	T of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COM	E SURVEY PLETED
		MHL026-812	B. WING		03/	20/2020
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, S			
AINBOV	<b>WOF SUNSHINE 2</b>		ARWOOD STI LAKE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ſS	V 000			
	on March 20, 2020. This facility is licens	w up survey was completed Deficiencies were cited. sed for the following service C 27G .5600C Supervised				
		h Developmental Disabilities.				
V 111	27G .0205 (A-B) Assessment/Treatn	nent/Habilitation Plan	V 111			
	PLAN (a) An assessment client, according to the delivery of servi be limited to:	ILITATION OR SERVICE t shall be completed for a governing body policy, prior to ces, and shall include, but not				
,	established diagnos of admission, excep detoxification or oth shail have an estab admission;					
	and (5) evaluations or a psychiatric, substar vocational, as appr	assessments, such as nce abuse, medical, and opriate to the client's needs.	7			
	establishment and treatment/habilitation referred to as the "p	are provided prior to the implementation of the on or service plan, hereafter blan," strategies to address th problem shall be documented		RECEIVED By DHSR Mental Health Licensu	re & Certification at 3:27	1 pm, Apr 08, 20
SION OF HE	ealth Service Regulation	ER/SUPPLIER REPRESENTATIVE'S SI	GNATURE TA	nah TITLE Prest	den <del>t</del>	(X6) DATE
an sa ca sari Ca			/an			4-6-20

<u>Division</u>	of Health Service Re	egulation			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED
					R
		MHL026-812	B. WING	· · · · · · · · · · · · · · · · · · ·	03/20/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY	, STATE, ZIP CODE	
RAINBO	N OF SUNSHINE 2		ARWOOD S LAKE, NC 🗆		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
V 111	Continued From pa	ge 1	V 111		
V 118	failed to complete a admission affecting (#3). The findings a Review on 03/13/20 revealed: -22 year-old male. -Moved into the fac 12/10/19. -Diagnoses include disability (mild), soc disorder, cyclothym neurocognitive diso Parkinson's disease -No initial assessme #3's admission to the Interview on 3/13/20 -Client #3 was prev facility and was tran owned/operated by -She was not aware sister facility to ano from one and admit receiving facility. -She would make s followed for any fut sister facility to ano	view and interview, the facility in assessment prior to one of three audited clients ire: 020 of client #3's record ility from a sister facility on d intellectual developmental cial (pragmatic)communication ic disorder; mild order probably due to e with behavioral disturbance. ent completed prior to client the facility from a sister facility. 020 the Licensee stated: iously a resident in a sister asferred to the current facility the Licensee on 12/10/19. e any client moved from one ther had to be discharged the as a new admission to the ure these procedures were ure clients moved from one ther. ication Requirements	V 118		
Division of He	ealth Service Regulation	and the second se	1		
STATE FORM			6899	7QML11	If continuation sheet 2 of 23

Division	of Health Service R	egulation	_			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		0011	
		1	B. WING		R	
		MHL026-812	B. WING		03/20/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PAINRO	W OF SUNSHINE 2	307 CEDA	RWOOD ST	REET		
NAINDO		SPRING L	AKE, NC 28	390		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
		the second the second time is the second	1			
V 118	Continued From pa	age 2	V 118			
	REQUIREMENTS					
	(c) Medication adm					
		non-prescription drugs shall				
		ed to a client on the written				
	•	uthorized by law to prescribe				
	drugs.					-
		all be self-administered by uthorized in writing by the				
	client's physician.	autorized in whang by the				
		cluding injections, shall be	!			-
		by licensed persons, or by				
		s trained by a registered nurse,				
		r legally qualified person and				
		re and administer medications.				
		Iministration Record (MAR) of				
		red to each client must be kept	1			-
	•	is administered shall be				
	MAR is to include t	ely after administration. The				
	(A) client's name;	ne following.				
		, and quantity of the drug;				
		administering the drug;				
	(D) date and time t	he drug is administered; and				
	(E) name or initials	of person administering the				
	drug.					
		for medication changes or				-
		corded and kept with the MAR				
		appointment or consultation				
	with a physician.					
			[			
		et as evidenced by:				
		views and interviews, the				
	•	ninister medications on the				
		hysician and maintain a				
		ing 3 of 3 clients audited				
<u></u>	(clients #1, #2, #3)			· · · · · · · · · · · · · · · · · · ·		
Division of H	ealth Service Regulation					

STATE FORM

6899

7QML11

If continuation sheet 3 of 23

<u> </u>	on of Health Service R	egulation				
	MENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND P	LAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	2
			B. WING			0/2020
ļ	<u></u>	MHL026-812			<u> </u>	012020
NAME	OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
]			ARWOOD STR			
RAIN	BOW OF SUNSHINE 2		LAKE, NC 28			
		·····		······································		1 (200
(X4) †		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) CCMPLETE
PREF		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
			1	DEFICIENCY)		
1	18 Continued From pa	an 2	V 118			
<sup>v</sup>	18 Continued From pa	ages	VIIO			
	Finding #1:					
	Review on 3/13/20	20 of client #1's record				
	revealed:					
	-38 year old female	e admitted 1/14/13.				
	-diagnoses include	d moderate mental retardation,				1
		ind depressive disorder, not				
	otherwise specified					
	1	19 for Bactrim DS 800-160 mg				
		let twice daily for 5 days.				
	(Antibiotic)					
		20 of client #1's MAR revealed	1			
		50 mg was documented twice				
		ginning 12/3/19 and ending				
	12/8/19.					
1	Finding #2:					
		20 of client #2's record				
	revealed:	1 10 154047				
	-54 year old male					
1		ed mild mental retardation;				
1		anoid type; intermittent				
1		; depressive disorder;	1			
		endence, gastroesophageal				
	reflux disease; hyp	2020 for Mitamin D 50 000				i I
		(2020 for Vitamin D 50,000				
	units weekly. (Sup					
		2020 for finger stick blood				
		. No physician's order or d quidelines for actions peeded				
		d guidelines for actions needed				
		Its were lower than a specified an a specified and a specified result.				
	result of higher the	an a specificul result.				
	Review on 3/12/20	)20 of client #2's MARs from				ļ
	12/1/19 - 3/13/202					1
		units documented weekly. No				Ì
		when the medication had				
	been administered					
		4.				
Division	of Health Service Regulation	2	<u>_</u>			1
DIVISION	or meanin bervice rregulation	1				

STATE FORM

7QML11

6899

If continuation sheet 4 of 23

Division of Health Servi	ce Regulation			
STATEMENT OF DEFICIENCIE:			E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUM	BER: A. BUILDING	:	COMPLETED
1				R
	MHL026-812	B. WING		03/20/2020
NAME OF PROVIDER OR SUP		STREET ADDRESS, CITY, S		
RAINBOW OF SUNSHINI	- 2	307 CEDARWOOD ST		
		SPRING LAKE, NC 2	8390	
	RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	· - /
	CIENCY MUST BE PRECEDED BY FI Y OR LSC IDENTIFYING INFORMATI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	
			DEFICIENCY)	i ·
V 118∶ Continued Fro	m page 4	V 118		
	in page i			
Finding #3:				
	13/2020 of client #3's recor	ď		
revealed: -22 year-old m				
	e facility from a sister facilit	von		
12/10/19.		, on		
	cluded intellectual developn	nental		
	), social (pragmatic)commu			
	hthymic disorder; mild			
	e disorder probably due to			
	sease with behavioral distu	•		
	2/9/19 to taper down Benzi			
	at bedtime, to 1 tablet at be			
	tablet every other night for ed to treat Parkinson's dise			
	ed to treat Parkinson's dise			
certain psychia				
	2/9/19 for Eveko 10 mg da	ilv.		
	attention deficit hyperactivit			
disorder - ADH		-		
	2/10/2020 for Escitalopram			
	treat depression and anxie			
	3/10/2020 for Famotidine 20	mg		
	sed to prevent ulcers in the			
stomach and i				
	2/10/2020 for Haloperidol 10 sed to treat mental/mood di			
	nia, schizoaffective disorde			
	2/10/2020 for Lamotrigine 1			
	sed to prevent and control s			
	ie extreme mood swings of			
disorder.)	5			
	3/10/2020 for Levetiracetam			
twice daily. (U	sed to treat and prevent sei	zures.)		
<b>n</b>	0/0000 - C 11 1 - 1 - 1	<b>6</b>		
· ·	3/2020 of client #3's MARs	Trom		
	3/2020 revealed:	until		
12/12/19.	aper order was not started i			(
	daily was not started until 1	2/16/19		
Division of Health Service Regu				

STATE FORM

6899

7QML11

If continuation sheet  $5 ext{ of } 23$ 

PTATEMENT OF DEFICIENCIES AND PLANCY CORRECTION AND PLANCY CONTROL RESERVED.         (**) PEONOPERIUPPLIER MHL028-812         000 NULTIFILE CONSTRUCTION A. BULDING:         (**) PEONOPERIUPPLIER B. WING         000 NULTIFILE CONSTRUCTION A. BULDING:         R 03/20/2020           NAME OF PROVIDER OR SUMPLIER TABLE STRUCT CONSTRUCTION RANNEYS TATELED TO DEFICIENCIES PRINCLAKE, NC 23399         000 NULTIFILE CONSTRUCTION CONTROL RACE, NC 23399         000 NULTIFILE CONSTRUCTION CONTROL RACE, NC 23399           V118         SLIMMARY STRUETED TO DEFICIENCIES PRINCLAKE, NC 23399         000 NULTIFILE CONTROL RACE, NC 23399         000 NULTIFILE CONTROL RACE, NC 23399           V118         SLIMMARY STRUETED TO DEFICIENCIES PRINCLAKE, NC 23399         000 NULTIFILE CONTROL RACE, NC 23399         000 NULTIFILE CONTROL RACE, NC 23399           V118         SLIMMARY STRUETED TO DEFICIENCIES PRINCLAKE, NC 23399         000 NULTIFILE CONTROL RACE, NC 23399         000 NULTIFILE CONTROL RACE, NC 23399           V118         SLIMMARY STRUETED TO DEFICIENCIES PRINCLAKE, NC 23399         000 NULTIFILE CONTROL RACE, NC 23399         000 NULTIFILE CONTROL RACE, NC 23399           V118         Cantification administration of counting and Levelication administration of counting and Levelication administration of counting and struct	<u>Division</u>	of Health Service Re	egulation				
MHL026-912         B. WMC         03/20/2020           NAME OF PROVIDER OR SUPPLER         STREET ADDRESS, DTY, STATE, ZP OCCE         307 CEDARWOOD STREET         307 CEDARWOOD STREET           ANINE OW OF SUNSHINE 2         SUMMARY STATEMENT OF DEPOSITORES         07         PROVIDER SPLAN OF CORRECTION         000           PREMX         READLATORY OR IS DEMINIFING INFORMATION         PREPX         CROSH REPERCIPTOR         000           Y115         Continued From page 5         V118         CROSH REPROVENT OF THE OF DEPOSITOR         CAMPER         CAMPER           - Excitalopram 20 mg daily was not documented for the 7 am scheduled dose on 3/13/2020.         Y118         V118         Continued From page 5         V118           - Excitalopram 20 mg daily was not documented for the 7 am scheduled dose on 3/13/2020.         V118         V118         Continued From 3/13/2020.         V118           - Banzhopine order dated 12/9/19 was not implemented for 3 days waiting on the pharmacy to fill the prescription.         Interview on 3/13/2020 the Group Home Manager stated:         State of the medication with the new order printed on the ball.         State of the medication with the prescription.           - Herview on 3/13/2020 the Licensee stated she would follow up with the physician.         This deficiency and must be corrected within 30 days.         Y281           V 201         Z7G. 5503 Supervised Living - Operations         Y281         10A NCAC 27							
NAME OF PROVIDER OR SUMPLER     STREET ADDRESS, CITY, STATE, ZIP CODE       ANNBOW OF SUNSHINE 2     307 CEDARWOOD STREET SPRING LAKE, NC 28390       Ovij) REDAL DEPORTORY OR LSC IDENTIFYING INFORMATION     D PRETRY (#AD) EDEFORMATION UNSTEE PRESED BY FLUL (#AD) EDEFORMATION UNSTEE PRESED BY FLUE (#AD) EDEFORMATION UNSTEE EDEFORMATION UNSTEE EDEFORMATION UNSTEE (#AD) EDEFORMATION UNSTEE PRESED EDEFORMATION UNSTEE (#AD) EDEFORMATION UNSTEE EDEFORMATION UNSTEE EDEFORMATION UNSTEE (#AD) EDEFORMATION UNSTEE EDEFORMATION UNSTEE (#AD) EDEFORMATION UNSTEE EDEFORMATION UNSTEE (#AD) EDEFORMATION UNSTEE EDEF			MHL026-812	B. WING			
307 CEDARWOOD STREET SPRING LAKE, NC 28390       CAUSING LAKE, NC 28390       CAUSING CAKE, NC 28390       CAUSING CAKE, NC 28390       CAUSING CAKE, NC 28390       CAUSING CAKE, NC 28390       TWO       RESULTATOR OF USE DEPRETATION DEFICIENCIES       TWO       RESULTATOR OF USE DETINGTING INCOMPTOND       TWO       Continued From page 5       V118       Continued From page 5       V118       Continued From addition 0 mg, and Levetinacetam 500 mg       were not documented for the 7 pm scheduled       doses on 3/12/2020, or the 7 am scheduled       doses on 3/12/2020, or the 7 am scheduled       doses on 3/12/2020, or the 7 am scheduled       doses on 3/12/2020 the Circle Added 12/9/19 was not       implemented for 13 days waiting on the pharmacy to send the medication with the new order printed on the label.       -Eveks 10mg daily was not started until 12/16/19       weating on the physician on guidelines for responding to blood sugar results.       Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.       Y 291     TGS -5603 Supervised Living - Operations st dieth when the distabilities. Any facility licensed on June 15, 2001, and providing services to more than sk dieth when the distabilities. Any facility licensed on June 15, 2001, and providing services to more than sk clients when the facility's licensed cap							
PRAINBOW OF SUBSINE 2     SPRING LAKE, NC 28390       00107 TAG     SubMary EXTENSION OF DEPOSITION OF THE PRECIDENCE OF AN OF CORRECTION RECULATORY OF LSC DEPOSITIE PRECIDENCE OF ALL TAG     PRECULATORY OF ALSO DEPOSITIE PRECIDENCE OF ALL RECULATORY OF LSC DEPOSITIENTS INFORMATION PRECULATORY OF LSC DEPOSITIENTS INFORMATION     PRECULATORY OF ALSO DEPOSITIENTS (and the first set of the precision of the first set set of the first set of	NAME OF I	PROVIDER OR SUPPLIER					
Prediction       Calculation       Description       Prediction       Calculation	RAINBO	W OF SUNSHINE 2					
<ul> <li>Escitalopram 20 mg daily was not documented for the 7 am scheduled dose on 3/13/2020. -Famotidine 20 mg, Haloperidol 10 mg, Lamotifiane 100 mg, and Levetiracetam 500 mg were not documented for the 7 pm scheduled doses on 3/13/2020, or the 7 am scheduled doses on 3/13/2020.</li> <li>Interview on 3/13/2020 the Group Home Manager stated: -Benztropine order dated 12/9/19 was not implemented for 3 days waiting on the pharmacy to send the medication with the new order printed on the label. -Eveko 10mg daily was not started until 12/16/19 waiting on the pharmacy to fill the prescription.</li> <li>Interview on 3/13/2020 the Licensee stated she would follow up with the physician on guidelines for responding to blood sugar results.</li> <li>Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.</li> <li>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</li> <li>V291</li> <li>27G .5603 Supervised Living - Operations</li> <li>V291</li> <li>V291 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.</li> </ul>	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
for the 7 iam scheduled dose on 3/13/2020. -Famotidine 20 mg, Haloperidol 10 mg, Lamotrigine 100 mg, and Levetiracetam 500 mg were not documented for the 7 pm scheduled doses on 3/13/2020, or the 7 am scheduled doses on 3/13/2020.         Interview on 3/13/2020 the Group Home Manager stated: -Benztropine order dated 12/9/19 was not implemented for 3 days waiting on the pharmacy to send the medication with the new order printed on the label. -Eveko 10 mg daily was not started until 12/16/19 waiting on the pharmacy to fill the prescription.         Interview on 3/13/2020 the Licensee stated she would follow up with the physician on guidelines for responding to blood sugar results.         Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.         This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.       V 291         V291       27G .5603 Supervised Living - Operations volvengement disabilities. Any facility tilensed on June 15, 2001, and providing services to more than six clients at the time, may continue to provide services at no more than the facility's licensed capacity.       V 291	V 118	Continued From pa	ge 5	V 118		•	
six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.		-Escitalopram 20 m for the 7 am schedu -Famotidine 20 mg Lamotrigine 100 m were not document doses on 3/12/2020 doses on 3/13/2020 Interview on 3/13/2 stated: -Benztropine order implemented for 3 of to send the medica on the label. -Eveko 10mg daily waiting on the phar Interview on 3/13/2 would follow up with for responding to bl Due to the failure to medication adminis determined if client as ordered by the p This deficiency con and must be correct 27G .5603 Supervis	<ul> <li>and daily was not documented uled dose on 3/13/2020.</li> <li>and Levetiracetam 500 mg (and Levetiracetam 500 mg (b), or the 7 pm scheduled 0), or the 7 am scheduled 0).</li> <li>020 the Group Home Manager dated 12/9/19 was not days waiting on the pharmacy tion with the new order printed was not started until 12/16/19 macy to fill the prescription.</li> <li>020 the Licensee stated she in the physician on guidelines lood sugar results.</li> <li>b) accurately document stration it could not be so received their medications shysician.</li> <li>stitutes a re-cited deficiency steed within 30 days.</li> <li>sed Living - Operations</li> <li>OPERATIONS</li> </ul>				
	Division of H	six clients when the developmental disa on June 15, 2001, a than six clients at th provide services at licensed capacity.	e clients have mental illness or ibilities. Any facility licensed and providing services to more nat time, may continue to				

