STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375320	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RAINBOW HEALTH CARE COMMUNITY AND RAINBOW ASSISTED	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)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to maintain an infection control program and implement measures to provide a safe environment to help prevent the development and transmission of COVID-19. The facility failed to: ~ Implement transmission based precautions for residents whose COVID-19 status was unknown for six (#1, #2, #3, #5, #6, and #7) of seven residents observed on the quarantine hall; ~ Ensure residents on quarantine status did not share a room for four (#1, #2, #5, and #6) of seven residents observed on the quarantine hall; ~ Ensure residents were distanced six feet apart for one (noon meal) of one meal service observed; ~ Ensure residents wore a mask when out of their rooms; and ~ Ensure an EPA List N disinfectant effective for use against [DIAGNOSES REDACTED]-CoV-2 was utilized on shared equipment, floors, and high touch surfaces. This had the potential to affect all 63 residents who resided in the facility. Findings: The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes documented, .Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. . The Center for Disease Control guidance titled, Considerations for Memory Care Units in Long-term Care Facilities Infection Prevention and Control (IPC) Guidance for Memory Care Units, documented, .Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel . The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes documented, .Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room . The Center for Disease Control guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic documented, .Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly. Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for [DIAGNOSES REDACTED]-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed. Refer to List Nexternal icon on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging [MEDICAL CONDITION] pathogens program for use against [DIAGNOSES REDACTED]-CoV-2 . 1. On 06/30/20 at 10:38 a.m., the quarantine hall was observed. Resident #4 had a bin with PPE outside the door, a biohazard bag in a biohazard box in the room, and a sign which documented contact precautions on the door. None of the other occupied rooms were observed to have signage indicating precautions, PPE available outside the resident rooms, or biohazard containers in the rooms. At 10:39 a.m., CNA #1 was asked why resident #4 was on contact precautions. She stated because the residents was a new admission to the facility and had a wound infection. She was asked what precautions the other six residents were on. She stated they were on 14 day precautions. She was asked what PPE was utilized for the quarantine residents. She stated masks and gloves. At 10:44 a.m., resident #1 was observed to wheel down the quarantine hall to her room. She was not observed to wear a mask nor did the staff offer her a mask. At 11:10 a.m., CNA #1 and CNA #2 were observed to enter the room of resident #3. They were observed to wear surgical masks and gloves. At 11:15 a.m., CNA #2 came out of the room with a clear trash bag with trash in it. She was asked what care she and CNA #1 provided to resident #3. She stated they provided incontinent care, changed his clothes, and got him out of bed and into his wheel chair. At 11:40 a.m., the DON/IP was asked what type of precautions the quarantined residents were on. She stated they were on the transition hall. She was asked why resident #4 was the only resident who was quarantined who had a sign posted on his door and a biohazard box in his room. She stated the resident was a new admission [MEDICAL CONDITION]. She was asked why the quarantine residents whose COVID status was unknown were not on droplet precautions. She stated the residents in quarantine were placed on droplet precautions if they showed symptoms of COVID-19. At 12:11 p.m., CNA #2 was observed to don a gown, gloves, and shoe covers. She had a surgical mask on but did not don a faceshield and entered resident #4's room to deliver his meal. At 12:19 p.m., RN #1 was asked what type of precautions the residents on the quarantine hall were on. She stated standard isolation. At 12:24 p.m., LPN #1 was asked what type of precautions the residents on the quarantine hall were on. She stated one resident was on contact precautions and the other residents were only quarantined. 2. On 06/30/20 at 10:38 a.m., the quarantine hall was observed. Resident #1 and resident #2 were observed to share a room. Resident #5 and resident #6 were observed to share a room. The DON/IP provided a list of residents on the quarantine unit. The list documented the following: ~ Resident #1 was a readmission from a hospital stay and scheduled to be off quarantine on 07/09/20; ~ Resident #2 was a new admission and scheduled off quarantine on 07/03/20; ~ Resident #5 was a new admission and scheduled off quarantine on 07/02/20; and ~ Resident #6 was a resident who received [MEDICAL TREATMENT]. At 11:20 a.m., the DON/IP was asked why residents #1 and #2 and residents #5 and #6 were roommates on the quarantine unit. She stated corporate informed her as long as the residents were asymptomatic and staff checked their temperatures every shift they could reside in the same room. She stated, I questioned that. 3. On 06/30/20 at 11:56 a.m., the main dining room was observed. Staff were observed assisting two residents at a table. The residents were not six feet apart. Several other tables were observed to be available to assist the residents with their meal and maintain social distancing. At 11:58 a.m., the following was observed in the memory care unit: ~Two residents were observed at a table and were not six feet apart; ~Three residents were observed at another table and were not six feet apart; and ~Two residents were observed at a third table. They were not six feet apart. An activity room adjacent to the dining area was observed to have space available for dining if needed. At 11:59 a.m., CNA #3 was asked how they maintained social distancing with residents who required assistance with meals. She stated they tried to put residents at different tables. She stated, These three like to sit and talk. At 12:19 p.m., RN #1 was asked how social distancing of six feet during assistance with meals was maintained on the memory care unit. She stated they tried to keep the residents six feet apart. She was asked how she monitored to ensure residents were six feet apart when they received assistance with dining. She stated she observed the residents at meal times. At 1:20 p.m., the DON/IP was asked why residents in the main dining room were not social distanced by six feet when being assisted with meals. She stated they were supposed to be six feet apart. She was asked why residents on the memory care unit were not six feet apart when being assisted with meals. She stated they may need to utilize the activity area to ensure social distancing with meals. 4. On 06/30/20 at 10:20 a.m., residents #15 and #14 were observed sitting at a dining table in the memory unit. They were not six feet apart and they were not wearing masks. At 10:23 a.m., resident #18 was observed pushing a male resident in his wheel chair to the table where resident #15 and #14 were sitting. He was not six feet from the female residents. Neither of the male residents wore masks. CNA #3 identified the three residents sitting at the table and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) the ambulatory resident. She was not observed to offer the residents a mask. At 11:40 a.m., the DON/IP was asked why residents on the long term care halls and the memory unit were not observed to wear masks nor were staff observed to offer masks. She stated, Well, I didn't know they were supposed to wear masks in the building. She stated she knew they had to wear them if they left the facility. At 12:49 p.m., three residents were observed sitting at a table in the memory care unit. They were not six feet apart and did not have masks on. At 12:50 p.m., CNA #3 was asked why the residents did not have masks on. She stated she did not think they would wear a mask. She was asked if residents had been offered a mask. She stated they had not ever offered the residents a mask. At 12:52 p.m., three residents were observed in wheel chairs at a table in front of the TV in the memory care unit. They were not observed to wear masks and were not six feet apart. At 12:52 p.m., CNA #4 was asked why residents were not wearing masks. She stated she did not know. She was asked if she had offered the residents masks. She stated she did not know she was supposed to. She was asked why residents were not six feet apart. She stated she did not know. Throughout the survey random observations were made of long term care and skilled nursing halls which revealed none of the residents wore face masks when out of their rooms nor were they offered a mask by staff. At 12:56 p.m., RN #1 was asked if residents wore masks or were offered masks when they were out of their rooms. She stated they only offered masks if the resident was leaving the facility. She was asked why residents were not offered masks and encouraged to wear them when they were out of their rooms. She stated, I need to find out. I don't know for sure. 5. On 06/30/20 at 10:00 a.m., housekeeper #1 was asked what disinfectant was utilized in the facility. He provided the surveyor a bottle of OdoBan disinfectant. He was asked what the contact time was for the disinfectant to be effective at killing coronavirus. He stated 60 seconds. He was asked what surfaces the disinfectant was used on. He stated the floors and high touch surfaces. At 11:04 a.m., CNA #2 was asked what disinfectant was utilized to disinfect shared equipment such as the mechanical lift. She stated OdoBan disinfectant. She was asked what the contact time for the disinfectant was to effectively kill coronavirus was. She stated 60 seconds. At 1:05 p.m., the housekeeping supervisor was asked what disinfectant was utilized on floors and high touch surfaces. She provided the surveyor a bottle of OdoBan and a bottle of Pine Sol All Purpose Cleaner. She was asked what the OdoBan and the Pine Sol was used on. She stated they used the OdoBan for the high touch surfaces, floors, and the CNAs disinfected equipment with it. She stated the Pine Sol was added to the floor solution and utilized. She was asked what the contact time for the OdoBan disinfectant and the Pine Sol was. She stated 60 seconds. The EPA number found on the OdoBan disinfectant was not found on List N. The Pine Sol was not observed to have an EPA number on the label. She was informed the OdoBan EPA registration number was not found on the EPA's list N when searched. She stated she did not know until yesterday when she received an email she needed an EPA approved disinfectant. She stated she had not heard of the EPA's List N disinfectants.