

Delivery via email to: BMay@mgmhealthcare.com

June 21, 2023

License Number: NH1904AL

Ms. Brenda May, Administrator
Rainbow Health Care Community and Rainbow Assisted
111 East Washington
Bristow, OK 74010

RE: Survey Event ID: VFEQ11

Dear Ms. May:

On **May 26, 2023**, 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 May 26, 2023.

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) 426-8200 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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. 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,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH1904AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/26/2023
NAME OF PROVIDER OR SUPPLIER RAINBOW HEALTH CARE COMMUNITY AND RAINBO		STREET ADDRESS, CITY, STATE, ZIP CODE 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 relicensure survey was conducted from 05/25/23 through 05/26/23. Listed below are abbreviations that will be used throughout this document. ADL - activities of daily living CMA - Certified Medication Aide CMP - Comprehensive Metabolic Panel CPR - Cardiopulmonary Resuscitation CVA - cerebrovascular accident DON - Director of Nursing LPN - Licensed Practical Nurse QA - Quality Assurance RN - Registered Nurse	C 000		
C 330 SS=F	310:663-3-3(b) DESCRIPTION OF SERVICES (b) The assisted living center's description of its services shall be included in the assisted living center's application for license and the resident service contract. This Rule is not met as evidenced by: Based on record review and interview, the center failed to include provisions for evacuation of the building in the resident service contracts for six (#1, 2, 3, 4, 5, and #6) of six sampled residents. The DON identified 11 residents who resided in the center.	C 330		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 330	Continued From page 1 Findings: A review of Resident #1 through #6's contract revealed the agreements did not contain the required description of the provisions for evacuation of the building and the staff to meet the evacuation needs. On 05/26/23 at 1:02 p.m., the DON stated the provisions for evacuation of the building structure and staff to meet the evacuation needs of residents was not described in the contract.	C 330		
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 observation, record review, and	C 911		

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C 911	Continued From page 2 interview, the center failed to ensure insulin was prepared for administration at the correct time and by qualified staff for three (#2, 5 and #8) of three sampled residents who were reviewed for insulin. The "Assisted Living Resident Condition and Care Overview" report, dated 05/25/23 documented three residents received injections. Findings: The center's undated "Medication Labeling, Packaging and Storage" policy, read in part, "...The same individual that prepared the medication must administer it as well..." A review of CMA #1 and CMA #4's personnel files revealed they had not been certified for insulin administration. CMA #1's medication skill's checklist, dated 12/20/22 and 01/09/23, documented CMA #1 had not been checked off for insulin administration. The skills checklist documented the residents self administered their insulin. CMA #4's medication skill's checklist, dated 05/08/23 and 05/09/23, documented CMA #4 had not been checked off for insulin administration. The skills checklist documented the residents self administered their insulin. 1. Resident #2 had diagnoses which included diabetes A physician's order, dated 07/07/22, read in parts, "...Lantus [long acting insulin]...Pen-injector...Inject 20 unit subcutaneously at bedtime related to TYPE 2	C 911		

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C 911	Continued From page 3 DIABETES..." A physician's order, dated 02/22/23 documented to administer Humalog Pen Injector (fast-acting/short acting insulin can cover insulin needs for meals eaten within 30 minutes after injection) six units subcutaneously before meals related to DM type II. On 05/25/23 at 3:12 p.m., CMA #4 was observed as they prepared Resident #2's insulin. CMA #4 placed the needle on the Humalog insulin pen and dialed the dose to six units. CMA #4 gave the insulin pen to Resident #2 to inject. CMA #4 removed the needle and disposed of the needle in the sharps container. On 05/25/23 between approximately 4:45 and 5:00 p.m. the intercom announced the evening meal was being served in the dining room. The short/fast acting Humalog had been prepared for Resident #2 to administer at 3:12 p.m. the evening meal was served at approximately 4:45 p.m. Resident #2 administered the Humalog prepared by the staff approximately one hour and 32 minutes before the evening meal was served. 2. Resident #5 had diagnoses which included diabetes A physician's order, dated 02/22/23 documented to administer Tresiba (A long acting insulin) FlexTouch 64 units in the morning related to DM type II. A physician's order, dated 05/26/23, read in parts, "...NovoLOG [fast-acting insulin] PenFill Solution...Inject 10 unit...three times a	C 911		

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C 911	Continued From page 4 day...MAKE SURE TO GIVE WITH MEALS DO NOT DEVIATE..." On 05/26/23 at 11:10 a.m., Resident #5 reported their blood sugar was 270. CMA #1 placed the needle on the Novolog insulin pen and dialed the dose of 10 units for Resident #5 and handed the resident the insulin. The Humolog was not administered with the meal as ordered. On 05/26/23 at 11:10 a.m., Resident #5 stated there had been a time when a newly hired CMA had attempted to give them the wrong insulin to administer. They stated they told the staff member it was wrong kind of insulin. 3. Resident #8 had diagnoses which included diabetes A physician's order, dated 10/21/22, read in parts, "...Lantus [long acting insulin]...Inject 30 unit subcutaneously in the morning..." A physician's order, dated 10/24/22, read in parts, "...NovoLIN R Flex Pen-injector...Inject as per sliding scale...subcutaneously as needed..." On 05/25/23 at 4:20 p.m., Resident #8 reported their blood sugar was 237. CMA #4 stated the resident required two units of insulin per the sliding scale. CMA #4 prepared the Novolin insulin pens. CMA #4 placed the needle on the insulin pen and dialed the dose to one unit. The CMA dialed the second Novolin pen to one unit. CMA #4 stated they had prepared two different Novolin insulin pens for the resident to give the insulin because there was not enough insulin in the opened Novolin pen to administer the ordered	C 911		

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C 911	Continued From page 5 two units. On 05/26/23 at 11:36 a.m., CMA #4 was asked about the insulin pens. They stated the DON had shown them how to prepare them for the residents. CMA #4 stated they prepared the doses of insulin for the residents but did not administer the insulin. CMA #4 was asked if they had any knowledge of the different types of insulin. They stated, "Not really." CMA #4 stated they knew Lantus was a long acting insulin and Novolog was short acting. CMA #4 stated they used to have advanced certification for glucose monitoring but did not currently have an advanced certifications for insulin or glucose. On 05/26/23 at 12:29 p.m., CMA #1 was asked about the insulin pens. They stated the LPN trained them on how to prepare the insulin pens. CMA #1 was asked if they had an advanced certification for insulin administration or glucose monitoring. They stated no. On 05/26/23 at 3:20 p.m., the DON was asked about the center's procedure for insulin administration. They stated the CMA put the needle on the insulin pens and dialed the pen to the correct dose for the residents and the residents self-administered the insulin. The DON was asked if the CMAs had been trained in insulin types, handling needles, and using an insulin pen. They stated yes. The DON was asked for the documentation. They stated it was verbal training and there was no documentation. The DON was asked if CMA #1 and CMA #4 had advanced certifications for insulin administration. They stated no. The DON was asked if the person who prepared the insulin was the same person who	C 911		

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C 911	Continued From page 6 administered the insulin. They stated the CMAs prepared the insulin for the residents and the residents self-administered the insulin.	C 911		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide evidence of CPR and First Aid training for three (#1, 2, and #3) of four sampled direct care aides. The DON identified four direct care aides were employed at the center. Findings: The center's "Staffing" policy, dated 01/12/10, read in parts, "...All staff of the Assisted Living shall have current certification in both First Aid and Cardio-Pulmonary Resuscitation..." A review of the personnel files for employee #1, 2, and #3 revealed there was no documentation of CPR or First Aid training. On 05/25/23 a 1:21 p.m., the DON was asked to	C 954		

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C 954	Continued From page 7 submit evidence of CPR/First Aid training for employee #1, 2, and #3. On 05/25/23 at 5:17 p.m., the DON stated they could not find evidence of CPR or First Aid training for employee #1, 2, or #3. On 05/26/23 at 4:00 p.m., the DON stated they did not have a policy for CPR/First Aid training.	C 954		
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an internal quality assurance committee monitored customer satisfaction. The DON identified 11 residents who resided at	C1110		

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C1110	Continued From page 8 the center. Findings: The Center's undated "Quality Assurance" policy, read in parts, "...Community shall establish and maintain an internal quality assurance committee...The committee shall...monitor customer satisfaction measures..." A review of the quarterly QA committee meetings for the past 12 months revealed customer satisfaction had not been documented as monitored. On 05/26/23 at 10:28 a.m., the DON stated they sent out customer satisfaction surveys. They were asked if they had any of the completed surveys. They stated no. On 05/26/23 at 11:17 a.m., the DON stated they did not have documentation customer satisfaction had been monitored.	C1110		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract.	C1304		

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C1304	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure planned programs for socialization, activities, and exercise were provided for three (#3, 5, and #9) of four sampled residents who were reviewed for activities. The DON identified 11 residents who resided in the center. Findings: Resident #3, 5, and #9's contract read in parts, "...The basic monthly rate...includes payment for...Planned programs for socializations, activities, and exercise..." On 05/25/23 from 11:15 a.m. through 5:30 p.m., no planned group activities were observed. There was not an activity calendar posted in the center. 1. Resident #3 had diagnoses which included hypertension, dementia, and chronic obstructive pulmonary disease. Resident #3's admission assessment, dated 05/15/23, documented the resident was alert, required one person assistance with bathing, independent with all other ADLs. On 05/25/23 at 3:52 p.m., Resident #3 stated they had not participated in activities since they had moved in to the center.	C1304		

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C1304	Continued From page 10 2. Resident #5 had diagnoses which included diabetes, CVA, and hypertension. Resident #5's annual assessment, dated 03/29/23, documented the resident was alert, had good judgment, required assistance of one for bathing, and was independent with all other ADLs. Resident #5's care plan for activities, dated 03/22/22, read in parts, "...The resident enjoys participating...Bingo...Movies...Bible Study...Frequency...Daily...Resident will participate in activities of interest and meet socialization needs...RESPONSIBLE PARTY...Self...Staff..." On 05/26/23 at 8:51 a.m., Resident #5 stated the center had not provided them with an activity calendar. Resident #5 was asked if the center had provided planned activities on 05/22/23 through 05/25/23. They stated, "No." 3. Resident #9 had diagnoses which included glaucoma and hypertension. An annual assessment, dated 04/14/23, documented Resident #9 was alert, confused at times, required assistance of one staff for bathing and was independent with all other ADLs. Resident #9's care plan for activities, dated 04/14/23, read in parts, "...The resident enjoys participating...Movies...Outings...Visiting...Frequency...Daily...Resident will participate in activities of interest and meet socialization needs...RESPONSIBLE PARTY...Self...Staff...Family/Sponsor...Other...TABLE MATES..." On 05/25/23 at 2:01 p.m., Resident #9 was asked	C1304		

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C1304	Continued From page 11 if the center provided planned activities. They stated not right now. They were asked if they had been provided with an activity calendar. They stated, "No.". Resident #9 stated they liked to play dominoes. On 05/26/23 at 7:33 a.m., CMA #1 stated the center did not have any planned activities for the day. CMA #1 was asked if the center had provided planned activities yesterday on 05/25/23. They stated, "No." CMA #1 stated they did not have an activities director for the assisted living. They stated the activities director worked in the nursing home. On 05/26/23 at 10:05 a.m., an activity calendar for the Month of May was observed at the front desk. CMA #1 stated CMA #4 brought the activity calendar from the nursing home that morning. On 05/26/23 at 11:17 a.m., the DON stated they did not have an activity calendar, planned programs, or an activity director for the assisted living center. On 05/26/23 at 11:37 a.m., CMA #4 stated they had brought the monthly activity calendar for May from the nursing home that morning to see if the residents wanted to go to the nursing home to participate in the activities. CMA #4 was asked if the assisted living had an activity calendar. They stated, "No." CMA #4 stated the assisted living center did not have any planned activities. CMA #4 stated the residents had not been on any outings. During the survey there were no assisted living residents observed being assisted to the nursing home for activities.	C1304		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER RAINBOW HEALTH CARE COMMUNITY AND RAINBO		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1505	Continued From page 12	C1505		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure a laboratory test was obtained per physician's orders for one (#1) of two sampled residents who were reviewed for laboratory tests. The DON identified 11 residents who resided in the center. Findings: Resident #1's physician's order, dated 07/27/22, read in part, "...CMP every 6 months in July and January..." A review of Resident #1's clinical record revealed there was no results for the CMP ordered to be drawn in January. On 05/26/23 at 3:50 p.m., the DON stated they did not have the results of the CMP. They stated the CMP had not been drawn.	C1505		
C5010 SS=D	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act.	C5010		

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C5010	Continued From page 14 C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure care was coordinated with home health to ensure the delivery of services for one (# 4) of two sampled residents who were reviewed for home health services. The DON identified two residents who received home health services. Findings: Resident #4 had diagnoses which included benign prostatic hyperplasia (enlargement of the prostate gland).	C5010		