STATE FORM

6899

7QML11

If continuation sheet 6 of 23

Division	of Health Service Ro	egulation			
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	):	COMPLETED
					R
		MHL026-812	B. WING		03/20/2020
				STATE, ZIP CODE	
NAMEOFF	PROVIDER OR SUPPLIER				
		307 CED/	ARWOOD S	TREET	
RAINBU	W OF SUNSHINE 2	SPRING	LAKE, NC 2	8390	
			ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	OPRIATE DATE
1.0				DEFICIENCY)	
	· · · · · · · · · · · · · · · · · · ·				
V 291	Continued From pa	age 6	V 291		
	(I.) Original Original	notion Coordination shall be			ļ
		nation. Coordination shall be			
	maintained betwee	n the facility operator and the			
		nals who are responsible for			
	treatment/habilitati	on or case management.			
	(c) Participation of	f the Family or Legally			
		n. Each client shall be	}		
1		tunity to maintain an ongoing			1
	relationship with he	er or his family through such			l.
		the facility and visits outside			j -
	the feality Depart	s shall be submitted at least			
	the facility. Report	ant of a minor regident or the			
		ent of a minor resident, or the			
		person of an adult resident.		:	
		writing or take the form of a			
		all focus on the client's			
	progress toward m	eeting individual goals.			
		ties. Each client shall have			
		es based on her/his choices,			
		itment/habilitation plan.			
		designed to foster community			
	Activities shall be o	uesigned to loster community			
		may be limited when the court			
		involved or when health or			
	safety issues beco	me a primary concern.			
	This Rule is not m	net as evidenced by:	1		
1		tions, interviews, and record			
1					
		failed to coordinate care			
	between the facilit				
		are responsible for			
	treatment/habilitati	ion affecting 1 of 4 clients			
	audited (client #4).	. The findings are:			
		<del>.</del>			
	Review on 2/12/20	20 of client #4's record			
	revealed:				
		a admittad 2/2/09	1		
	-32 year old femal		1		
		ed mild mental retardation,			
	bipolar disorder, a	nd diabetes.			
	- · · ·				
	Review on 3/13/20	20 of client #4's level 1 inciden	t		
Division of H	lealth Service Regulation		· · · · · · · · · · · · · · · · · · ·		
STATE FOR			6899	7QML11	If continuation sheet 7 of 23
	11.11.1			7 NETVILLET	

Division	of Health Service Re	egulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE COMF	
		MHL026-812	B. WING	· · · · · · · · · · · · · · · · · · ·	r	₹ 2 <b>0/2020</b>
	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	TATE, ZIP CODE		
	NONDER OR OUT EEK		ARWOOD STI			
RAINBO	W OF SUNSHINE 2		AKE, NC 28			
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRATE	DATE
V 291	Continued From pa	ge 7	V 291	n <b>8</b> 9- 1 - 1		
: 	reports dated 2/4/2	020 and 2/7/2020 revealed:				
1		am client #4 went to take her	-			
		ipped as she went to sit on the				
		er foot. Client #4 Informed the				
		r foot as she fell. Staff applied				
		stay off her foot. Staff notified				
		anager. The incident report	:			
	was signed and dat $-Op 2/7/20$ at 3:15	pm client #4 twisted and				-
		she went to step up on the				
		ping. The Group Home	!			J
		fied Professional (QP) were				- -
		as documented as a witness				
	to the incident.					
	office visit summary -History of present i slipped trying to get her ankle." She had	20 of client #4's orthopedic y dated 2/10/2020 revealed: illness: Client #4 reported she t out of her shower and "rolled I been walking on her ankle				
		ed her pain as severe, with a ient #4 described her				
	symptoms as sharp	, throbbing, and constant.				   
		n unchanged. Symptoms were				
		with walking, bending,				
		. Client #4 reported she was				}
		ng, numbness, stiffness,				
	limping and tingling					
		al examination findings: There				
		formity noted along the lateral				
		. Swelling, tenderness,				
		ig) noted about the lateral				
	ankle and malleolus					
		sis: Non-displaced closed al malleolus of the left fibula.				
	-A short leg cast wa					
	-	lient #4 was to be non-weight				
		ower extremity. Rest and				
		ed. She was to return in 1-2				
Division of He	ealth Service Regulation		<u> </u>			

STATE FORM

6899

7QML11

If continuation sheet 8 of 23

Division	of Health Service Re	gulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	SURVEY LETED
		MHL026-812	B. WING		03/2	R 0/2020
				TATE, ZIP CODE		
NAME OF 1	-ROMBER OR SOFFEER		RWOOD STR			
RAINBO	W OF SUNSHINE 2		AKE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 291	Continued From pa	ge 8	V 291			
	weeks for follow up					
	Review on 3/16/202 orthopedic office vis revealed: -History of present there had been no symptoms. Pain wi "10/10." Client #4 p short leg cast. She who stated the grou- client #4 walk on he was client #4 or the staff there that she however, they were experiencing sever -Left ankle examina- tenderness or ecch ankle and malleolus -X-rays demonstrat lateral malleolus fra -Treatment plan: C short leg cast (had She was to be non- Observations on 3/ 9 am revealed: -Client #4 was stan and ready to leave client did not have 1 -Client #4 did not h When asked about her bright pink shor placed over her left -At Approximately 9 a walker from her b	20 of client #4's follow up sit summary dated 2/26/2020 illness: Client #4 reported significant changes in her as severe with a rating, presented ambulating on her was present with a "nurse" up home had been having er cast. "She (unclear if this enurse) notes she told the is not supposed to be walking; having her walk. She is e pain at this time." ation documented no ymosis noted about the lateral s. ed a healing, non-displaced acture lient #4 was placed back in been removed for x-rays). weight bearing on her left leg. 13/2020 between 8:45 am and ding in her bedroom, dressed for her Day Program. The her walker with her. ave a shoe on her left foot. this, she showed the surveyor t leg cast. A sock had been				
	Interview on 3/13/2	020 client #4 stated:				
Division of H	ealth Service Regulation		·		· · · · ·	·

