STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964521	**02/17/2017**
NAME OF PROVIDER OR SUPPLIER **RAINBOW PLACE, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **522 SOUTH RAINBOW DRIVE** **HOLLYWOOD, FL 33021**	

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

0000 - Initial Comments

An unannounced monitoring visit was conducted at Rainbow Place, Inc Assisted Living Facility from . . . . . to . . . . . . The facility had deficiencies found at the time of this survey.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to have a signed and completed health assessment to assist in the determination of the appropriateness of a resident's admission and continued stay in the facility for 1 out of 5 sampled residents (Resident #5). Specifically, the facility failed to receive clear directions from the physician on whether Resident #5 needed assistance with self-administration of medications or needed medication administration.

Findings include:

A review of Resident #5's health assessment, dated , indicated that the resident needed help with taking their medications. In Resident #5's health assessment, the checkboxes for 'needs assistance with self-administration of medications' and 'needs medication administration' were both marked. There were no additional comments described by the physician to clarify the individual's need for medication administration.

In an interview with the Assistant Administrator on at 10:50 AM, she stated that she did not follow-up with Resident #5's physician to clarify whether the resident needed assistance with self-administration of medications or needed medication administration. At this time, the assistant administrator stated that the facility provides assistance with self-administration of medications for Resident #5 and that Resident #5 does not receive medication administration from an employee at the facility or from a third-party provider.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review and interview, the facility failed to use bed rails, for 3 out of 4 residents (Residents #1, 2 and 3) without the residents' choices and without review by the residents' physicians.

The findings are:

In an observation on from 10:15AM to 10:25AM, Residents #1, 2 and 3's beds had full side rails

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installed on them. Review of the facility records indicated that Residents #1, 2 and 3 were admitted to the facility on , and respectively. Further review of each of the residents' records indicated that their physicians did not review their individual use or installation of side bed rails on their beds.

In an interview with the Assistant Administrator on at 10:30am, she stated that none of Residents #1, 2 or 3's physicians had reviewed each resident's individual needs to have side bed rails installed on their beds and that none of the residents had a clinical need to have beds with side rails. She stated at this time that none of the residents chose to have beds with side rails installed on the beds. She also stated at this time she was not aware if each of the residents could remove or avoid the full side rails without any assistance from the staff.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to return medications to a resident, the residents' family or the resident's guardian after the resident's stay in the facility ended, for 1 of 1 sampled discharged resident (resident #6).

Findings include:

In an observation of the medication cabinet on at 10:15 AM, a prescription bottle of for the discharged resident (Resident #6) was located in the bottom drawer of the medication cabinet.

In an interview with the nurse's aide on at 10:15 AM, she stated that the discharged resident (Resident #6) was not living at the facility when she started working at the facility in , 2017.

In an interview with the assistant administrator on at 10:35 AM, she stated, "there is no [Resident 6's name] here. I guess it is a previous resident."

A review of the admission/discharge log revealed a discharge date of for resident #6.

Class III

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

Based on interview and record review, the facility failed to have a written medication order issued and

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signed by the residents' health care provider, for 5 of 5 sampled residents (residents # 1-5).

Findings include:

A review of the residents' files and the medication observation records revealed no physician's orders for residents' #1,2,3,4 & 5. During the monitoring inspection on , the Assistant Administrator could not produce a doctor's order for Residents' # 1,2,3,4 & 5 medications.

In an interview with the Assistant Administrator on at 10:35 AM, she stated that the facility's protocol for medication orders was to receive the medications from the pharmacy or from the resident's family on intake, and to take the dosage information from the prescription label and write these instructions in the medication observation record for each resident.

Class III