

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/12/2024
NAME OF PROVIDER OR SUPPLIER  Rainbow Health Care Community and Rainbow Assisted		STREET ADDRESS, CITY, STATE, ZIP CODE  111 East Washington Bristow, OK 74010	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35749</p> <p>On 11/07/24, an IJ situation was determined to exist related to the facilities failure to ensure staff were aware of proper transportation after a resident slid out of a wheelchair during a transport. On 10/29/24, Resident #3 came out of their wheelchair during a transport from the hospital to the facility when the facility driver had to slam on the brakes. CNA #1 and transport driver #1 where unable to lift Resident #3 back into the wheelchair. This resulted in Resident #3 riding approximately 30 miles on the floor of the transport van.</p> <p>On 11/07/24 at 1:20 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.</p> <p>On 11/07/24 at 1:30 p.m., the administrator was notified of the IJ situation and the IJ template was provided.</p> <p>On 11/08/24 at 10:29 a.m., an acceptable plan of removal was provided. The plan of removal documented:</p> <p>There is the potential for serious harm, impairment, or death if the transportation vehicle is involved in an accident.</p> <p>Current driver training acknowledgment will be updated to include 'van will not operate unless resident is safely secured according to the proper van seatbelt instructions.'</p> <p>Current staff members assigned as van drivers and CNAs to accompany residents while being transported were educated on 11.7.24 by administration r/t actions to be taken in the event of a resident incident or van incident. In the event of a resident incident, get to a safe place and immediately call 911. Stay in place until 911 arrives. Do not operate the van until resident has been assessed by 911 with no injuries noted and can continue with transport after properly secured. If resident requires first aide, treat with supplies in first aide kit until 911 arrives. Ensure administrator is contacted or DON if admin not available.</p> <p>Also included in education if van breaks down, proceed to a safe place, ensure resident is safe and immediately reach out to facility administrator who will provide direction.</p> <p>DON was educated on 11.7.2024 by the Regional Director of Operations on the same as above.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The AD was asked who transported Resident #3 from the hospital. They stated they and CNA #1 had. The AD stated CNA #1 had loaded the resident in the van, secured the wheelchair with four straps, and placed the lap belt on the resident. They stated the shoulder strap did not work. The AD stated when they were getting on the on ramp to the turnpike, a few vehicles in front of them hit their brakes and they had to do the same. The AD stated when they hit the brakes Resident #3 slid out of their wheelchair onto the van floor. They stated they drove to the service road and found a place to park. The AD stated Resident #3 sustained a skin tear to their left elbow. The AD stated they and CNA #1 were unable to get the resident off of the floor and back into the wheelchair.</p> <p>The AD stated they spoke to the DON on the phone and were instructed to make Resident #3 comfortable and to drive back to the facility as carefully as they could. The AD stated the ride was around 25 to 30 minutes on the turnpike. They stated they thought they should have called 911 to see if they could help get Resident #3 back in their wheelchair. The AD stated they thought the shoulder strap may have helped keep the resident in the wheelchair.</p> <p>On 11/06/24 at 12:40 p.m., an observation of the facility transport van was made with the AD. There was no shoulder strap located in the vehicle. The AD stated it was not there during the transport for Resident #3.</p> <p>On 11/06/24 at 1:17 p.m., CNA #1 stated they there was no shoulder strap in the facility transport van when Resident #3 had been transported. CNA #1 stated they had asked the DON if they should call 911 for help after Resident #1 slid out of their wheelchair. They stated the DON instructed them to make the resident as comfortable as possible, since they were not injured, and to bring the resident to the facility.</p> <p>On 11/06/24 at 1:36 p.m., the DON stated all staff who go on transports have had to watch a video, take a quiz, and do a return demonstration to ensure they know how to secure a resident sitting in a wheelchair in the transport vans. The DON was asked how they ensured safe transports. They stated with a lap belt and shoulder straps. The DON was asked how Resident #3 was kept safe during the transport when they rode approximately 30 miles on the van floor. The DON stated they instructed the staff to make Resident #3 as comfortable as possible and return to the facility.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>35749</p> <p>Based on observation, record review, and interview, the facility failed to ensure proper handwashing was conducted during incontinent care, between residents, and/or a roll gauze that was dropped on the floor was not used to perform a treatment for seven (#1, 2, 5, 6, 7, 8, and #9) of seven sampled residents observed for infection control.</p> <p>The charge nurse identified 70 residents resided in the facility.</p> <p>Findings:</p> <p>A Hand Hygiene policy, dated 04/28/22, documented hand hygiene should be performed before and after providing care, before and after applying and removing gloves, and after handling soiled linens. It documented staff could use alcohol based hand rub if their hands were not visibly soiled.</p> <p>An Incontinent Care policy, dated 07/21/22, read in part, Perform Hand Hygiene and Apply Gloves .Remove Soiled Brief .Cleanse Perineal Area .Remove Soiled Gloves, Perform Hand Hygiene &amp; Apply Clean Gloves . Apply Clean Brief &amp; Clothing .Discard Contaminated Items .Remove Gloves &amp; Perform Hand Hygiene</p> <p>On 11/05/24 at 10:11 p.m., CNA #2 was observed touching Resident #5's incontinent brief with bare hands to determine if it was soiled. They did not wash their hands or use alcohol rub.</p> <p>On 11/05/24 at 10:15 p.m., CNA #2 was observed to apply gloves and provide incontinent care to Resident #6. They did not wash hands or use alcohol rub prior to or after providing incontinent care. They did not remove their soiled gloves prior to touching the bed control and repositioning the resident.</p> <p>On 11/05/24 at 10:24 p.m., CNA #2 was observed taking Resident #7's head phones to adjust the volume with soiled hands.</p> <p>On 11/05/24 at 10:30 p.m., CNA #2 was observed to touch Resident #9's incontinent brief with their bare hands to determine if it was soiled. They did not wash their hands or use alcohol rub.</p> <p>On 11/05/24 at 10:32 p.m., CNA #2 was observed to touch Resident #8's incontinent brief with their bare hands to determine if it was soiled. They did not wash their hands or use alcohol rub.</p> <p>On 11/05/24 at 10:33 p.m., Resident #2 asked CNA #2 for denture tablets. CNA #2 went to the supply room, picked up a packet of denture tablets, and then gave them to Resident #2.</p> <p>On 11/05/24 at 10:44 p.m., LPN #1 was observed providing wound care to Resident #1's right lower leg while CNA #2 held the leg up. LPN #1 was wrapping the leg with roll gauze, dropped it on the floor, CNA #2 picked the roll gauze up, handed it to the LPN, and LPN #2 continued wrapping the leg with the soiled roll gauze.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/06/24 at 8:50 p.m., CNA #2 was asked what the policy was for providing perineal care and handwashing. They stated to gather supplies, provide care, and remove gloves. CNA #2 stated they did not use alcohol rub because it made their hands too dry. They stated they wash their hands after removing gloves. CNA #2 stated they wash their hands when they get to work, before they leave work, prior to feeding a resident, after they used the restroom, and between residents. They stated they would wash their hands after picking up trash or soiled linens. CNA #2 was asked if they would perform handwashing when checking briefs. They stated they'd wash before and after, or use hand sanitizer. CNA #2 was asked if they would wash their hands prior to touching residents' personal items or bed controls after providing perineal care. They stated, Yes.</p>