

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 11/18/2025
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 11/17/25 through 11/18/25. No deficiencies were cited. Facility Census: 15	C 000		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Delivery via email to: ryan.alsup@mgmhealthcare.com

November 20, 2025

License Number: NH1904AL

Mr. Ryan Alsup, Administrator
Rainbow Health Care Community And Rainbow Assisted
111 East Washington
Bristow, OK 74010

RE: Survey Event ID: FOI411

Dear Mr. Alsup:

Enclosed is a report of the inspection conducted at your Assisted Living Center on **November 18, 2025**. No deficiencies were cited. Oklahoma Statutes 63-1-1910 require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Respectfully,



Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure