STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965407	**12/07/2016**
NAME OF PROVIDER OR SUPPLIER **RAINBOW MANOR,INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **2075 RAINBOW DRIVE CLEARWATER, FL 33765**	

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

0000 - Initial Comments

Assisted Living Facility

On 12/7/16, a change of ownership (CHOW) state licensure survey was conducted at Rainbow Manor ALF (Lic. #9781). Rainbow Manor, Inc., Assisted Living Facility, had deficiencies identified at the time of the visit.

0003 - Licensure - Change of Ownership (CHOW) - 58A-5.014 FAC

Based on record review and interview, the transferee had not notified six of six residents sampled (#1-6) in writing of the manner in which he was holding their funds, stating the name and address of the depository where their funds were being held, the amount held, and the type of funds credited.

Findings included:

Although administrative documentation review found evidence of an internal bookkeeping system tracking resident funds/other monies having been transferred from the seller to the new owner as of mid- , 2016, further review revealed no formal notification having been issued to any of the facility's six (6) residents identifying what financial institution the new owner was using to hold these funds and in what amounts, etc. Interview with the administrator/owner at 10am on indicated that "he had not formally told any of his residents what bank he was utilizing or any other specifics about their individual accounts."

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, three of three staff sampled (A-C) had not submitted a written statement from a health care provider (physician; ARNP; physician's assistant) within the last 6 months verifying they were free from signs/symptoms of communicable within 30 days of employment, while their ( ) screenings were either expired or hadn't been taken.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965407	12/07/2016
NAME OF PROVIDER OR SUPPLIER **RAINBOW MANOR,INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **2075 RAINBOW DRIVE** **CLEARWATER, FL 33765**	

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

Findings included:

A personnel file review during the / survey revealed that there were no statements attesting to freedom from signs and symptoms from communicable signed off by a health care provider conducted within the last 6 months for Staff A-C (hired , , and , respectively. Further review of these files indicated that although Staff A had a screening, it had expired , while the assessment for Staff B had expired / . Finally, there was no evaluation available for Staff C. Interview with the administrator at 2:25pm on provided no clarification regarding these discrepancies.

Class III

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

Based on record review and interview, one of two direct care staff sampled (C) who had been employed at least 30 days had not received all the required training.

Findings included:

A personnel file review during the survey indicated that Staff C (hired) had not yet taken the following trainings: a) the 1 hr. training in the facility's resident elopement policies and procedures; b) the 1 hr. in-service on the reporting of major and adverse incidents, as well as the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation; and c) a 1 hr. training on resident rights in an assisted living facility and recognizing and reporting resident , neglect and . Interview with the administrator at 2:40pm on provided no clarification other than believing Staff C's RN training would meet most of these requirements.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and interview, the facility failed to comply with all minimum dietary requirements with respect to the posting of its menu and the maintenance of a sufficient 3-day disaster food supply.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965407	12/07/2016
NAME OF PROVIDER OR SUPPLIER **RAINBOW MANOR,INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **2075 RAINBOW DRIVE** **CLEARWATER, FL 33765**	

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

Findings included:

During the facility tour conducted between 10:20am and 10:50am on , as well as throughout the duration of the survey, the facility menu was noted to be posted on the refrigerator in the kitchen and nowhere else on the premises. Interview with the administrator at 11:25am on indicated that residents were not allowed in the kitchen area.

Observation of the facility's 3-day emergency food supply at 2pm on found no non-perishable fruit and no non-perishable dairy foodstuffs on hand. Interview with the administrator at this time revealed that "he used up most of what he had in his disaster supply and hadn't replenished it yet. He stated further that he thought it wasn't as important due to the hurricane season being over, etc."

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Rainbow Manor, Inc.
2075 Rainbow Drive
Clearwater, FL 33765

Dear Administrator:

This letter reports the findings of a change of ownership (CHOW) state licensure survey that was conducted on , 2016, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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.

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

XG90