STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965882	R 08/23/2016
NAME OF PROVIDER OR SUPPLIER **RAINBOW HEIGHTS HOME CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1430 NW 35 STREET** **MIAMI, FL 33142**	

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

0000 Initial Comments

A Standard Biennial Revisit Survey was conducted on 23, 2016. Rainbow Heights Home Care Inc License #10187 had the following deficiencies identified at time of the survey:

0078 Staffing Standards - Staff

Based on record review and interview the facility failed to ensure qualified staff submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable and have proof of a negative examination documented on an annual basis for one out of six (F) sampled staff.

Findings included:

Record review of staff files showed Staff F has no documentation proving she is free from signs or symptoms of communicable .

Interview on at 10:00 AM with Manager after review of her file acknowledged staff did not have the physical.

Uncorrected Class III

Z814 Background Screening Clearinghouse

Based on record review and interview the facility failed to ensure all staff member are registered through background screening clearinghouse.

Finding included:

Observations made on of the facility found the staff schedule posted on the wall in the dining six staff members listed.

Internet search on / of facility roster found Staff F was not listed.

Interview with Staff F on at 11 AM acknowledged she was not listed on the employee roster.

Unclassified

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW HEIGHTS HOME CARE INC	**1430 NW 35 STREET** **MIAMI, FL 33142**

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

Z815 Background Screening: Prohibited Offenses

Based on record review and interview the facility failed to ensure that one out of six (E) sampled staff had documentation of compliance with level 2 background screening.

Findings included:

Record review on showed that Staff E (hired / /)'s file contained no documentation of level 2 background screening after 5 years. A Internet search of Background Screening website showed " A New Screening is Required."

Interview with the Staff F on at 11:00 AM acknowledged Staff E needed an updated background screening.

Unclassified

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11965882 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW HEIGHTS HOME CARE INC	1430 NW 35 STREET MIAMI, FL 33142

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 A0080	Correction	ID Prefix A0084	Correction	ID Prefix A0160	Correction
Reg. # 429.52(1-2) FS; 58A-5.0191(1) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed	Reg. # 58A-5.024(1) FAC	Completed
LSC		LSC		LSC	
ID Prefix AZ813	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 59A-35.090(3)(c), FAC	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	
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)	DATE 9/7/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
6/28/2016	

EVENT ID: JBHQ12

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Rainbow Heights Home Care Inc
1430 Nw 35 Street
Miami, FL 33142

Dear Administrator:

This letter reports the findings of a Standard Biennial revisit survey conducted on , 2016by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

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 , 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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

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Miami, FL 33166
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