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 _____	01/30/2019

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 January 30, 2019. According to the Director of Operations there are no clients being served at the facility. The last time clients were served at the facility was February 6, 2018. Observation on 01/30/19 of the facility at approximatley 9:30am revealed: - No one at the facility. - No response to the front door or side door. Telephone interview on 01/30/19 with the Regional Director and Director of Operations 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 Director of Operations agreed to contact DHSR if/when any client(s) were admitted to the facility.	V 000		

Division of Health Service Regulation

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