STATE FORM

0ľ.q

6899

7QML11

If continuation sheet 9 of 23

Division of Health Service Regulation       (X1) PROVIDERSUBPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:       (X3) DATE SURVEY COMPLETED         AND PLAN OF CORRECTION       (X1) PROVIDERSUBPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       R         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       03/20/2020         NAME OF SUNSHINE 2       307 CEDARWOOD STREET SPRING LAKE, NC 28390       CODRECTION ACTION SPLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       PROVIDER'S PLAN OF CORRECTION SOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETE DATE         V 291       Continued From page 9       V 291       V 291       Continued From page 9       V 291         -She had a cast on her left foot. -She had fallen in her shower and broken her foot. -She was waiting to go to her Day Program.       V 291       V 291         Telephone interview on 3/18/2020 Staff #6 stated: -She was not working the night client #4 hurt her ankle in the bathroom. She worked the next night. -Client #4 had complained that her ankle hurt "a little bit." Staff told her to stay off her foot. Her foot was not swollen at first, but later on it did       Her
MHL026-812     B. WING     03/20/2020       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     307 CEDARWOOD STREET       RAINBOW OF SUNSHINE 2     307 CEDARWOOD STREET     SPRING LAKE, NC 28390       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     ID     PREFIX     CROSS-REFERENCED TO THE APPROPRIATE     CMPLETE       TAG     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION     (X5)       V 291     Continued From page 9     V 291     CROSS-REFERENCED TO THE APPROPRIATE     CMPLETE       -She had a cast on her left foot.     -She had fallen in her shower and broken her foot.     -She was waiting to go to her Day Program.     V 291       Telephone interview on 3/18/2020 Staff #6 stated:     -She was not working the night client #4 hurt her ankle in the bathroom. She worked the next night.     -Client #4 had complained that her ankle hurt "a little bit." Staff told her to stay off her foot. Her foot was not swollen at first, but later on it did     -She was not swollen at first, but later on it did
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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (X5) COMPLETE DATE       V 291     Continued From page 9     V 291       V 291     Continued From page 9     V 291       -She had a cast on her left foot. -She had fallen in her shower and broken her foot. -She was waiting to go to her Day Program.     V 291       Telephone interview on 3/18/2020 Staff #6 stated: -She was not working the night client #4 hurt her ankle in the bathroom. She worked the next night. -Client #4 had complained that her ankle hurt "a liftle bit." Staff told her to stay off her foot. Her foot was not swollen at first, but later on it did
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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (X5) COMPLETE DATE       V 291     Continued From page 9     V 291       V 291     She had a cast on her left foot. -She had fallen in her shower and broken her foot. -She was waiting to go to her Day Program. Telephone interview on 3/18/2020 Staff #6 stated: -She was not working the night client #4 hurt her ankle in the bathroom. She worked the next night. -Client #4 had complained that her ankle hurt "a liftle bit." Staff told her to stay off her foot. Her foot was not swollen at first, but later on it did
RAINBOW OF SUNSHINE 2         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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (X5) COMPLETE DATE         V 291       Continued From page 9       V 291       V 291       V 291         She had a cast on her left foot. -She had fallen in her shower and broken her foot. -She was waiting to go to her Day Program.       V 291       V 291         Telephone interview on 3/18/2020 Staff #6 stated: -She was not working the night client #4 hurt her ankle in the bathroom. She worked the next night. -Client #4 had complained that her ankle hurt "a little bit." Staff told her to stay off her foot. Her foot was not swollen at first, but later on it did       Her
WY JD TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETE DATE         V 291       Continued From page 9       V 291       V 291         -She had a cast on her left foot. -She had fallen in her shower and broken her foot. -She was waiting to go to her Day Program.       V 291         Telephone interview on 3/18/2020 Staff #6 stated: -She was not working the night client #4 hurt her ankle in the bathroom. She worked the next night. -Client #4 had complained that her ankle hurt "a little bit." Staff told her to stay off her foot. Her foot was not swollen at first, but later on it did       V
-She had a cast on her left foot. -She had fallen in her shower and broken her foot. -She was waiting to go to her Day Program. Telephone interview on 3/18/2020 Staff #6 stated: -She was not working the night client #4 hurt her ankle in the bathroom. She worked the next night. -Client #4 had complained that her ankle hurt "a little bit." Staff told her to stay off her foot. Her foot was not swollen at first, but later on it did
-She had fallen in her shower and broken her foot. -She was waiting to go to her Day Program. Telephone interview on 3/18/2020 Staff #6 stated: -She was not working the night client #4 hurt her ankle in the bathroom. She worked the next night. -Client #4 had complained that her ankle hurt "a little bit." Staff told her to stay off her foot. Her foot was not swollen at first, but later on it did
<ul> <li>swell and she was taken to the doctor.</li> <li>Staff were told to apply ice and elevate her leg and to stay off of it as much as possible.</li> <li>Client #4 was very independent and staff had to remind her to stay off the leg.</li> <li>Telephone interview on 3/18/2020 Staff #2 stated:</li> <li>He worked the day shift and was not working when client #4 huisted her ankle in the bathroom.</li> <li>When client #4 huisted her ankle out shopping she was with her "1 on 1" day worker from the Day Program. Client #4 told them she hurt her ankle and they wrapped it. Client #4 did complain of pain, but this was typical for her to complain of pain.</li> <li>They did not realize it was that "bad off" before she went to the doctor. When she went to the doctor. When she went to the doctor when she her to elevate her foot, but they had to redirect her as she would not keep it elevated.</li> <li>Telephone interview on 3/18/2020 Staff #7 stated:</li> </ul>
-On 2/10/2020 she went with the Group Home Manager to take client #4 to the doctor. After the doctor took X-rays, she took client #4 to the
orthopedic doctor.     Image: Control of Health Service Regulation

STATE FORM

6899

7QML11

If continuation sheet 10 of 23

TATEMEN	of Health Service R	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING:	<u> </u>			
		MHL026-812	B. WING			R 03/20/2020	
		STREETA	DDRESS, CITY, ST.	ATE, ZIP CODE			
		-	ARWOOD STR				
RAINBO	N OF SUNSHINE 2	SPRING	LAKE, NC 283				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(XS) COMPLET DATE	
V 291	Continued From p	age 10	V 291				
	-The orthonedic d	octor put a cast on client #4's				İ	
	leg.						
	i -The physician's s	taff tried to teach her how to					
	walk on crutches	but her balance was such that					
	she was not able	to do this, so they gave her a				ļ	
		hey told her to not put weight o				i	
	her foot.	4 to the follow up orthopedic					
	annointment too	Client #4 was told not to walk				l	
	on the foot.						
	-Her ankle was su	wollen on the first visit to the					
	MD.						
	Intendiew on 3/13	/2020 and 3/18/2020 the Group					
	Home Manager s	tated:					
	-Client #4 had a s	light limp after she re-injured					
	her ankle on 2/7/2	2020 when she twisted her foot					
	stepping up on a	curb. It was not a "terrible" lim what was wrong she said she					
	and when asked	nkie on a curb. Staff applied ic	e				
	to her ankle He	did not see any swelling or					
	bruising.						
	-On 2/10/2020 he	e took client #4 to her primary					
	care physician ap	pointment for medication refills					
		slight limp and the physician	1				
	asked her why sh	e physician did an X-ray in his					
	I ne primary can office and put the	e x-ray on a disc. He sent client	t I I				
	#4 to an orthope	dic physician that same day.					
	-The orthopedic	physician put her in a cast and					
	i provided her with	i a walker.				í	
	-The staff who w	ent with the client said the					
		cian diagnosed a "hair line				ļ	
	fracture."	uctions from the orthopedic					
	physician as far a	as client #4's fracture.					
		3/2020 and 3/18/2020 the					
	Licensee stated:	d the Group Home Manager					
	- i ne stan notifie	u ine Group Home Managel					

Division	of Health Service Re	egulation				
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		MHL026-812	B. WING		F 03/2	R <b>0/20</b> 20
	- with the second se		1			
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
RAINBO	W OF SUNSHINE 2		RWOOD ST			
		SPRING L	AKE, NC 28	390		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 291	Continued From pa	ige 11	V 291			
V 291	when she slipped in the Licensee. Swe Home Manager tole check it at her upoo She did not recall s -On 2/7/2020 client shopping. The stat her to elevate her h -Client #4 continue during this time. -Staff #7 took client physician appointm walker. -The facility got no orthopedic physicia weight bearing. -On 3/13/2020 the the orthopedic physicia weight bearing. -On 3/13/2020 the the orthopedic physicia for office notes an Monday via facsim for office notes rec 3/16/2020 and 3/17 Review on March 2 Protection signed to 3/19/2020 revealed - "What will you im above rule violation from further risk or immediately Rainb a policy to Insure s and all loss of bala which causes them flooring as a result	<ul> <li>a the shower, and he notified lling developed and the Group d her he would have her doctor oming doctor appointment.</li> <li>areeing client #4 limping.</li> <li>are the hurt her ankle while if put ice on her ankle and had eg.</li> <li>a to attend the Day Program</li> <li>a t #4 to the orthopedic tent. Client #4 was given a</li> <li>a instructions from the ent to include instructions for</li> <li>Licensee stated she would call sician and get a copy of the ad send to the surveyor on ite. (See above record reviews eived via facsimile on 7/2020.)</li> <li>20, 2020 of the Plan of by the Licensee dated March d: mediately do to correct the ns in order to protect clients additional harm? Effective ow of Sunshine will implement taffing reports to the QP any nces sustained by a consumer in to strike a wall, furniture or of loss of balance irregardless</li> </ul>				
	of them showing an from further injury,	ny signs of injury. To protect staff will obtain written medical lining the necessary				
	procedures and procedures and procedures and procedures and processing the process of the process of the procedures and proced	ecautions to protect the rom further harm. Staff will do neir power to insure the				
Division of I	Health Service Regulation		· · · · · · · · · · · · · · · · · · ·			

STATE FORM

6399

7QML11

If continuation sheet 12 of 23

Division	of Health Service R	egulation			
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL026-812	B. WING		R 03/20/2020
	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, ST		
			ARWOOD STR		
RAINBO	W OF SUNSHINE 2		LAKE, NC 283		
			1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 291	Continued From pa	age 12	V 291		
	- "Describe your pl	to all physicians order's." ans to make sure the above			
	review the state re-	v of Sunshine leadership will quirements for filing an iris			
	Report and evaluat				; ;
-		any incident that meets the			
		quirement for filing an Iris onable. Any incident which			
		the QP will document the			
		ne's procedures for protecting			
	the Consumer and	submit the report to the	1		
	Human Rights Cor	nmittee for review."			
	2/3/08 with diagnos developmental disa diabetes. Client #4	abilities, bipolar disorder, and 4 injured her left ankle on			
	1	e fell in the bathroom, and e ankle on 2/7/2020 while in			
		ne direct care staff reported			
		e Group Home Manager and			
		ied first aid. Staff stated the			
		n, swelling, and a limp. Facility			
		nent did not recognize the injury. Client #4 continued to			
		ay program and walking on the			
		dical attention was sought for			
		a routine appointment with her			
		on 2/10/2020 he noted Client			
		ered an x-ray. The x-ray			
		ad a fracture. Client #4 was			
		pedic specialist and seen that			
		sical exam the orthopedic ated client #4 reported her pain			
		throbbing, constant, and			
ļ		inset." He diagnosed a			
		ture of the left lateral			
		a short leg cast, and instructed			
	the client to be non	-weight bearing. On 2/26/2020			
		rthopedic physician for follow	-		
Division of H	ealth Service Regulation	· · · · · · · · · · · · · · · · · · ·	······································	*=n	

STATE FORM

6899

7QML11

If continuation sheet 13 of 23

Division	of Health Service R	egulation			FORM.	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		(X3) DATE COMP	SURVEY LETED
		MHL026-812	B. WING		F 03/2	R 10/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, 4	STATE, ZIP CODE		
RAINBO	W OF SUNSHINE 2		ARWOOD ST			
			AKE, NC 2	8390		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 291	Continued From pa	age 13	V 291			
	presented ambulat was reported to the home had been ha physician gave inst non-weight bearing client #4 was obse her bed, without a Manager and Licer instructions from th Neither (Group Hot knew what the phy facility failed to ens #4's broken leg and orthopedic speciali- following the injury, increased pain and client #4 constitutin deficiency constituti serious neglect and days. An administr imposed. If the vio 23 days, an additio \$500.00 per day wi	documented client #4 ing on her short leg cast. It e physician that the group ving her walk on her cast. The ructions to continue on her left leg. On 3/13/2020 rved in her room standing by walker. The Group Home isee stated there were no care is orthopedic physician. me Manager or Licensee) sician had recommended. The ure timely treatment for client d also failed to follow the st's directions for care These failures resulted in delayed medical treatment for ig serious neglect. This res a Type A1 rule violation for d must be corrected within 23 rative penalty of \$2,000.00 is lation is not corrected within nal administrative penalty of II be imposed for each day the appliance beyond the 23rd day.				
V 366	27G .0603 Incident	Response Requirments	V 366			
	implement written p response to level l, shall require the pro (1) attending of individuals involv (2) determini	JIREMENTS FOR B PROVIDERS B providers shall develop and policies governing their II or III incidents. The policies povider to respond by: to the health and safety needs				

Division of Health Service Regulation STATE FORM

6899

7QML11

If continuation sheet 14 of 23

TATEMEN	of Health Service R	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		
ND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _			
MHL026-812		B. WING		R 03/20/2020		
	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
			RWOOD STR	REET		
(AINBO)	W OF SUNSHINE 2		AKE, NC 283			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLE
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	DATE
V 366	Continued From pa	age 14	V 366	,		
	measures accordir	ng to provider specified				
	timeframes not to					
	(4) developii	ng and implementing measures				1
	to prevent similar i	ncidents according to provider				
	specified timefram	es not to exceed 45 days;	{			
	(5) assigning	g person(s) to be responsible				
		of the corrections and				
	preventive measur	res;				
		to confidentiality requirements				
	set forth in G.S. 75	5, Article 2A, 10A NCAC 26B,				
		ad 3 and 45 CFR Parts 160 and				
	164; and	the state of the second				
	(7) maintain	ing documentation regarding				
	Subparagraphs (a	)(1) through (a)(6) of this Rule.				
	(b) in addition to t	he requirements set forth in				
	Paragraph (a) of u	his Rule, ICF/MR providers lents as required by the federal				
	regulations in A2 (	FR Part 483 Subpart I.				
	(c) in addition to t	he requirements set forth in				
	Paragraph (a) of t	his Rule, Category A and B				
	nroviders excludi	ng ICF/MR providers, shall	1			
	develop and imple	ment written policies governing				
		a level III incident that occurs				
		is delivering a billable service				
	or while the client	is on the provider's premises.				
	The policies shall	require the provider to respond				
	by:					
	(1) immedia	tely securing the client record				
	by:					
		, the client record;				
		a photocopy;				
	1	g the copy's completeness; and ing the comute an internal				
		ing the copy to an internal				
	review team;	ng a meeting of an internal				1
	<ul> <li>(2) convenii</li> <li>review team within</li> </ul>	ng a meeting of an internal n 24 hours of the incident. The				
		am shall consist of individuals	}			
		lived in the incident and who	ţ			
		ible for the client's direct care or				
	- HOLD HOLLOOPOILO		r			

