PRINTED: 03/25/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING MHL026-812 03/20/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 307 CEDARWOOD STREET **RAINBOW OF SUNSHINE 2** SPRING LAKE, NC 28390 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual survey was completed on March 20, 2019. Deficiencies were cited. DHSR - Mental Health This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. APR 1 5 2019 V 118 27G .0209 (C) Medication Requirements V 118 Lic. & Cert. Section 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and

Division of Health Service Regulation

with a physician.

drug.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(E) name or initials of person administering the

(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation

Tambye TITLE President

(X6) DATE 4-5-19

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL026-812 03/20/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 307 CEDARWOOD STREET **RAINBOW OF SUNSHINE 2** SPRING LAKE, NC 28390 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 118 V 118 Continued From page 1 This Rule is not met as evidenced by: Based on record review, observation and Nurse will provide MAR training 4/12/19 interview, the facility failed to administer for all staff. Staff will review medications on the written order of a physician MAR's for any deficiencies before and failed to keep the MARs current affecting two the start and end of the shift. of three clients (#1 and #4). The findings are: Residential manager will review Finding #1: MAR's 5 days out of a week. QP Review on 03/20/19 of client #1's record will review MAR's 2 x's. Nurse revealed: will review MAR's weekly. - 31 year old female. - Admission date of 02/03/08. - Diagnoses of Bipolar Disorder, Moderate Intellectual Developmental Disability (IDD), Diabetes Mellitus and Gastro Esophageal Reflux Disorder. Review on 03/20/19 of client #1's medication orders dated 01/03/19 revealed: - Check Finger Stick Blood Sugar (FSBS) values twice daily. Review on 03/20/19 of client #1's FSBS records for January 2019 and February 2019 revealed the following blanks: January 2019 - 01/16/19, 01/28/19 and 01/30/19 in the evening. February 2019

Division of Health Service Regulation

evening.

- 02/05/19 in the morning and 02/27/19 in the

her blood sugar values twice daily.

Interview on 03/20/19 client #1 stated staff check

IDE111

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL026-812	B. WING		03/20/2	03/20/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDR				STATE, ZIP CODE			
RAINBOW OF SUNSHINE 2 307 CEDARWOOD STREET SPRING LAKE, NC 28390							
(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 SHOUL CROSS-REFERENCED TO THE APPROP	D BE COMPLETE		
V 118	revealed: - 38 year old male Admission date of - Diagnoses of Mod Hyperactivity Disord Review on 03/20/19 physician orders da - Vitamin D (treats v units - take one cap Review on 03/20/19 and March 2019 MA February 2019 - No staff initials to s administered between March 2019 - No staff initials to it administered.  Interview on 03/19/16 his medications as of Interview on 03/20/16 - She understood the needed to be kept of - She would follow to issues.  Due to the failure to medication administers.	12/16/16. erate IDD, Attention Deficit fer and Hypertension.  of client #4's signed ted 01/03/19 revealed: vitamin D deficiency) 50,000 sule weekly.  of client #4's February 2019 ARs revealed the following: signify the Vitamin D was en 02/12/19 thru 02/27/19.  Indicate the Vitamin D was and Client #4 stated he received ordered.  If the Licensee stated: If the Mars for the clients for the clients for the identified medication accurately document for the could not be be received their medications	V 118				
V 736		y and Grounds Maintenance	V 736				

IDE111

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: B WING MHL026-812 03/20/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 307 CEDARWOOD STREET **RAINBOW OF SUNSHINE 2** SPRING LAKE, NC 28390 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 736 V 736 Continued From page 3 10A NCAC 27G .0303 LOCATION AND **EXTERIOR REQUIREMENTS** (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. 4/12/19 This Rule is not met as evidenced by: Weekly inspections of the home Based on observation and interview, the facility will be completed by Residential was not maintained in a safe, clean, attractive Manager. QP will also follow up and orderly manner. The findings are: with a monthly inspections to Observation on 03/19/19 at approximately check for any deficiencies of the 1:30pm revealed: home. Bedroom #2 and #3 walls - Client #1 and #2's bedroom revealed the will be painted. Brass handle on window would not raise for egress. An window in Bedroom #3 will be approximately 7 foot by 2 foot unpainted white patched area on the wall. Two softball sized completed for easier access. unpainted white patched areas on the wall. Hallway bathroom blind will be - Client #3's bedroom revealed an approximately replaced. 12 inch by 12 inch unpainted white patched area on the wall. The windows had plexiglass on the surface which impeded the ability to raise for an - The hallway bathroom revealed a broken slat in the window blind. Interview on 03/20/19 the Licensee indicated she would have identified areas repaired.

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