Oklahoma State Department of Health
Creating a State of Health

October 31, 2019

License Number: NH1904AL

Mr. Adam Young, Administrator
Rainbow Health Care Community And Rainbow,
111 East Washington
Bristow, OK 74010

RE: Survey Event ID: DOHI11

Dear Mr. Young:

On **September 25, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on September 25, 2019.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;

(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH1904AL	A. BUILDING: _____ B. WING _____	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW HEALTH CARE COMMUNITY AND R	111 EAST WASHINGTON BRISTOW, OK 74010

(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
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 09/24/19 to 09/25/19. Census was 11. Deficient practice was cited as follows.	C 000		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review it was determined the center's registered nurse failed to ensure blood pressure checks were done for 2 (#2 and #4) of 2 sampled residents with an order to check blood pressure prior to administering blood pressure medication. This deficient practice had the potential for more than minimal harm at a pattern. Resident #2 had a physician's order, dated 08/25/19, for Lopressor 50 milligram (mg) Give 0.5 tablet by mouth two times a day for hypertension and hold if blood pressure is less than 110/70. Resident #4 had a physician's order, dated 07/20/19, for Amlodipine-benzapril 10/20 mg one capsule daily for essential hypertension. Hold if blood pressure is less than 110/70.	C 911		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH1904AL	A. BUILDING: _____ B. WING _____	09/25/2019

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C 911	Continued From page 1 On 09/24/19 at 3:15 p.m., advanced certified medication (ACMA) #2 administered resident #2's blood pressure medication but she did not record a blood pressure before she gave the medication. At 4:20 p.m. ACMA #2 was asked if she checked resident #2's blood pressure prior to administering her pill, she stated no. At 4:25 p.m. licensed practical nurse #1 was asked why there was no record of blood pressure checks for the whole month of September, 2019 for resident #2's evening dose. She stated it should be documented on the MAR (medication administration record). Resident #2 did not have blood pressure checks recorded for 10 of 11 evening doses in August, 2019 and 24 of 24 evening doses in September, 2019. Resident #4 did not have blood pressure checks recorded for 24 of 24 evening doses in September, 2019. On 09/25/19 at 10:50 a.m., registered nurse #1 reported reviewing the medications on a monthly basis on the computer. When asked who was responsible for the paper MAR, she did not reply. LPN #1 stated it was her responsibility to ensure blood pressure results were recorded on the MAR. Policy was provided by the center that stated blood pressures would be obtained and recorded per physician's order, prior to medication administration.	C 911		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
NH1904AL	RAINBOW HEALTH CARE COMMUNITY AND RAINBOW,

Type of Survey (select all that apply)

2				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
MC 1. 41872	09/24/2019	09/25/2019	0.25	0.00	10.75	0.00	5.50	6.25
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14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

NOV 0 5 2019 jm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH1904AL	A. BUILDING: _____ B. WING _____	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW HEALTH CARE COMMUNITY AND RAINBO'	111 EAST WASHINGTON BRISTOW, OK 74010

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N 000	Initial Comments A re-licensure survey was conducted on 09/24/19 to 09/25/19. Census was 11. Deficient practice was cited as follows.	N 000		
N1442 SS=F	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center's nurse failed to validate skills for 3 (#2, #5 and #6) of 4 sampled certified medication aides (CMA's) prior to passing medications or annually. This deficient practice had the widespread potential for more than minimal harm. Findings: On 09/24/19 at 2:15 p.m. the personnel files were reviewed with the licensed practical nurse (LPN) #1. The files did not contain evidence of validation of skills for CMA #2, #5, and #6. At 2:15 p.m., LPN #1 reported the skills checks had not been done.	N1442	1) All staff skills were immediately verified via skills validation checklist. 2) Residents who reside at the assisted living have the potential to be affected. 3) A) Each new hire CMA and CNA will be observed performing duties and checked off before being allowed to work independently. B) Each CMA and CNA will be reviewed annually for continued compliance. 4) The DON and/or designee will be responsible for performing audit of new hires and existing employees. monthly x2, and reviewed at QA x 2 months This will be completed 11/08/2019	
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 09/24/19	C 000		

Oklahoma State Department of Health

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C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review it was determined the center's registered nurse failed to ensure blood pressure checks were done for 2 (#2 and #4) of 2 sampled residents with an order to check blood pressure prior to administering blood pressure medication. This deficient practice had the potential for more than minimal harm at a pattern. Resident #2 had a physician's order, dated 08/25/19, for Lopressor 50 milligram (mg) Give 0.5 tablet by mouth two times a day for hypertension and hold if blood pressure is less than 110/70. Resident #4 had a physician's order, dated 07/20/19, for Amlodipine-benzapril 10/20 mg one capsule daily for essential hypertension. Hold if blood pressure is less than 110/70.	C 911	1) A) DON immediately added clarification to MAR's to alert CMA to obtain BP before administering medication, with parameters. B) DON immediately inserviced all staff about proper medication administration and following dr's orders when administering medications related to blood pressure. 2) 7 of 11 residents have the potential to be affected. 3) DON will perform weekly audits of MAR's x 2 months, bi-monthly x 1, and randomly thereafter. 4) the DON and/or designee will be responsible for MAR audits weekly x 2 month, bi-monthly x 1, and randomly thereafter. 5) This will be complete 11/08/2019	

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Oklahoma State Department of Health
Creating a State of Health

December 23, 2019

License Number: NH1904AL

Mr. Adam Young, Administrator
Rainbow Health Care Community And Rainbow,
111 East Washington
Bristow, OK 74010

RE: Survey Event DOHI12

Dear Mr. Young:

On **December 10, 2019,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **September 25, 2019,** have now been corrected effective **November 8, 2019.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH1904AL	A BUILDING _____ B WING _____	R 12/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW HEALTH CARE COMMUNITY AND R	111 EAST WASHINGTON BRISTOW, OK 74010

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{N 000}	Initial Comments A follow up survey was completed on 12/10/19. Census was 10. All deficient practice was cleared.	{N 000}		
{C 000}	INITIAL COMMENTS A follow up survey was completed on 12/10/19. Census was 10. All deficient practice was cleared.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
NH1904AL	RAINBOW HEALTH CARE COMMUNITY AND RAINBOW,

Type of Survey (select all that apply)

2 D

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
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E Initial Certification
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I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

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Team Leader ID 1. 41872	12/10/2019	12/10/2019	0.50	0.00	1.00	0.00	2.00	0.50
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Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**