STATE FORM

6899

7QML11

If continuation sheet 15 of 23

					E SURVEY PLETED	
	F CORRECTION IDENTIFICATION DETE		A. BUILDING: _	, <u></u> ,,		-
MHL02		MHL026-812	B. WING			R 20/2020
			DDRESS, CITY, ST		<u></u>	
	ROVIDER OR SUPPLIER		ARWOOD STR			
RAINBO	W OF SUNSHINE 2		LAKE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
<u> </u>	<u> </u>					
V 366	Continued From p		V 366			
:		ional oversight of the client's				
		e of the incident. The internal				
	review team shall complete all of the activities as follows:					
		e copy of the client record to				
	determine the fact	s and causes of the incident				
	and make recommendations for minimizing the					
	occurrence of futu					
	(B) gather o (C) issue wi	ther information needed; itten preliminary findings of fac	4			
	(C) Issue within five working	days of the incident. The	*			
	nreliminary finding	is of fact shall be sent to the				
		chment area the provider is				
		LME where the client resides,				
	if different; and					
		inal written report signed by the	9			
		months of the incident. The				
	final report shall b	e sent to the LME in whose				
		e provider is located and to the ent resides, if different. The	*			
		shall address the issues				
		ternal review team, shall				
		documents pertinent to the				Ì
	incident, and shal	make recommendations for				
	minimizing the oc	currence of future incidents. If				
		eded for the report are not				
		ree months of the incident, the				
		provider an extension of up to				
		ubmit the final report; and ately notifying the following:				
		responsible for the catchment				
		ervices are provided pursuant to				
	Rule .0604;					
		E where <b>the cl</b> ient resides, if				
		vider agency with responsibility				
	for maintaining ar	nd updating the client's				
		different from the reporting				
	provider;	. 0				)
			Ł			÷

STATE FORM

6899

7QML11

If continuation sheet 16 of 23

Division	of Health Service Re	egulation			T ORM	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:	(X3) DATE COMF	SURVEY
		MHL026-812	B. WING			२ 20/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY.	, STATE, ZIP CODE		
DAINDO			ARWOOD S			
RAINBO	W OF SUNSHINE 2	SPRING	LAKE, NC 🖇	28390		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 366	Continued From pa	ige 16	V 366			
	(D) the Depar (E) the client applicable; and	-				
	facility failed to imp governing their resu findings are: Review on 3/13/202 revealed: -32 year old female -Diagnoses include bipolar disorder, an Review on 3/13/202 reports revealed: -Level 1 incident re client #4 informed s she fell in the bathr told her to stay off the Manager was notified -Level 1 incident re #4 twisted her foot retail store. Staff do foot as she went to Group Home Mana (QP) were notified. Review on 3/16/202	s and record reviews the lement written policies conse to incidents. The 20 of client #4's record admitted 2/3/08. d mild mental retardation, d diabetes. 20 of client #4's level 1 incident port: 2/4/2020 at 6:18 pm staff she twisted her foot as com. Staff applied ice and her foot. The Group Home				
Division of H	revealed: ealth Service Regulation	·····	]			
STATE FOR			6899	7QML11	If continuatio	n sheet 17 of 23

STATEMEN	of Health Service R T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLETED
		MHL026-812	B. WING		R 03/20/2020	
NAME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, S			
RAINBO\	W OF SUNSHINE 2	SPRING I	AKE, NC 28	390		
(X4) ID PRÉFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 366	her shower and "ro walking on her and rating "10/10." Syn when with walking -Swelling, tendern by the physician. -Physician diagnos lateral malleolus o -Short leg cast app Interview with the 3/13/2020 reveale physician following routine office visit care physician for no care instruction physician.	d she slipped trying to get out of bled her ankle." She had been kle since. Pain was severe, nptoms were made worse , bending, standing, and lifting. ess, bruising were documented sed a non-displaced fracture of if left fibula, closed fracture.				
V 367	10A NCAC 27G .( REPORTING RE- CATEGORY A AN (a) Category A an level II incidents, the provision of b consumer is on the incidents and level to whom the prov 90 days prior to the responsible for the services are prov becoming aware	nt Reporting Requirements 0604 INCIDENT QUIREMENTS FOR ID B PROVIDERS IND B PROVIDERS				

Division of Health Service Regulation STATE FORM

6899

7QML11

if continuation sheet 18 of 23

h Service R	Regulation			rURW	IAPPROVED
CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			E SURVEY PLETED
	MHL026-812	B. WING			R 20/2020
OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE. ZIP CODE		
	SPRING L	AKE, NC 28	3390		
CH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETE DATE
ed From pa	age 18	V 367			
iny. The report on, facsimile The report tion: reporting ation inform client ide type of in description status of of the incide other indi- ording. egory A and or incomple- bmit an up ecipients by enever: the provide us, mislead the provide us, mislead the provide us, mislead the provide us, mislead the provide us, mislead the provide us, the provide able. egory A and quest by the d regarding hospital r tion; reports by the provide egory A and quest by the d regarding hospital r tion; reports by the provide egory A and cel III incide dealth, Dev ince Abuse S ing aware of s shall sen s involving	port may be submitted via mail, e or encrypted electronic t shall include the following provider contact and nation; ntification information; icident; on of incident; the effort to determine the ent; and ividuals or authorities notified d B providers shall explain any lete information. The provider dated report to all required y the end of the next business der has reason to believe that ed in the report may be ding or otherwise unreliable; or der obtains information ident form that was previously d B providers shall submit, e LME, other information the incident, including: records including confidential y other authorities; and der's response to the incident. d B providers shall send a copy ent reports to the Division of velopmental Disabilities and Services within 72 hours of f the incident. Category A d a copy of all level III a client death to the Division of				
	CIENCIES COR SUPPLIER NSHINE 2 SUMMARY ST CH DEFICIENC ULATORY OR reporting reporting ration inforr client ide type of in descriptiv status of of the incide other ind or incompl bmit an up- ecipients by enever: the provide us, mislead of the provide us, mislead the provide the prov	IDENTIFICATION NUMBER:         MHL026-812         OR SUPPLIER       STREET AD         NSHINE 2       307 CEDA         SUMMARY STATEMENT OF DEFICIENCIES       SPRING L         SUMMARY STATEMENT OF DEFICIENCIES       Ch DEFICIENCY MUST BE PRECEDED BY FULL         ULATORY OR LSC IDENTIFYING INFORMATION)       INFORMATION)         Indeed From page 18       Interport may be submitted via mail, on, facsimile or encrypted electronic         The report shall include the following tion:       reporting provider contact and         Information;       client identification information;         type of incident;       description of incident;         status of the effort to determine the of the incident; and other individuals or authorities notified ording.         egory A and B providers shall explain any or incomplete information. The provider bmit an updated report to all required ecipients by the end of the next business enever:         The provider has reason to believe that tion provided in the report may be us, misleading or otherwise unreliable; or the provider obtains information         d on the incident form that was previously able.         egory A and B providers shall submit, quest by the LME, other information	CIENCIES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPL A. BUILDING         B. WING       B. WING         OR SUPPLIER       STREET ADDRESS, CITY, 3         NSHINE 2       307 CEDARWOOD ST SPRING LAKE, NC 21         SUMMARY STATEMENT OF DEFICIENCED BY FULL ULATORY OR LSCIDENTIFYING INFORMATION;       ID PREFIX TAG         V 367       PREFIX TAG         Int, facsimile or encrypted electronic The report may be submitted via mail, on, facsimile or encrypted electronic The report shall include the following tion:       V 367         red From page 18       V 367         Int, facsimile or encrypted electronic The report shall include the following tion:       V 367         reporting provider contact and ation information; client identification information; type of incident; status of the effort to determine the of the incident; and other individuals or authorities notified ording.       V 367         egory A and B providers shall explain any or incomplete information. The provider bmit an updated report to all required ecipients by the end of the next business enever:       Interprovider has reason to believe that tion provider in the report may be us, misleading or otherwise unreliable; or the provider has reason to believe that tion provider in the report may be us, misleading or otherwise unreliable; or the provider seponse to the incidential tion; reports by other authorities; and the provider's response to the incident.         egory A and B providers shall submit, quest by the LME, other information d regarding the incident, including: hospital records including conf	CIENCES       (X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER:       R2 MULTIPLE CONSTRUCTION A. BUILDING:         MHL026-812       B. WING         OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         NSHINE 2       307 CEDARWOOD STREET         SUMMARY STATEMENT OF DEFICIENCIES       ID PROVIDER'S PLAN OF CORE SUMMARY STATEMENT OF DEFICIENCIES       ID PROVIDER'S PLAN OF CORE (EACH CORRECT'VE ACTION SI (EACH CORRECT'VE ACTION SI CROSS-REFERENCY OF CORE (EACH CORRECT'VE ACTION SI (CACH CORRECT'VE ACTION SI (CACH CORRECT'VE ACTION SI CROSS-REFERENCY OF CORE (EACH CORRECT'VE ACTION SI (CACH CORCTON SI (CACH CORRECT'VE	CIENCIES       (X1) PROVIDERSUPPLIENCLIA       R2 MULTIPLE CONSTRUCTION       (X3 particular construction         CMI       DEMTIFICATION NUMBER:       A BUILDING:       (X3 particular construction)       (X3 particular construction)         OR SUPPLIER       STREET ADDRESS. CITY, STATE, ZP CODE       307 CEDARWOOD STREET       037         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       037         OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       037         DECOMPTY OR L3C DENTIFYING INFORMATION)       PREEX       (K4 construction)       037         ILLIATORY OR L3C DENTIFYING INFORMATION)       PREEX       (K4 construction)       037         ILLIATORY OR L3C DENTIFYING INFORMATION)       PREEX       (K4 construction)       040         ILLIATORY OR L3C DENTIFYING INFORMATION)       PREEX       (K4 construction)       040         ILLIATORY OR L3C DENTIFYING INFORMATION)       PREEX       (K4 construction)       040       07 <td< td=""></td<>

Division of Health Service Regulation STATE FORM

6899

7QML11

If continuation sheet 19 of 23

Division	of Health Service Re	egulation				
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	• •		(X3) DATE S COMPL	
		MHL026-812	B. WING		R 03/20	)/2020
				STATE, ZIP CODE	*	
NAME OF I	ROVIDER OR SUPFLIER		RWOOD ST			
RAINBO	W OF SUNSHINE 2		AKE, NC 28	3390		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) Complete Date
V 367	Continued From pa	ige 19	V 367			
ŕ		the incident. In cases of seven days of use of seclusion				
	or restraint, the pro	vider shall report the death quired by 10A NCAC 26C				
	.0300 and 10A NCA	AC 27E .0104(e)(18).				
	report quarterly to t	I B providers shall send a he LME responsible for the				
	The report shall be	ere services are provided. submitted on a form provided				
1		a electronic means and shall formation as follows:				
	(1) medicatio	n errors that do not meet the Il or level III incident;				
	(2) restrictive	interventions that do not meet				
	•	evel II or level III incident; of a client or his living area;				
	(4) seizures ( the possession of a	of client property or property in a client:				
		umber of level II and level III				
	(6) a stateme	ent indicating that there have				
	incidents have occu	incidents whenever no urred during the quarter that				
		eria as set forth in Paragraphs Rule and Subparagraphs (1)				
	through (4) of this F	Paragraph.				
	This Rule is not me	-				
		views and interviews, the ort all level II incidents to the			Ì	
	LME responsible fo	r the catchment area where				
	-	ed within 72 hours of the incident. The findings are:			-	
	Review on 3/13/202	20 of client #4's record				
Division of H	revealed: ealth Service Regulation			,,,,,,, _		

STATE FORM

6899

7QML11

If continuation sheet 20 of 23

<u>Division</u>	of Health Service Re	egulation	·		1	
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	
					R	
			B, WING		03/20/	2020
		MHL026-812	<u></u>		1 03/20/	2020
	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE		
			RWOOD ST			
RAINBO	W OF SUNSHINE 2					
		SPRING	AKE, NC 28			
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
TAG				DEFICIENCY)		
·	i			· · · · · · · · · · · · · · · · · · ·		
V 367	Continued From pa	age 20	V 367			
	22 upor old formold	admitted 2/3/08			ļ	
	-32 year old female		1		Í	
		ed mild mental retardation,				
1	bipolar disorder, ar	iu diadetes.	1			
	During an Alterna	00 of allocative antices and				
		20 of client #4's orthopedic		2 2 2		
1		ummary dated 2/10/2020				
1	revealed:	also alianad tarias to got ant of				
		she slipped trying to get out of			l	
		led her ankle." She had been				
	walking on her ank					
		non-displaced fracture of				
		f left fibula, closed fracture.				
	-Short leg cast app	liea.				
	1. h	000 the Linence stated				
		2020 the Licensee stated:	ļ.			
		el 2 incident report made after				
		by an orthopedic physician on				
	2/10/2020.					
		onsible for submitting level 2				
	incident reports.					
V 736	27G .0303(c) Facil	ity and Grounds Maintenance	V 736			
1	10A NCAC 27G .0	303 LOCATION AND	6			
	EXTERIOR REQU	IIREMENTS			Í	
		d its grounds shall be				
	maintained in a sa	fe, clean, attractive and orderly				
	manner and shall I	be kept free from offensive				
	odor.	-				
Į						
1			]			
				1		
1			5		Ì	
	This Rule is not m	net as evidenced by:				
		tions and interview, the facility				
		d in a safe, clean, attractive				
	and orderly manne	er, free from offensive odor.	1			
	The findings are:					
1			ļ	·		
Division of I	l Health Service Regulation					

STATE FORM

6899

7QML11

If continuation sheet 21 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER				CONSTRUCTION		SURVEY PLETED
IND PLAN	OF GORRECTION		A, BUILDING:		-   R	
MHL026-812		B. WING	B. WING		20/2020	
IAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		307 CED	ARWOOD STRE	EET		
AINBO	W OF SUNSHINE 2	SPRING	LAKE, NC 283	90		
(X4) 1D	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5) COMPLET
PRÉFIX TAG	(EACH DEFICIENC REGULATORY OR 1	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
V 736	Continued From pa	age 21	V 736			
	Observations on 3	/13/2020 between 9 am and 10				
	am revealed:					
		Missing handles on client's				
	dresser, middle dra	-				
:		Missing bottom drawer in				
		iddle drawer off track. Seven	1			
		window blinds. Accordion				
		k. Unpainted wall patch by the				
		y 24 by 12 inches in size. No				
	globe over light bu					
	-Hall bath: Black o	discolorations of calking around				
	the tub.	6				
		Musty odor present.				
	-Hall wall adjacent	to client #5's room: Vertical				
	area about 10 incl	ies in height and 2 inches in				
		the approximate size of a nail				
		not been repaired and painted				
	to match the surro					
	-Clients #1 and #4	's room: Curtain rod swayed in				
	the middle Sink f	aucet knob for sink stop pull				
	missing exposing	the screw where the knob				
	should be attache	d. Gray ceiling stains above the				
	shower.		- J			
		te floor planks separated at				
	seams. Insect we	b under the sink attached to the	e			
		ebris particles collected inside				
	the sink base cabi					
		wooden ramp had been built				
	attaching the front	porch to the ground. Ramp				
	was steen and me	easured 21 inches high from the	<b>}</b>			
	around to the poin	t it attached to the porch, and 8	, į			
	feet in length from	the top edge of the slope to th	e			
	point of contact wi					
	-Clients #1 #4 ar	d #5 were observed ambulating	a			
	down the ramp as	they left the home. Client #4				
		the aid of a walker and had a				
	cast on her left leg					Ì
		_				
	This deficiency co	institutes a re-cited deficiency				

<u>Division</u>	of Health Service Re	egulation			FORMAPPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL026-812			R 03/20/2020
NAME OF I				STATE, ZIP CODE	1 00.20.2020
			DARWOOD S		
	W OF SUNSHINE 2		LAKE, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 736	Continued From pa	ge 22	V 736		
	and must be correc	ted within 30 days.			
	ealth Service Regulation		<u> </u>	I	
STATE FORM	Λ		6899 7	QML11 I	f continuation sheet 23 of 23

STATE FORM

# Tara Ingram, President/Executive Director Rainbow of Sunshine. Inc 307 Cedarwood Street Spring Lake, NC 28390 910-527-3083

April 4, 2020

Re: Annual and Follow Up Survey completed March 20, 2020
 Rainbow of Sunshine 2, 307 Cedarwood street, Spring Lake, NC 28390
 MHL 026-812
 E.-mail Address: <u>danny05dan@aol.com</u>

# V 111

Rainbow of Sunshine recognize that our agency did not discharge this client from their current location to another agency location by not preparing a new admission assessment.