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C5010	Continued From page 15 Resident #4's comprehensive assessment, dated 11/11/22, documented Resident #4 was alert, had an indwelling urinary catheter, and received home health services for indwelling catheter changes monthly. On 05/26/23 at 1:30 p.m., the DON stated Resident #4 was receiving home health services for monthly urinary catheter changes, oxygen equipment, and medication monitoring. The DON was asked when the last time Resident #4 was seen by a home health nurse. They stated they did not know. The DON was asked how they ensured home health was providing care to the resident. They stated they asked Resident #4's family. The DON was asked if they had the home health certification and plan of care for Resident #4. They stated they did not have any paperwork from the home health company. On 05/26/23 at 1:44 p.m., the branch director of the home health company was asked if Resident #4 was receiving home health services. They stated no. The branch director stated Resident #4 had been discharged from home health on 05/01/23 due to denial of insurance coverage. On 05/26/23 at 1:51 p.m., the home health RN was asked if Resident #4 was receiving home health services. They stated Resident #4 was seen on 05/01/23 for discharge from home health. The home health RN stated they had not changed Resident #4's catheter in three months. They stated it had been changed by the urologist. On 05/26/23 at 2:00 p.m., the DON was asked if Resident #4 was currently on home health services. They stated yes, if the home health	C5010		

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C5010	Continued From page 16 company had discharged the resident from services they had not notified the center. The DON was asked how the center coordinated care with home health to ensure delivery of services. They stated they were not able to coordinate care with home health because the home health nurses were not communicating with the center's staff when they made their visits. On 05/26/23 at 2:30 p.m., Resident #4 was asked if they were receiving home health. They stated no, they had been discharged from home health about three weeks ago, because insurance would not pay for the home health. Resident #4 was asked when the last time their catheter had been changed. They stated one of the nurses who worked in the nursing home on the continuum of care campus had changed it on approximately 05/09/23. On 05/26/23 at 4:00 p.m., the DON was asked for the center's policy for home health coordination of care. They stated they did not have a policy.	C5010		

Delivery via email to: BMay@mgmhealthcare.com

June 28, 2023

License Number: NH1904AL

Ms. Brenda May, Administrator
Rainbow Health Care Community And Rainbow Assisted
111 East Washington
Bristow, OK 74010

RE: Survey Event VFEQ11

Dear Ms. May:

On **May 26, 2023**, a re-licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. **Our acceptance does not absolve the facility's responsibility** for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **June 21, 2023**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 05/25/23 through 05/26/23. Listed below are abbreviations that will be used throughout this document. ADL - activities of daily living CMA - Certified Medication Aide CMP - Comprehensive Metabolic Panel CPR - Cardiopulmonary Resuscitation CVA - cerebrovascular accident DON - Director of Nursing LPN - Licensed Practical Nurse QA - Quality Assurance RN - Registered Nurse	C 000	The preparation of the following plan of correction does not constitute and should not be interpreted as the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for the deficiencies were executed solely between provision of state and federal law which requires it. 1) Immediate fix (corrective action) 2) Potential resident/s affected 3) System Changes 4) Monitoring/QAPI 5) Doc/signatures	
C 330 SS=F	310:663-3-3(b) DESCRIPTION OF SERVICES (b) The assisted living center's description of its services shall be included in the assisted living center's application for license and the resident service contract. This Rule is not met as evidenced by: Based on record review and interview, the center failed to include provisions for evacuation of the building in the resident service contracts for six (#1, 2, 3, 4, 5, and #6) of six sampled residents. The DON identified 11 residents who resided in the center.	C 330	C 330 Description of Services 1) An addendum was added to the Assisted Living Admissions Agreement on 06.13.23. Addendum included evacuation education and demographic map of facility with exits noted. Each resident was given a copy of the addendum, in-serviced and signed where appropriate. 2) All residents had the potential to be affected by deficiency. 3) Staff in-serviced on 06.13.23 on the importance of keeping Admission Agreement up to date at all times. 4) Adm./designee will monitor through facility audit tool monthly x's (3), then quarterly x's (3) to ensure ongoing compliance. 5) Date of compliance	06.21.2023

