

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 05/02/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965432	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER RAINBOW GARDENS ALF #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 NE 182 STREET MIAMI, FL 33162	

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

0000 Initial Comments

An Abbreviated Biennial 2nd Revisit was conducted on 05/22, 2016 and concluded on 05/28, 2016. Rainbow Gardens ALF #2 had a deficiency identified at time of the survey.

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appoint a separate manager for each facility.

Findings included:

Review of the health finder website revealed Staff B was the Manager of another facility. Internet search through the health finder website found Staff B is the manager of a home health agency.

Interview with Administrator via phone on 05/25/2016 at 11:00 AM stated, "I can add my son he has registered to take the Core test soon."

Uncorrected Class III



RICK SCOTT
GOVERNOR
ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Rainbow Gardens Alf #2
1801 Ne 182 Street
Miami, FL 33162

Dear Administrator:

This letter reports the findings of a **second** Abbreviated Biennial Licensure Revisit Survey concluded on 12/28, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than 1, 2016.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

YOSF



STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11965432	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
Y1	Y2	Y3
NAME OF FACILITY RAINBOW GARDENS ALF #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 NE 182 STREET MIAMI, FL 33162

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0010	Correction	ID Prefix A0030	Correction	ID Prefix A0079	Correction
Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC	Completed	Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS	Completed	Reg. # 58A-5.019(3) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0093	Correction	ID Prefix A0160	Correction	ID Prefix AZ815	Correction
Reg. # 58A-5.020(2) FAC	Completed	Reg. # 58A-5.024(1) FAC	Completed	Reg. # 408.809, 435.02(2), 435.06	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>er</i>	DATE 5/2/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/22/2015		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		