Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL083-029	A. BUILDING: _____ B. WING _____	05/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW 66 STOREHOUSE, INC	22521 BUNCH ROAD LAUREL HILL, NC 28351

(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
V 000	INITIAL COMMENTS An annual survey was attempted on May 9, 2018. According to the Licensee and the Regional Director there are no clients being served at the facility. The last time clients were served at the facility was February 6, 2018. Observation on 05/09/18 of the facility at approximatley 9:30 revealed: - Two adult female staff of the Licensee and one male staff of the Licensee were on site "spring cleaning" the facility and completing yard work at the facility. Telephone interview on 05/09/18 with the Licensee and the Regional Director revealed: -No clients were residing at the facility since 02/06/18. -The former resident/client was transferred to a sister facility on 02/06/18 and discharged from the current facility. -The Regional Director agreed to fax the discharge summary for the former resident to DHSR surveyor.	V 000		

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