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Brenda L. May

Administrator

06-26-23

STATE FORM

8899

VFEQ11

If continuation sheet 1 of 17

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C 330	Continued From page 1 Findings: A review of Resident #1 through #6's contract revealed the agreements did not contain the required description of the provisions for evacuation of the building and the staff to meet the evacuation needs. On 05/26/23 at 1:02 p.m., the DON stated the provisions for evacuation of the building structure and staff to meet the evacuation needs of residents was not described in the contract.	C 330		
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 observation, record review, and	C 911	C 911 Nurse 1) Facility Charge Nurse will obtain blood sugars, follow all physician orders, prepare and administer all insulins. 2) (4) of (11) residents had the potential to be affected by the deficiency. 3) Staff nurses/CMA's were in-serviced 05.29.23 on insulin administration. 4) Adm./designee will monitor through facility audit tool weekly x's (4) weeks, Q2 weeks for (3) months, then randomly to ensure ongoing compliance. 5) Date of compliance	06.21.2023

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C 911	Continued From page 2 interview, the center failed to ensure insulin was prepared for administration at the correct time and by qualified staff for three (#2, 5 and #8) of three sampled residents who were reviewed for insulin. The "Assisted Living Resident Condition and Care Overview" report, dated 05/25/23 documented three residents received injections. Findings: The center's undated "Medication Labeling, Packaging and Storage" policy, read in part, "...The same individual that prepared the medication must administer it as well..." A review of CMA #1 and CMA #4's personnel files revealed they had not been certified for insulin administration. CMA #1's medication skill's checklist, dated 12/20/22 and 01/09/23, documented CMA #1 had not been checked off for insulin administration. The skills checklist documented the residents self administered their insulin. CMA #4's medication skill's checklist, dated 05/08/23 and 05/09/23, documented CMA #4 had not been checked off for insulin administration. The skills checklist documented the residents self administered their insulin. 1. Resident #2 had diagnoses which included diabetes A physician's order, dated 07/07/22, read in parts, "...Lantus [long acting insulin]...Pen-injector...Inject 20 unit subcutaneously at bedtime related to TYPE 2	C 911		

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C 911	Continued From page 3 DIABETES..." A physician's order, dated 02/22/23 documented to administer Humalog Pen Injector (fast-acting/short acting insulin can cover insulin needs for meals eaten within 30 minutes after injection) six units subcutaneously before meals related to DM type II. On 05/25/23 at 3:12 p.m., CMA #4 was observed as they prepared Resident #2's insulin. CMA #4 placed the needle on the Humalog insulin pen and dialed the dose to six units. CMA #4 gave the insulin pen to Resident #2 to inject. CMA #4 removed the needle and disposed of the needle in the sharps container. On 05/25/23 between approximately 4:45 and 5:00 p.m. the intercom announced the evening meal was being served in the dining room. The short/fast acting Humalog had been prepared for Resident #2 to administer at 3:12 p.m. the evening meal was served at approximately 4:45 p.m. Resident #2 administered the Humalog prepared by the staff approximately one hour and 32 minutes before the evening meal was served. 2. Resident #5 had diagnoses which included diabetes A physician's order, dated 02/22/23 documented to administer Tresiba (A long acting insulin) FlexTouch 64 units in the morning related to DM type II. A physician's order, dated 05/26/23, read in parts, "...NovoLOG [fast-acting insulin] PenFill Solution...Inject 10 unit...three times a	C 911		

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C 911	Continued From page 4 day...MAKE SURE TO GIVE WITH MEALS DO NOT DEVIATE..." On 05/26/23 at 11:10 a.m., Resident #5 reported their blood sugar was 270. CMA #1 placed the needle on the Novolog insulin pen and dialed the dose of 10 units for Resident #5 and handed the resident the insulin. The Humolog was not administered with the meal as ordered. On 05/26/23 at 11:10 a.m., Resident #5 stated there had been a time when a newly hired CMA had attempted to give them the wrong insulin to administer. They stated they told the staff member it was wrong kind of insulin. 3. Resident #8 had diagnoses which included diabetes A physician's order, dated 10/21/22, read in parts, "...Lantus [long acting insulin]...Inject 30 unit subcutaneously in the morning..." A physician's order, dated 10/24/22, read in parts, "...NovoLIN R Flex Pen-injector...Inject as per sliding scale...subcutaneously as needed..." On 05/25/23 at 4:20 p.m., Resident #8 reported their blood sugar was 237. CMA #4 stated the resident required two units of insulin per the sliding scale. CMA #4 prepared the Novolin insulin pens. CMA #4 placed the needle on the insulin pen and dialed the dose to one unit. The CMA dialed the second Novolin pen to one unit. CMA #4 stated they had prepared two different Novolin insulin pens for the resident to give the insulin because there was not enough insulin in the opened Novolin pen to administer the ordered	C 911		

