STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445283	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rainbow Rehab and Healthcare	8119 Memphis Arlington Road Bartlett, TN 38133

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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, record review, facility document and policy review, the facility failed to implement procedures for missing items and grievances for 1 of 1 (Resident #105) resident reviewed for personal property. Findings included: A facility policy titled, Complaint and Grievance Process, revised 01/01/2022, revealed, Purpose: To enable any individual to file a complaint either directly to the Facility (internal complaint) or to the Secretary of Health and Human Services. The policy continued, 5. The Facility will receive and document complaints, but no response is required. 6. Complaints and their disposition will be documented, if any. An Face Sheet revealed the facility admitted Resident #105 on 04/25/2025. According to the Face Sheet, the resident had a medical history that included diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (blockage of blood flow) affecting the left dominant side. A 5-Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/02/2025, revealed Resident #105 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. A document titled, 24 Hour Report/Change of Condition Report, dated 05/04/2025, revealed Resident #105 was missing light blue top- Lands End, 2 XL [extra-large]. The facility's Record of Concern Log for May 2025 revealed no documented grievances or concerns involving Resident #105. During an interview on 06/19/2026 at 10:23 AM, the Social Service Director (SSD) stated that when a missing item was reported, she made sure it was on the inventory sheet. She completed a grievance, searched the room to make sure it did not get mixed into the roommate's items, and called the family to see if they had the item. If the item was not on the inventory sheet, she gave the family an option to purchase the same item and then reimburse the item. The SSD stated that if a resident had been discharged and reported an item missing, the process was the same. The SSD stated that if a grievance was reported to her or discussed during the morning meetings, she created a grievance. If the item was not found, then the Business Office Manager ordered another item like the missing item and provided a receipt that was attached to the grievance. The SSD reviewed the grievances and stated that she did not have a grievance for Resident #105's missing light blue shirt. During an interview on 06/19/2026 at 11:13 AM, the Business Office Manager (BOM) stated that if an item was reported missing, the social worker was supposed to investigate it. Their process was to pull the inventory sheet to review for replacement or reimbursement. If the item was not on the inventory list, it got replaced most of the time, depending on the cost. If the item was purchased by the resident, family, or representative, the BOM asked for receipts and requested a check from the corporate office. If it was a high-ticket item, it was reviewed by the Administrator for reimbursement. The BOM reviewed the payment systems and did not locate a reimbursement to Resident #105 or their representative in April, May, or June. The BOM reviewed her notes and did not have any notes outlining a discussion of reimbursement with Resident #105 or their representative. During an interview on 06/19/2026 at 12:45 PM, the Administrator stated that he expected grievances related to missing items to be handled through the grievance process.

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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review, observation, interview, and facility document review, the facility failed to ensure staff provided catheter care appropriately for 1 of 2 (Resident #24) residents reviewed for catheter care. Findings included: A facility policy titled, Catheter Care Procedure- Urinary, revised 12/28/2023, indicated, 5. Catheters should be secured to prevent pulling and damage to the urethral meatus. This may be accomplished by: a. Utilizing the appropriate drainage device (leg bag or catheter bag) b. leg strap c. Velcro strap d. Linen/clothing clamp e. Adhesive securing device.An undated facility document titled Peri and Catheter Care, revealed a skills checkoff list for catheter care. Per the document, questions 8 through 10 included a list of tasks to complete for catheter care and an option to document whether the staff member met or did not meet the task requirement. The document revealed the tasks for catheter care included, Stabilize the catheter near the insertion point. Using a new, clean cloth wipe the catheter tubing starting near the insertion point and working downward. Clean at least 4 inches of tubing. If multiple wipes are required to cleanse the tubing grab a new cloth each time, starting from the meatus and working downward. Repeat steps to rinse and dry as indicated. A Face Sheet indicated that the facility admitted Resident #24 on 03/06/2025. According to the Face Sheet, the resident had a medical history that included diagnoses of other neuromuscular dysfunction of the bladder, chronic kidney disease, and presence of urogenital implants. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/12/2026, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. The MDS revealed that the resident had an indwelling catheter.Resident #24's Care Plan Report included a focus area initiated on 03/06/2025 that indicated Resident #24 had a need for an indwelling suprapubic catheter related to neurogenic bladder. Interventions directed staff to assist the resident with catheter care as needed (revised 04/22/2025) and to keep the catheter tubing free of kinks and twists (initiated 03/25/2025).Resident #24's physician Order Summary Report for active orders as of 06/17/2026, revealed an order started on 02/04/2026 to cleanse area around the supra pubic catheter site with soap and water, rinse and pat dry then apply split 4x4 gauze daily and as needed.During a catheter care observation on 06/17/2026 at 10:09 AM, Certified Nurse Aide (CNA) #3 opened Resident #24's incontinence brief and used wet wipes to wipe the catheter insertion site. CNA #3, without securing or stabilizing the catheter tubing, then used another wipe and cleaned the catheter away from the resident, tugging on the tubing. The CNA repeated the wiping steps three additional times, then discarded the wipe. During an interview on 06/18/2026 at 10:27 AM, CNA #3 stated that he was supposed to hold the base of the catheter when he cleaned the catheter. During an interview on 06/19/2026 at 12:51 PM, the Director of Nursing stated that it was her expectation that staff provide catheter care according to the skills checklist. During an interview on 06/19/2026 at 2:50 PM, the Administrator stated that he would defer all medical questions to the nursing team, as he was not a clinical professional.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents were free from significant medication errors, which affected 1 of 1 (Resident #4) resident reviewed for antibiotic use. Findings include:An Face Sheet indicated the facility originally admitted Resident #4 on 04/15/2025 and readmitted the resident on 05/13/2026. According to the Face Sheet, the resident had a medical history that included diagnoses of pressure ulcer of sacral region, stage 4, and osteomyelitis (infection in a bone) of vertebra, sacral, and sacrococcygeal region.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/09/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that Resident #4 had a sacral pressure ulcer.Resident #4's Care Plan Report included a focus area initiated 07/14/2025 and revised on 05/14/2026 that indicated the resident had a sacral wound infection. Interventions directed staff to administer medications and treatments as ordered. Resident #4's After Visit Summary from the hospital, dated 05/13/2026, indicated in the comments section, pt [patient] needs IV [intravenous] ertapenem [an antibiotic] 1gm [gram] q24 [every 24 hours] x 06/22/2026.Resident #4's Order Recap [recapitulation] Report, for the timeframe from 05/01/2026 through 06/01/2026 included an order for ertapenem sodium injection solution 1 gram intravenously one time a day for sacral decubitus infection until 05/22/2026 (start date 05/15/2026). The Order Recap Report also included an order for ertapenem sodium injection solution 1 gram intravenously one time a day for sacral decubitus infection until 06/29/2026 (start date 05/27/2026). Resident #4's May 2026 Medication Administration Record revealed no documented evidence the ertapenem sodium solution 1 gram IV was administered on 05/23/2026, 05/24/2026, 05/25/2026, and 05/26/2026. During an interview on 06/18/2026 at 10:38 AM, the Wound Care Physician (WCP) stated Resident #4 went to the hospital and returned to the facility with a peripherally inserted central catheter (PICC) line and on antibiotic therapy due to a wound infection. During an interview on 06/18/2026 at 5:14 PM, Registered Nurse (RN) #16 confirmed she entered the antibiotic (ABT) order for ertapenem into the computer with a discontinuation date of 05/22/2026. She confirmed that the hospital discharge orders had a discontinuation date of 06/22/2026. RN #16 stated that she received the ABT order verbally from another nurse who no longer worked in the facility. She stated that she did not check the ABT order herself prior to entering the order into the computer system. During an interview on 06/18/2026 at 5:29 PM, the Director or Nursing stated that Resident #4 had missed four doses, and the wound care doctor was contacted and extended the stop date for four additional days. During a follow-up interview on 06/19/2026 at 10:13 AM, the WCP stated that she was made aware that the ABT had been discontinued prematurely. She stated that she gave orders to continue the medication. The WCP stated that with osteomyelitis, there was only a 70% chance of healing with the first course of medication, and the wound was looking good; therefore, it was significant for Resident #4 to receive the medication. During an interview on 06/19/2026 at 2:50 PM, the Administrator stated that he would defer all medical questions to the nursing team, as he was not a clinical professional.