Rainbow of Sunshine have corrected this deficiency by ensuring that all client transfers will receive an admission assessment prior to the transfer. Rainbow of Sunshine will review all potential client transfers by following the company's written policy of in-agency client discharge and transfer to another home location.

Rainbow of Sunshine Executive Director will be responsible to ensure that all discharges and transfers are carried out in accordance with the company's policy.

Rainbow of Sunshine shall monitor this process as needed when a potential discharge and transfer is anticipated.

# V II8 27G.0209 (C) Medication Requirements

Rainbow of Sunshine currently has corrected the medication error of client by ensuring that the client's pharmacy prescription has been corrected to reflect the physician order.

Rainbow of Sunshine will ensure that measures be put in place such as submitting and requesting that the agency's physician order form with prescribed medication be provided to the physician office and given to agency's staff prior to exiting the office visit.

Rainbow of Sunshine shall communicate with the prescribing pharmacy to ensure that all prescribed medications will be filled and delivered in a timely manner. Rainbow of Sunshine will also put in place an alternate pharmacy to ensure that all client's medications are received, recorded and administered in accordance with the physician orders.

Rainbow of Sunshine Qualified Professional shall be responsible to ensure that physician order form be given and collected after each physician visit for confirm medication compliance.

Rainbow of Sunshine physician order policy shall be monitored on a consistent basis to ensure that all client medications will be filled and distributed as ordered in accordance with the physician medication orders.

Rainbow of Sunshine shall ensure that all client's medication is administer by physician orders and documented on the client's MAR accurately.

Rainbow of Sunshine Qualified Professional shall conduct in-service training to all staff members on the policy and procedures on the

correct way of ensuring the administering of client's medications and preparing the MAR.

# V 291.27G.5603 Supervised Living – Operations

Rainbow of Sunshine shall ensure going toward that there will be ongoing communication between staff and the Qualified Professional pertaining to all notified injuries to clients and staff in a mandatory manner.

Rainbow of Sunshine shall adhere to the written and signed Plan of Protection dated March 19, 2020 stated that the facility shall implement a policy to insure staffing reports to the Qualified Professional any and all loss of balances sustained by a consumer which causes them to strike a wall, furniture or flooring as a result of loss of balance regardless of them showing any signs of injury. To protect from further injury, staff will obtain written medical documentation outlining the necessary procedures and precautions to protect the consumers injury from further harm. Staff will do everything within their power to ensure the consumers adhere to all physicians' orders.

Rainbow of Sunshine leadership will review the state requirements for filling an Iris Report and evaluate any incident and immediately report any incident that meets the states minimum requirement for filing an Iris Report or is questionable. Any incident which results in an injury the Qualified Professional will document the Rainbow of Sunshine procedures for protecting the consumer and submit the report to the Human Rights committee for review in a timely manner.

Rainbow of Sunshine has assigned the Qualified Professional the responsibility to ensure that the facility policy and procedures are adhered as written.

Rainbow of Sunshine Qualified Professional shall conduct mandatory inservice training to all staff on reporting all types of incidents: neglect, abuse and exploitation in a timely manner.

Rainbow of Sunshine monitoring of these policies and procedures shall be on a consistent basis.

Rainbow of Sunshine Qualified Professional shall conduct health and wellness check on a every two basis to all consumers residing within the facility homes.

# V 366 27G.0603 Incident Response Requirements

Rainbow of Sunshine going forward shall implement written policies governing their response to all identify incidents.

Rainbow of Sunshine Qualified Professional shall be responsible for the reporting of all identify incident to all required agencies as reference to the consumer catching area LME were the consumer resides, guardians and all other agencies that has jurisdiction pertaining to the consumer.

Rainbow of Sunshine shall conduct an internal investigation if necessary, to resolve any underline problems that could possibly comprise the outcome of the reason of the projectable incident.

Rainbow of Sunshine Executive Director shall monitor all incident reporting and ensure that incidents are being monitored and are adhering to all policies and regulations as required by state statuses.

# V 367 27G.0604 Incident Reporting Requirement.

Rainbow of Sunshine Qualified Professional shall follow the Incident Reporting requirements as they relate to Level II incidents within 72 hours of becoming aware of the incident. Rainbow of Sunshine Qualified Professional shall conduct an internal investigation if warranted to provide any accompany information as required to resolve any potential confusion.

Rainbow of Sunshine Executive Director shall be responsible to ensure that all Level II and III incidents are conducted and prepared to the required agencies by the Qualified Professional in the required time frame.

Rainbow of Sunshine shall monitor all incidents and reporting documentations at all time in a consistent manner.

# V 736 27G.0303 © Facility and Ground Maintenance

Rainbow of Sunshine desired goals are to maintain in a safe, clean, attractive and orderly manner, free from offensive odor in their facilities always.

Client #3 room:

Missing handles on client's dresser, middle drawer replaced: Completed

Client #6 room:

- Missing bottom drawer in client's dresser-
- Middle drawer off track---
- Seven broken slats in the window blinds—
- Accordion closet door off track—
- Unpainted ted wall patch by the door approximately 24 by 12 inched in size---

• No globe over light bulb in ceiling fan---Hall bath:

• Black discolorations of calking around the tub---

Client #2's room:

• Musty odor present---

Hall wall adjacent to client's #5 room:

 Vertical area about 19 inches in height and 2 inches in width with 4 holes the approximate size of a nail or screw; area had not been repaired and painted to match the surrounding wall. ---

Client's #1 and #4's room:

- Curtain rod swayed in the middle.
- Sink faucet knob for sink stop pull missing, exposing the screw where the knob should be attached. –
- Gray celling stains above the shower---

Kitchen:

- Laminate floor planks separated at seams---
- Insect web under the sink attached to the plumbing---
- Black debris particles collected inside the sink base cabinet—

Front of home:

- A wooden ramp had been built attaching the front porch to the ground --
- Ramp was steep and measured 21 inches high from the ground to the point it attached to the porch, and 8 feet in length from the top edge of the stope to the point of contact with the ground---

Client's ! #, #4, and \$5

- were observed ambulating down the ramp as they left the home---
- Client's #4 was walking with the aid of a walker and had a cast on her leg---

Rainbow of Sunshine shall correct all the above cited deficiencies within the 30 days as required.

Rainbow of Sunshine shall ensure that these deficiencies or other future deficiencies will be repaired within a reasonable time after visual inspections of discovering the deficiencies.

Rainbow of Sunshine shall use the facility Inspection Form to record all deficiencies as a running log for documentation.

Rainbow of Sunshine shall designate the Group Home Manager the sole responsible staff to ensure that all deficiencies are corrected in timely manner.

Rainbow of Sunshine staff shall receive in-service training to ensure that all staff are aware of their responsibilities to assist in the professional care of the clients, the internal and external care of the facility and grounds.

ATTention Mrs Besty bodwin From: Rainbow of Sunshine 2 (Tara Ingram)

I will mail the original copies.

Thank you Tamp 4-7-2020