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C 911	Continued From page 5 two units. On 05/26/23 at 11:36 a.m., CMA #4 was asked about the insulin pens. They stated the DON had shown them how to prepare them for the residents. CMA #4 stated they prepared the doses of insulin for the residents but did not administer the insulin. CMA #4 was asked if they had any knowledge of the different types of insulin. They stated, "Not really." CMA #4 stated they knew Lantus was a long acting insulin and Novolog was short acting. CMA #4 stated they used to have advanced certification for glucose monitoring but did not currently have an advanced certifications for insulin or glucose. On 05/26/23 at 12:29 p.m., CMA #1 was asked about the insulin pens. They stated the LPN trained them on how to prepare the insulin pens. CMA #1 was asked if they had an advanced certification for insulin administration or glucose monitoring. They stated no. On 05/26/23 at 3:20 p.m., the DON was asked about the center's procedure for insulin administration. They stated the CMA put the needle on the insulin pens and dialed the pen to the correct dose for the residents and the residents self-administered the insulin. The DON was asked if the CMAs had been trained in insulin types, handling needles, and using an insulin pen. They stated yes. The DON was asked for the documentation. They stated it was verbal training and there was no documentation. The DON was asked if CMA #1 and CMA #4 had advanced certifications for insulin administration. They stated no. The DON was asked if the person who prepared the insulin was the same person who	C 911		

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C 911	Continued From page 6 administered the insulin. They stated the CMAs prepared the insulin for the residents and the residents self-administered the insulin.	C 911		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide evidence of CPR and First Aid training for three (#1, 2, and #3) of four sampled direct care aides. The DON identified four direct care aides were employed at the center. Findings: The center's "Staffing" policy, dated 01/12/10, read in parts, "...All staff of the Assisted Living shall have current certification in both First Aid and Cardio-Pulmonary Resuscitation..." A review of the personnel files for employee #1, 2, and #3 revealed there was no documentation of CPR or First Aid training. On 05/25/23 a 1:21 p.m., the DON was asked to	C 954	C 954 Staff Qualifications 1) As of 06.13.2023, all staff are Certified in First Aide/CPR. A new policy has been written and added, stating all staff will be trained in CPR before working at the Assisted Living. Educational materials on First Aide/CPR will be added to employee packets. 2) All residents had the potential to be affected by the deficiency. 3) Staff was in-serviced 05.29.2023 on importance of obtaining CPR training and keeping up on certifications. 4) Adm./designee will monitor through facility audit tool monthly x's (4) quarters to ensure ongoing compliance. 5) Date of compliance	06.21.2023

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C 954	Continued From page 7 submit evidence of CPR/First Aid training for employee #1, 2, and #3. On 05/25/23 at 5:17 p.m., the DON stated they could not find evidence of CPR or First Aid training for employee #1, 2, or #3. On 05/26/23 at 4:00 p.m., the DON stated they did not have a policy for CPR/First Aid training.	C 954		
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an internal quality assurance committee monitored customer satisfaction. The DON identified 11 residents who resided at	C1110	C 1110 Quality Assurance 1) All residents were given a Customer Satisfaction Survey form. Of the eleven (11) given five (5) have been returned, at the time of this writing. 2) All residents had the potential to be affected by the deficiency. 3) Adm. in-serviced DON/SS, 05.29.2023 on importance of obtaining Customer Satisfaction Forms, reviewing info. and tracking for any trends and/or issues noted. 4) Adm./designee will monitor through facility audit tool quarterly to ensure on going compliance, and no trends and/or resident incidents. 5) Date of compliance	06.21.2023

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(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
C1110	Continued From page 8 the center. Findings: The Center's undated "Quality Assurance" policy, read in parts, "...Community shall establish and maintain an internal quality assurance committee...The committee shall...monitor customer satisfaction measures..." A review of the quarterly QA committee meetings for the past 12 months revealed customer satisfaction had not been documented as monitored. On 05/26/23 at 10:28 a.m., the DON stated they sent out customer satisfaction surveys. They were asked if they had any of the completed surveys. They stated no. On 05/26/23 at 11:17 a.m., the DON stated they did not have documentation customer satisfaction had been monitored.	C1110		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract.	C1304		

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C1304	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure planned programs for socialization, activities, and exercise were provided for three (#3, 5, and #9) of four sampled residents who were reviewed for activities. The DON identified 11 residents who resided in the center. Findings: Resident #3, 5, and #9's contract read in parts, "...The basic monthly rate...includes payment for...Planned programs for socializations, activities, and exercise..." On 05/25/23 from 11:15 a.m. through 5:30 p.m., no planned group activities were observed. There was not an activity calendar posted in the center. 1. Resident #3 had diagnoses which included hypertension, dementia, and chronic obstructive pulmonary disease. Resident #3's admission assessment, dated 05/15/23, documented the resident was alert, required one person assistance with bathing, independent with all other ADLs. On 05/25/23 at 3:52 p.m., Resident #3 stated they had not participated in activities since they had moved in to the center.	C1304	C 1304 Resident Service Contract 1) A monthly activity calendar will be provided to each resident at the beginning of each new month. Calendar will also be posted in common area. This calendar will have the next months planned activities noted for each day. 2) All residents had the potential to be affected by the deficiency. 3) Adm. in-serviced DON/Activity Director on 05.29.2023 on importance of having planned activities written on a monthly calendar, given to each resident timely, and calendar posted in area for residents and visitors to view. 4) Adm./designed will monitor through facility audit tool monthly x's (3) then quarterly x's (3) to ensure ongoing compliance. 5) Date of compliance	06.21.12023

Oklahoma State Department of Health

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C1304	Continued From page 10 2. Resident #5 had diagnoses which included diabetes, CVA, and hypertension. Resident #5's annual assessment, dated 03/29/23, documented the resident was alert, had good judgment, required assistance of one for bathing, and was independent with all other ADLs. Resident #5's care plan for activities, dated 03/22/22, read in parts, "...The resident enjoys participating...Bingo...Movies...Bible Study...Frequency...Daily...Resident will participate in activities of interest and meet socialization needs...RESPONSIBLE PARTY...Self...Staff..." On 05/26/23 at 8:51 a.m., Resident #5 stated the center had not provided them with an activity calendar. Resident #5 was asked if the center had provided planned activities on 05/22/23 through 05/25/23. They stated, "No." 3. Resident #9 had diagnoses which included glaucoma and hypertension. An annual assessment, dated 04/14/23, documented Resident #9 was alert, confused at times, required assistance of one staff for bathing and was independent with all other ADLs. Resident #9's care plan for activities, dated 04/14/23, read in parts, "...The resident enjoys participating...Movies...Outings...Visiting...Frequency...Daily...Resident will participate in activities of interest and meet socialization needs...RESPONSIBLE PARTY...Self...Staff...Family/Sponsor...Other...TABLE MATES..." On 05/25/23 at 2:01 p.m., Resident #9 was asked	C1304		

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C1304	Continued From page 11 if the center provided planned activities. They stated not right now. They were asked if they had been provided with an activity calendar. They stated, "No.". Resident #9 stated they liked to play dominoes. On 05/26/23 at 7:33 a.m., CMA #1 stated the center did not have any planned activities for the day. CMA #1 was asked if the center had provided planned activities yesterday on 05/25/23. They stated, "No." CMA #1 stated they did not have an activities director for the assisted living. They stated the activities director worked in the nursing home. On 05/26/23 at 10:05 a.m., an activity calendar for the Month of May was observed at the front desk. CMA #1 stated CMA #4 brought the activity calendar from the nursing home that morning. On 05/26/23 at 11:17 a.m., the DON stated they did not have an activity calendar, planned programs, or an activity director for the assisted living center. On 05/26/23 at 11:37 a.m., CMA #4 stated they had brought the monthly activity calendar for May from the nursing home that morning to see if the residents wanted to go to the nursing home to participate in the activities. CMA #4 was asked if the assisted living had an activity calendar. They stated, "No." CMA #4 stated the assisted living center did not have any planned activities. CMA #4 stated the residents had not been on any outings. During the survey there were no assisted living residents observed being assisted to the nursing home for activities.	C1304		

