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	MHL026-813	A. BUILDING: ______ B. WING ______	09/26/2018

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RAINBOW OF SUNSHINE 1	4661 PENNYSTONE DRIVE FAYETTEVILLE, NC 28306

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V 000	INITIAL COMMENTS A complaint survey was completed September 26, 2018. The complaint was unsubstantiated (intake #NC00142714). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the	V 132		

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V 132	Continued From page 1 investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR). The findings are: See Tag V367 for specifics. Interview on 09/25/18 the Licensee stated she had not reported the allegation of abuse/harm to the HCPR as required.	V 132		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME	V 367		

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responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of

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becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure a critical incident report was submitted to the Local Management Entity (LME) within 72 hours as required. The findings are.

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V 367	Continued From page 4 Review on 09/25/18 of the North Carolina Incident Response Improvement System (IRIS) revealed no report from the facility regarding client #2's allegation of abuse/harm or injury during a restraint which involved staff #1. Review on 09/26/18 of a medical progress report for client #2 dated 08/28/18 revealed: - Client #2, "chief complaint: rib injury, pt (patient) complains of rib pain on right side, ongoing for past week." -"There is no bruising, erythema or swelling noted over the right rib area." Review on 09/26/18 of an xray/imaging report for client #2 dated 08/29/18 revealed: -"Reason For Exam: Pleurodynia...Impression: Nondisplaced seventh and eighth right rib fractures..." Review on 09/25/18 of the facility's in-house incident report dated 08/08/18 and completed by staff #1 revealed: -Client #2 was upset and destroying property and attempted to hit staff #1 and was placed in a therapeutic hold by staff #1. -Staff #1 contacted the facility Group Home Manager and the Qualified Professional (QP) to inform them of the therapeutic hold performed on client #2. Review on 09/25/18 of the facility's in-house incident report dated 08/28/18 and completed on 08/29/18 by staff #1 revealed: -Client #2 had fallen out of the bed and complained his side was sore. Interview on 09/25/18 client #2 stated: -He was not aware of any abuse or harm by any	V 367		

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staff at the facility and he "lied" about being hurt by staff #1 during a restraint (08/08/18) because he did not want to live at the group home any longer and he had hurt his ribs by, "falling off the bed, bed too short" and he sleeps "wild and got to be careful when I turn over."
-He had "lied to get [staff #2] fired."

Interview on 09/25/18 client #1 stated:
-He was not aware of any abuse or harm by any staff at the facility.
-He was doing "good" at the facility and had no complaints/concerns.

Interview on 09/25/18 staff #2 stated:
-He had taken client #2 to the medical visit on 08/28/18 after he complained about pain in his side.
-Client #2 stated he had "lied" about staff #1 hurting him during a restraint and he had hurt his ribs when "he fell off his bed."
-Client #2 would "embellish" things and was a "manipulator" and "didn't like anyone, don't like [staff #1]."
-He followed up with the appointment for xray/imaging and client #2 had been prescribed a breathing machine on 08/28/18 at the doctor's appointment.

Interview on 09/25/18 staff #1 stated:
-He was not aware of any harm or abuse by any staff at the facility.
-He had been made aware of the allegations made by client #2 and had been interviewed by the local DSS regarding client #2's allegation of harm/abuse during a restraint (08/08/18).
-He had not harmed or abused any client in the facility and had placed client #2 in a therapeutic hold (08/08/18) due to client #2 destroying

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V 367	Continued From page 6 property and attempting to hit him (staff #1). -He had not seen any injuries to client #2 as a result of the restraint/therapeutic hold conducted on 08/08/18. Interview on 09/25/18 the Licensee stated: -She was made aware of the allegation of abuse/harm on 08/31/18 made by client #2 when the local Department of Social Services informed her of their investigation regarding client #2's allegation of staff #1 causing abuse/harm during a restraint. -Client #2 was taken to the doctor's office for follow up when he began complaining about pain with his side/ribs (08/28/18) and was taken for xray/imaging (08/29/18)and prescribed a breathing machine. -Client #1 had a history of making false allegations and stated he had lied about staff #1 hurting him during a restraint and he had hurt his ribs when he fell off of his bed. -Staff had reported client #2 had a new behavior of episodes of falling out of his bed and may be attempting "to get the attention of a new female staff." -Client #1 "always" stated he wanted to leave the group home and live elsewhere. -She was not sure what had happened or how client #2 had rib fractures. -She had talked to the QP who had conducted an internal investigation of client #2's allegation. -She was waiting for the local DSS to completed their investigation and had not contacted Health Care Personnel Registry (HCPR) or completed an IRIS report regarding client #2's allegation.	V 367		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION,	V 521		

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PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL
(e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions:
(9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum:
(A) notation of the client's physical and psychological well-being;
(B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior;
(C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;
(D) a description of the intervention and the date, time and duration of its use;
(E) a description of accompanying positive methods of intervention;
(F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;
(G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
(H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

This Rule is not met as evidenced by:

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V 521	Continued From page 8 Based on record reviews and interviews, the facility failed to document restrictive interventions as required to include, but not limited to, the time and duration of its use, debriefing, and planning, client's physical and psychological well-being, affecting 1 of 3 audited clients (client #2). The findings are: See Tag V367 for specifics. Review on 09/25/18 of client #2's record revealed: -44 year old male admitted 12/06/16. -Diagnoses included Intellectual Disablity Disorder, Oppositional Defiant Disorder, Impulse Control Disorder, Intermittent Explosive Disorder, History of Seizures, Schizoaffective Disorder, Psychosis Disorder, Not Otherwise Specified, Conduct Disorder, Pervasive Development Disorder and High Blood Pressure. -Behavior Plan letter dated, 12/15/16 and reviewed on 09/26/18 signed by a local Licensed Psychologist revealed: -"As part of the development of a behavioral modification plan, I have several recommendations prior to completing the plan...it is recommended that [client #2]'s caregivers and group home staff be permitted to use therapeutic restraint to prevent [client #2] from running away and/or harming himself or others...a full report and/or behavior plan will follow once additional information is provided for perusal." -No Behavior plan available for review on client #2's record. Review on 09/25/18 of Client #2's record 08/08/18 through 09/25/18 revealed: -No documentation of time and duration for the 08/08/18 restrictive intervention or client's	V 521		

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V 521	Continued From page 9 physical and psychological well-being, or debriefing. Interview on 09/25/18 the Licensee stated: -She was "not sure" when the restrictive intervention/therapeutic hold happened" and client #2 had a current behavior plan. -Staff had not completed the required documentation for the restraint/restrictive intervention which occurred on 08/08/18.	V 521		