activities. A review of the of the posted activity calendar , conducted on _____ , revealed that it was unclear if this was a current activity calendar. A review of the facility's background screening employee roster, conducted on _____ , revealed that the employee status was not updated within ten-business days of termination for former employees Staff B, C, and D. A record review for the Administrator, conducted on _____ , revealed that the Administrator did not have an eligible level 2 background screening, or a signed attestation of compliance every five years as required. The Administrator did obtain a negative _____ statement annually from a health care provider. A record review for Staff A, conducted on _____ , revealed that Staff A did not have a signed attestation of compliance or a yearly negative _____ statement annually from a health care provider.	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 18 A review of the comprehensive emergency management plan, conducted on _____, revealed that the facility did not have an approved emergency management plan. A review the facility's visitation policy and procedures, conducted on _____, revealed that the facility did not have a visitation policy allowing visitors into the facility. A review of Residents #1, #2, #3, #4, #5, #6, #7, #8, and #9's medication observation records, conducted on _____, revealed that staff did not update Residents #1, #2, #3, #4, #5, #6, #7, #8, and #9's medication observation records immediately when medications were offered to the residents. The facility did not document Resident #1's refusals of medications on the resident's medication observation records. There were medications that were not documented as given to Residents #1, #5, #8, and #9. There were medications that were documented as given to Residents #2, #3, #4, #6, and #7 although the dates and times had not occurred. Residents #1, #4, #5, and #9 did not receive their medications as prescribed by their primary care providers. A record review for Residents #1 and #5's, conducted on _____, revealed that the facility did not obtain new health assessments and signed contracts upon the residents' admission to the facility. The facility failed to obtain an elopement risk assessment and _____ semi-annually for Resident #5. A review of the facility's staffing levels, conducted on _____, revealed that there were two employees for the facility, the Administrator and	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 079	Continued From page 19 Staff A. There were nine in-house residents. The minimum required staffing levels were 212-direct care staffing hours per week. The Administrator and/or Staff A provided 168-hours per week. There was a lack of 44-direct care staffing hours. During an interview with Staff A (Assistant Administrator), conducted on _____ at 12:16pm, Staff A stated that she comes to the facility as needed and usually it was once or twice per week so that the Administrator can run errands. Staff A stated that the last time she was at the facility was on _____. Staff A stated that the facility did not provide activities because the residents liked to watch television. Staff A stated that the facility used to have vendors that came in and provided different activities but only a few residents would show up so the facility purchased cable television instead of activities. Staff A stated that the facility had major issues with staffing since the start of COVID-19. During an interview with the Administrator, conducted on _____ from 09:30am through 02:58pm, the Administrator stated that he had Staff A were the only employees at the facility. The Administrator stated that there were no residents that received their medications during the day and only provided medications at 08:00am and 08:00pm. The Administrator agreed that Residents #1 and #5 did not have signed contracts with the facility. The Administrator agreed that the visitation policy and procedures was for a closed sister facility and not for the facility. The Administrator stated that there was no other visitation policy and procedures since _____. The Administrator agreed that the facility's employee roster was not up to date and stated that Staff B, C, and D no	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 079	Continued From page 20 longer worked at the facility and had not worked there for a long time. The Administrator agreed that his level 2 background screening had expired on . The Administrator agreed that his attestation of compliance was signed greater than five years ago and that Staff A did not have a signed attestation of compliance. The Administrator agreed that he and Staff A did not obtain a negative from a health care provider annually as required. The Administrator agreed that the facility had not submitted the requested documents to the local emergency management office. The Administrator agreed that he did not notify or document Resident #1's medication refusals. The Administrator stated that he signed Residents #2, #3, #4, #6, and #7 MORs early so that he did not forget to sign them. The Administrator agreed that Residents #1, #5, #8, and #9 had medications that were not documented as given. The Administrator stated that he knew that medications were supposed to be signed at the time they were offered to residents. The Administrator agreed that there were no orders for direction changes for Resident #1, #4, #5, and #9 and agreed that he was not providing the residents' medications as prescribed. The Administrator agreed that Resident #5 did not have documented semi-annually. The Administrator agreed that Residents #1 and #5 did not have signed contracts with the facility or new 1823s assessments upon admission to the facility. The Administrator agreed that the facility did not provide the minimum staffing levels and stated that he was unable to get staffing. Class III	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
A 162 A 162 SS=D	Continued From page 21 59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily	A 162 A 162	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 162	Continued From page 22 living must have their ✓ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , (), CF-ES 1006, , , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004 . The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 23 documentation from the Department of Children and Families. (m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 24 (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain _____ records for residents that required assistance with activities of daily living semi-annually. Additionally, the facility failed to obtain a new health assessment (1823) within thirty days of admission. Furthermore, the facility failed to have a contract signed by residents for two Residents (#1 and #5) of two sampled residents. Findings Included: A record review for Resident #1, conducted on _____, revealed that Resident #1's most recent 1823 dated _____ had no telephone number or address of the Examiner. Resident #1 was admitted to the facility on _____. Resident #1 had a signed contract from the facility where he was admitted from but no signed contract for this facility. A record review for Resident #5, conducted on _____, revealed that Resident #5's most recent 1823 dated _____ was documented on the _____ form and had no elopement assessment. According to Resident #5's 1823, the resident required assistance with bathing, _____, and grooming. Resident #1 and one _____ documented in his record on _____. There were no other _____ found or provided for	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2022
NAME OF PROVIDER OR SUPPLIER RAINBOW MANOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RAINBOW DRIVE CLEARWATER, FL 33765			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 162	Continued From page 25 Resident #5. Resident #5 was admitted on . Resident #5 had a signed contract from the facility where he was admitted from but no signed contract for this facility. During an interview with the Administrator, conducted on from 01:46pm through 02:45pm, the Administrator agreed that Resident #5 did not have documented semi-annually. The Administrator agreed that Residents #1 and #5 did not have signed contracts with the facility or new 1823s assessments upon admission to the facility. Class III	A 162			