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C1505	Continued From page 12	C1505		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505	C 1505 Resident Rights- Medical Care 1) Resident #1, had lab drawn on 05.30.23. Any new physician orders will be followed as ordered and noted in residents' medical chart. 2) All residents had the potential to be affected by the deficiency. 3) Adm. in-serviced DON on 05.29.2023 on importance of falling all physician orders. 4) Adm./designee will monitor through facility audit tool monthly x's (3) then quarterly x's (3) to ensure ongoing compliance. 5) Date of compliance	06.21.2023

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C1505	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure a laboratory test was obtained per physician's orders for one (#1) of two sampled residents who were reviewed for laboratory tests. The DON identified 11 residents who resided in the center. Findings: Resident #1's physician's order, dated 07/27/22, read in part, "...CMP every 6 months in July and January..." A review of Resident #1's clinical record revealed there was no results for the CMP ordered to be drawn in January. On 05/26/23 at 3:50 p.m., the DON stated they did not have the results of the CMP. They stated the CMP had not been drawn.	C1505		
C5010 SS=D	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act.	C5010		

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C5010	Continued From page 14 C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure care was coordinated with home health to ensure the delivery of services for one (# 4) of two sampled residents who were reviewed for home health services. The DON identified two residents who received home health services. Findings: Resident #4 had diagnoses which included benign prostatic hyperplasia (enlargement of the prostate gland).	C5010	C5010 <u>Care Services / Coordination of Care</u> 1) Facility created a communication form to be completed by Home Health Aide and/or Home Health Nurse each time they make a visit to facility to see a resident. Home Health will also check into the facility at front desk to sign in and out at each visit time. 2) All residents had the potential to be affected by the deficiency. 3) Adm. in-serviced staff on 05.29.23 on importance of obtaining Home Health signatures and ensuring communication forms are completed at each visit. 4) Adm./designee will monitor through facility audit tool monthly x's (3) then quarterly x's (3) to ensure ongoing compliance. 5) Date of compliance	06.21.2023

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C5010	Continued From page 15 Resident #4's comprehensive assessment, dated 11/11/22, documented Resident #4 was alert, had an indwelling urinary catheter, and received home health services for indwelling catheter changes monthly. On 05/26/23 at 1:30 p.m., the DON stated Resident #4 was receiving home health services for monthly urinary catheter changes, oxygen equipment, and medication monitoring. The DON was asked when the last time Resident #4 was seen by a home health nurse. They stated they did not know. The DON was asked how they ensured home health was providing care to the resident. They stated they asked Resident #4's family. The DON was asked if they had the home health certification and plan of care for Resident #4. They stated they did not have any paperwork from the home health company. On 05/26/23 at 1:44 p.m., the branch director of the home health company was asked if Resident #4 was receiving home health services. They stated no. The branch director stated Resident #4 had been discharged from home health on 05/01/23 due to denial of insurance coverage. On 05/26/23 at 1:51 p.m., the home health RN was asked if Resident #4 was receiving home health services. They stated Resident #4 was seen on 05/01/23 for discharge from home health. The home health RN stated they had not changed Resident #4's catheter in three months. They stated it had been changed by the urologist. On 05/26/23 at 2:00 p.m., the DON was asked if Resident #4 was currently on home health services. They stated yes, if the home health	C5010		

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C5010	Continued From page 16 company had discharged the resident from services they had not notified the center. The DON was asked how the center coordinated care with home health to ensure delivery of services. They stated they were not able to coordinate care with home health because the home health nurses were not communicating with the center's staff when they made their visits. On 05/26/23 at 2:30 p.m., Resident #4 was asked if they were receiving home health. They stated no, they had been discharged from home health about three weeks ago, because insurance would not pay for the home health. Resident #4 was asked when the last time their catheter had been changed. They stated one of the nurses who worked in the nursing home on the continuum of care campus had changed it on approximately 05/09/23. On 05/26/23 at 4:00 p.m., the DON was asked for the center's policy for home health coordination of care. They stated they did not have a policy.	C5010		



Delivery via email to: Bmay@mgmhealthcare.com

July 20, 2023

License Number: NH1904AL

Ms. Brenda May, Administrator
Rainbow Health Care Community And Rainbow Assisted
111 East Washington
Bristow, OK 74010

RE: Survey Event VFEQ12

Dear Ms. May:

On **July 17, 2023**, an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 26, 2023**, have now been corrected effective **June 21, 2023**.

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Sincerely,

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 07/17/23. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE