	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03/01/2022	
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD			
		ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	5	V 000			
	An annual and complaint survey was completed March 1, 2022. The complaints were substantiated (intake #NC00184029 and #NC00185589). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
	The survey sample of current clients.	consisted of audits of 3				
	as referred to throug twin like bed with res client #1's bedroom larger bed for sleepin straps which fastene ankles. Client #1's E 12/2/21 revealed: "the very restrictive	his report: The "small bed" hout this report was a small straints which was located in positioned adjacent to a ng and included 4 leather ed to client #1's wrists and Behavior Support Plan dated e nature of the wrist band alized bed with leg and wrist				
V 109	27G .0203 Privilegin	g/Training Professionals	V 109			
	QUALIFIED PROFE ASSOCIATE PROFE (a) There shall be m qualified professional (b) Qualified professional professionals shall d and abilities required (c) At such time as a employment system then qualified profess professionals shall d	ESSIONALS o privileging requirements for als or associate professionals. sionals and associate emonstrate knowledge, skills d by the population served.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING	03	8/01/2022	
iame of Pi	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 109	Continued From page	e 1	V 109			
	NCAC 27G .0104 (18 met the requirements employment system i MH/DD/SAS. (f) The governing bo develop and implement for the initiation of an plan upon hiring each (g) The associate pro- supervised by a qualit population served for	dge; ss; ; lls; skills; and ionals as specified in 10A B)(a) are deemed to have s of the competency-based in the State Plan for dy for each facility shall ent policies and procedures individualized supervision associate professional.				
	interviews 1 of 1 Qua Executive Director (E knowledge, skills, and population served. Th	ews, observation, and lified Professional (QP)/ D) failed to demonstrate the d abilities required by the ne findings are:				
	Service Plan (V112). and interviews, the fa	A NCAC 27G .0205- atment/Habilitation or Based on record reviews acility failed to implement assessment affecting 1 of 3				

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	8/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 109	Continued From pag	e 2	V 109			
	clients (#1).					
	(V290). Based on rec and interviews the fa staff-client ratios abo enable staff to respon	ve the minimum number to nd to individualized client f an emergency affecting 3 of				
	Incident Response R & B Providers (V366)	A NCAC 27G .0603 - lequirements for Category A). Based on record reviews cility failed to document their ncidents.				
	Incident Reporting R & B Providers (V367) and interview, the fac	A NCAC 27G .0604 - equirements For Category A). Based on record reviews cility failed to report incidents ment Entity/Managed Care ICO) as required.				
	Restrictive Alternative interviews and record provide services/sup	d reviews the facility failed to ports that used the least n procedure to reduce a				
	reviews, and intervie adhere to prohibited the client for the purp	es (V514). Based on record ws, the facility failed to procedures administered to				
		A NCAC 27E .0104 - Restraint and Isolation				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	I	ADDRESS, CITY, STATE,	ZIP CODE		<i>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</i>
			AND CREEK ROAD			
RAINBOW	/ FARMS		POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 109	Continued From page	e 3	V 109			
	Time-Out and Protect Behavioral Control (W reviews, observation, failed to ensure that as the physical and psyc client throughout the intervention, and faile least restrictive altern attempted whenever (#1). Cross Reference: 10. Seclusion, Physical F Time-Out and Protect Behavioral Control (W reviews and interview ensure the necessary client record when a utilized for 1 of 3 clien Cross Reference: 10. Seclusion, Physical F Time-Out and Protect Behavioral Control (W reviews, observation failed to ensure perio	tive Devices Used for /518). Based on record and interviews, the facility staff were present to monitor chological well-being of the duration of the restrictive ed to ensure that positive and hatives were considered and possible for 1 of 3 clients A NCAC 27E .0104 - Restraint and Isolation tive Devices Used for /521). Based on record /s, the facility failed to / documentation was in the restrictive intervention was nts (#1). A NCAC 27E .0104 - Restraint and Isolation tive Devices Used for /523). Based on record and interviews, the facility dic observation of the client ninutes during a physical e safety of the client, s (#1).				
	Time-Out and Protec Behavioral Control (V reviews and interview document notification legally responsible pe	of the treatment team and				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
				A. BUILDING:			
		MHL071-027	B. WING		03	/01/2022	
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 109	Continued From page	Continued From page 4					
	Cross Reference: 10A NCAC 27E .0104 - Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V525). Based on record reviews and interviews, the facility failed to maintain a log of restrictive interventions performed at the facility and conduct regular reviews of restrictive interventions as required, affecting 1 of 3 clients (#1). Cross Reference: 10A NCAC 27E .0104 -						
	Time-Out and Protect Behavioral Control (V review and interviews document the type of effectiveness of proce	-					
	Time-Out and Protect Behavioral Control (V reviews and interview that consent or appro interventions shall be more than six months continue a specific int clear and recent beha intervention is having	A NCAC 27E .0104 - Restraint and Isolation tive Devices Used for (528). Based on record vs the facility failed to ensure val for planned restrictive considered valid for no s, and that the decision to tervention shall be based on avioral evidence that the a positive impact and ed, affecting 1 of 3 clients					
	Time-Out and Protect Behavioral Control (V reviews and interview	A NCAC 27E .0104 - Restraint and Isolation tive Devices Used for (529). Based on record (the facility failed to have client file of description and					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03	8/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
	SUMMARY ST			PROVIDER'S PLAN O		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 109	Continued From page	e 5	V 109			
	frequency of debriefing, bi-monthly evaluations of the planned intervention, and monthly review of the planned intervention by the treatment/habilitation team affecting 1 of 3 clients (client #1). Review on 1/5/22 of the QP/ED's personnel record revealed: -Date of hire: 6/24/14 -Job Title: Qualified Professional (QP)/ Executive Director (ED)					
	2/8/22 and signed by -"What immediate ac ensure the safety of t Effective immediately utilize his small bed f whether he requests Management will be Support and Program that the restraints has bed and is no longer utilize. Staff will also utilize EBPI (Evidence Interventions) technic themselves and [client behavioral occurrence destruction, and/or se place."	notifying all ASAP (Autism ns, Inc) staff via email today ve been removed from the available for [client #1] to be informed in the email to be Based Protective ques and training to protect nt #1] in the event that any ses of aggression, property elf injurious behaviors take				
	happens. All restrain removed from [client bedroom and will not purposes effective im	EBPI techniques to prevent, nanage maladaptive v be displayed in an				

Division of Health Serv STATE FORM

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NAME OF PROVIDER OR SUPPLIER	200 ISL/	A. BUILDING: B. WING		03	/01/2022
NAME OF PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE		03	/01/2022
NAME OF PROVIDER OR SUPPLIER	200 ISL/				/01/2022
RAINBOW FARMS	KOCKI	AND CREEK ROAD POINT, NC 28457			
				DEOTION	
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES IST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
V 109 Continued From page 6		V 109			
utilize gym mats to prote head/body on the floor, w add a protective barrier f while continuing to close during behavioral episod [Qualified Professional Director], ASAP's Execut Qualified Professional co Coordinator to inform hel higher level of care, whic provide. [Care Coordina Coordinator for [client #1 Management Entity's] Ex determine if there were a needing to be transferred [Programs Director an held an emergent Board meeting via zoom (1/19/2 matter and the B.O.D. ag needs a higher level of co needs. [Programs Direct Director] spoke to [Care her of the B.O.D.'s decisi care. we also discussed	nmediately via email the small bed as a ms Director, who is also ide a refresher course to techniques which will be and all staff safe during the event [client #1] falls ang his head, staff are to oct him from hurting his vall, etc. The mat will also or staff to remain safe ly monitor [client #1] es. I (QP)/Executive ive Director and intacted [client #1's] Care of [client #1] requiring a th ASAP is unable to tor], the Care] spoke to [Local tecutive Team to liternatives to him d to higher level of care. d QP/Executive Director] of Director's (BOD) 2022) to discuss the greed that [client #1] care to address his tor and QP/Executive Coordinator] to inform on for as higher level of with her the need to ndividual Support Plan) to n of using the small bed so contacted [Behavior				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING			3/01/2022
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,		03	5/01/2022
	ROVIDER OR SOFFLIER		AND CREEK ROAD	ZIF CODE		
RAINBOW	V FARMS		POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 109	Continued From page	e 7	V 109			
	The Care Coordinator is actively looking for placement with a higher level of care for [client #1]. Once placement is arranged, ASAP will discharge [client #1] from the organization. Until placement is determined for [client #1] (outside of A.S.A.P.) and he has been officially discharged/transitioned into new placement, A.S.A.P. will continue to schedule two staff per shift."					
Review on 3/1/22 of the Plan of Pro 3/1/22 and signed by the QP/ED re -"What immediate action will the far ensure the safety of the consumer Effective immediately, [client #1] w utilize his small bed for the purpose whether he requests the restraint of Management will be notifying all AS Support and Programs, Inc) staff v that the restraints have been remo bed and is no longer available for [utilize. Staff will also be informed i utilize EBPI (Evidence Based Prote Interventions) techniques and train themselves and [client #1] in the ev behavioral occurrences of aggress destruction, and/or self injurious be place."	the QP/ED revealed: tion will the facility take to the consumer's in your care? , [client #1] will no longer for the purpose of a restraint the restraint or not. notifying all ASAP (Autism ns, Inc) staff via email today ve been removed from the available for [client #1] to be informed in the email to be Based Protective ques and training to protect int #1] in the event that any ses of aggression, property					
	happens. All restrain removed from [client bedroom and will not purposes effective im members will utilize f redirect, and better m behaviors which may aggressive and/or SI	EBPI techniques to prevent, nanage maladaptive v be displayed in an B (self-injurious behavior) Director], ASAP's Programs				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
			A. BUILDING:			
		MHL071-027	MHL071-027 B. WING		03	/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	V FARMS		AND CREEK ROAD			
		ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 109	Continued From page	e 8	V 109			
	(1/17/2022) not to util restraint. ASAP's Pro- the EBPI trainer will p review all EBPI restra- used to keep [client # behavioral episodes. to the floor or begins utilize gym mats to pu- head/body on the floor add a protective barri while continuing to cl during behavioral epi [Qualified Professional Coordinator Professional Coordinator to inform higher level of care, w provide. [Care Coord Coordinator for [clien Management Entity's determine if there we needing to be transfe [Programs Director held an emergent Bo meeting via zoom (1/ matter and the B.O.D. needs a higher level needs. [Programs Di Director] spoke to [Ca her of the B.O.D.'s de care. we also discus revise [client #1's] IS reflect the discontinua- for de-escalation. W Analyst] with [commu- and requested he rew plan to reflect the discontinua- tor fue comparison of the size of the size of the size plan to reflect the discontinua- tor fue comparison of the size of the	lize the small bed as a lograms Director, who is also provide a refresher course to aint techniques which will be 41] and all staff safe during In the event [client #1] falls to bang his head, staff are to rotect him from hurting his or, wall, etc. The mat will also ier for staff to remain safe osely monitor [client #1] sodes. onal (QP)/Executive ecutive Director and al contacted [client #1's] Care ther of [client #1] requiring a which ASAP is unable to dinator], the Care t #1] spoke to [Local] Executive Team to the alternatives to him erred to higher level of care. r and QP/Executive Director] ard of Director's (BOD) 19/2022) to discuss the 0. agreed that [client #1] of care to address his irector and QP/Executive are Coordinator] to inform ecision for as higher level of sed with her the need to P (Individual Support Plan) to ation of using the small bed e also contacted [Behavior unity mental health business] vise [client #1's] behavior continuation of using the				
ivision of Hea	plan to reflect the dis small bed for de-esca	continuation of using the alation . lient #1's] guardian does not				

Division of Health Service Regula STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MHL071-027		B. WING		3/01/2022
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		03	5/01/2022
	NONDER OR SOFT EIER		AND CREEK ROAD			
RAINBOW	/ FARMS		POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 109	Continued From page	e 9	V 109			
	(Individual Support P small bed has been r ISP has been change meeting the end of th meets, we may or ma signed ISP, dependin after the meeting. If request the unsigned Coordinator to have a requests. The Care Coordin placement with a hig #1]. Once placemen discharge [client #1] Client #1 was a 31 ye 6/10/09 with diagnos disorder and severe addition, client #1 su movement/digestion and frequent headac and medical history r physical assaults, pro potentially life threate hitting his head again himself in the face, a Based on client #1's 12/2/21, the facility u intervention to addree The "small bed" was larger bed for sleepin straps which fastene ankles. Expectations documented observa- increments to ensure and the successful in	Ian) which reflects that the removed as a resource. The ed and the team will be his week. Once the team ay not have an updated and hg on the guardian's stance he chooses not to sign, I will I plan from the Care as our attempt to comply with hator is actively looking for her level of care for [client t is arranged, ASAP will from the organization." ear-old male admitted es of autism spectrum intellectual disability. In ffered from frequent bowel issues, neck pain issues, hes. Client #1's diagnoses manifested in the form of operty destruction, and ening SIBs. His SIBs included hat floors and walls, punching nd punching his genitalia. Behavior Support Plan dated tilized a "small bed" ss self-injurious behaviors. positioned adjacent to a ng and included 4 leather d to client #1's wrists and for staff monitoring were tions of 15- minute e accurate data collection				
vision of Hea	behavior plan. The "s	small bed" intervention was nged in use from 2-30 times				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MUU 074 007		B. WING		
	ROVIDER OR SUPPLIER	MHL071-027	DDRESS, CITY, STATE,		03	8/01/2022
	NOWDER OR SOLT EIER		AND CREEK ROAD			
RAINBOW	/ FARMS		POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 109	Continued From page	e 10	V 109			
	8 hours in duration. T each shift with the QF occasionally working Staff failed to recogni #1 in 15 minute incre- while in the restrictive debriefing protocols, restrictive intervention prohibited procedures for the purpose of rec- intensity of behaviors staff-client ratios on of documentation was in response/reporting, n extended restrictive in restrictive intervention time employed, and a considered. In addition bi-monthly team reviews #1's record of when r implemented, bi-annu- intervention, treatmen notifications, or a rest QP/ED failed to take follow policies and pri- agencies, and mainta documentation of inci- This deficiency const violation for serious n corrected within 23 da penalty of \$5,000.00 not corrected within 2	alone on overnight shifts. ze the observation of client ments, observe client #1 a interventions, complete implement the least ns available, adhere to s administered to client #1 ducing the frequency or a and failed to maintain safe overnight shifts. Supporting nsufficient with no level II to authorizations for netervention times, no data on n effectiveness, length of alternative interventions on, there were no records of intervention evaluations, s, documentation in client estrictive interventions were ual approvals of the nt team/guardian trictive intervention log. The the necessary steps to ocedures, notify relevant an appropriate idents. itutes a Type A1 rule heglect and must be ays. An administrative is imposed. If the violation is 23 days, an additional y of \$500.00 per day will be y the facility is out of				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		NUL 074 007				
	ROVIDER OR SUPPLIER	MHL071-027	ADDRESS, CITY, STATE		03	/01/2022
RAINBOW	FARMS	ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 THE APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From pag	e 11	V 112			
V 112	TREATMENT/HABILITATION OR SER PLAN	ent/Habilitation Plan	V 112			
(2 1 1 0 7 7 (((c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a 					
	projected date of ach (2) strategies; (3) staff responsible	nievement;				
	(4) a schedule for re	eview of the plan at least ion with the client or legally				
	outcome achievemer	tion or assessment of nt; and or agreement by the client or				
	responsible party, or	a written statement by the such consent could not be				
	This Rule is not met	as evidenced by:				
	Based on record revi facility failed to imple	iews and interviews, the ment strategies based on g 1 of 3 clients (#1). The				
sion of Hor	alth Service Regulation		1			1

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BUILDING.			
		MHL071-027	B. WING		03	/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX	-	ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN O (EACH CORRECTIVE AC		(X5) COMPLET
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE
V 112	Continued From page	e 12	V 112			
	Review on 1/5/22 and	d 1/6/22 of client #1's record				
	revealed: -31 year-old male					
	-Admission date of 6/					
	-Diagnoses of autism intellectual disability-	espectrum disorder and				
	-	with communication often				
		vsical guidance to desired				
	source	f 15-minute observation				
	checks presented					
		d 1/6/22 of client #1's				
		an dated 6/1/21 revealed: EED TO KNOW TO BEST				
		Situation: I need close 1:1				
		ion and need 24-hour awake				
		h and safety concerns I checks at least every 15				
	· ·	r sleep/wake cycles, safety,				
). I engage in extreme				
		considered life threatening."				
	SUPPORT MEMed	EED TO KNOW TO BEST lical/Behavioral: Mv				
		d every 15 minutes and				
		a dayDuring the day I have				
		nd have awake staff over checksI require a specially				
		ronment, direct supervision				
		upervision in the community				
		ervision during all waking				
		ensive support 7 days/week, (truly 24 hours/day). If no				
	,	may injure myself requiring				
	medical attention or h					
		client #1's Behavior Support				
	Plan dated 12/2/21 re	evealed: vith Restraints - duration of				
	alth Service Regulation					

	f Health Service Regu				I	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	/01/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	FADMS	200 ISL/	AND CREEK ROAD			
NAINDOW		ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From page	e 13	V 112			
		ecifically and only used by				
	,	ort and Programs, Inc.) for				
	restraints for severe					
	-"Estimated Function	is of Problem ient #1] is placed in the small				
		to check on him every 15				
	•	f he is ready to get out of the				
	small bed Sometimes his yes/no cards are used					
		and sometimes he is asked				
	sooner or later than ?					
		Rationales[Client #1] will				
	receive interaction ev	-				
		noncongruent reinforcement) to help decrease nis motivation for engaging in undesired				
		inforced by attention."				
		ceduresStaff will be using				
		sheets that track occurrence				
	-	ding) of each behavior every				
		be calculated as percentage				
	of total weekly 15-mi	nutes intervals during which				
		red, and analyzed at least				
	monthly."					
	-"Behavior Support F					
		social interaction at least the absence of target				
	•	uld be able to see and hear				
	[client #1]."					
	Review on 1/5/22 an	d 1/6/22 of client #1's Partial				
	Interval Recording Sl revealed:	heet dated 9/13/21 - 1/2/22				
		were listed in 16 daily				
	-	8am - 11pm, and one single				
		I the hours of 11pm - 7am.				
	-Individual blocks we	re separated into two				
		s and recorded using tick				
	marks. Behavior #1 v					
		havior #2 was identified as				
	"Self-Injurious Behav					
	-Staff Initials were mi alth Service Regulation	ssing for 192 individual block				

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03	8/01/2022
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
AINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 112	Continued From page	e 14	V 112			
	hours. -Staff initials were missing for 2 blocks which captured observation between the hours of 11pm - 7am (9/28/21 and 11/26/21). Review on 2/4/22 of client #1's Log Book for the dates of 10/6/21 - 2/2/22 revealed: -There was no documentation of 15 minute checks recorded. Attempted interviews with client #1 on 1/5/22 and 1/6/22 proved unsuccessful due to verbal limitations and client #1's detachment from the interview process.					
	stated: -She had been emplo approximately 1 year	1/10/22 and 2/7/22 staff #2 byed with the agency for on client #1 every 2 hours to				
	ensure that he was a to ensure his safety.	ble to use the bathroom and				
	on day shift.	vith regards to time observed				
	log book at the end o	nt #1 were to be recorded in f each shift but were not f regularly and were not				
	a year.	byed with the agency for over				
	regards to observation he was in his room.	ific requirements with on times for client #1 when t #1 was dependent on the				
	staff working and the					
	Interviews on 1/4/22	1/12/22 and 2/4/22 staff #4				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03	8/01/2022	
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE			
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457				
(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 THE APPROPRIATE	(X5) COMPLET DATE	
V 112	Continued From page	e 15	V 112				
	November of 2021. -Supervision requirer remain in line of sight awake. -There were no spectore regards to observation he was in bed. -There were no spectore requirements for observation several months for observation several months, but several months, but	ervations of client #1. client #1 every 30 minutes mall bed." taff #7 stated: byed with the agency for she had been employed with cking on client #1 every					
	approximately 1 year -She had never been observation requirem -Observations of clief a log book but were n regularly and were no	byed with the agency for educated on specific nents for client #1. nt #1 were to be recorded in not completed by all staff ot accurate.					
	stated: -She resigned from the 2021.	former staff #5 (FS #5) he agency in December of pushed" how often client #1					

STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		MHL071-027	B. WING		03/01/2022		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE			
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457				
	SUMMARY ST			PROVIDER'S PLAN ((¥5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 112	Continued From page 16 -There were no specific observation requirements for client #1. -Staff would interact with client #1 when he was happy. However, staff would "just place him in his room and listen for him" when he was upset or "having a bad day."		V 112				
	Interview on 1/18/22 the local managment entity (LME)/managed care organization (MCO) Care Coordinator stated:						
	observation logs with observations appropri	•					
	supervision during av	ve been under line of sight wake hours due to the elf-injurious behaviors.					
		the behavior analyst stated: receiving services since					
		eviously used 15-minute stopped recording those in					
	log designed to moni basis.	ed to their own observation tor behaviors on an hourly					
	recording data on clie	have been checking and ent #1 every 15 minutes restraint, including the "small					
	(QP)/ Executive Dire -Client #1 required 1	the Qualified Professional ctor (ED) stated: 1 supervision and should of sight when he was					
		viously employed 15 minute 1 was using his small bed. ed documenting the					

STATE FORM

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD			
			POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 112	Continued From page	e 17	V 112			
	had not been docume -Staff were required t ensure he was not we "small bed." -Staff were to be cher minutes during sleep -She was responsible completed client docu This deficiency is cro NCAC 27G .0203 Co Professionals and As	co check on client #1 to et when he was using the cking on client #1 every 30 hours. e for ensuring staff umentation. ss referenced into 10A impetencies of Qualified isociate Professionals rule violation and must be				
V 114	AND SUPPLIES (a) A written fire plan area-wide disaster plan shall be approved by authority. (b) The plan shall be and evacuation proce posted in the facility. (c) Fire and disaster of shall be held at least repeated for each shi under conditions that	7 EMERGENCY PLANS for each facility and an shall be developed and	V 114			
	This Rule is not met Based on record revi	as evidenced by: ew and interviews, the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03	6/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		ND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 114	Continued From page	e 18	V 114			
		e fire and disaster drills were peated on each shift. The				
	12/31/21 revealed:	acility records, from 1/1/21 - rills documented between				
	-There were no disas between 4/01/21 - 12					
		-				
	Interviews on 1/6/22, stated:	Interviews on 1/6/22, 1/10/22, and 2/7/22 staff #2 stated:				
	approximately 1 year					
		ls were to be completed not personally participated				
	-Fire and disaster dril	ils had been completed more cility had employed Team				
	Interview on 2/4/22 s -She had been emplo a year.	taff #3 stated: byed with the agency for over				
	-She worked all shifts -Fire and disaster dril "periodically," but she fire or disaster drills.					
	stated:	1/12/22 and 2/4/22 staff #4 byed with the agency since				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03	3/01/2022
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
AINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 114	Continued From page	e 19	V 114			
		Ils were to be completed not personally participated drills.				
	August of 2021.	taff #6 stated: byed with agency since ated in any fire or disaster				
	approximately 1 year -She primarily worke	byed with the agency for d the overnight shifts. ated in fire or disaster drills				
	September of 2020. -Fire and disaster dri monthly, but she cou	byed with the agency since				
	stated: -She was hired in Fe from the agency in D	former staff #5 (FS #5) bruary of 2020 and resigned ecember of 2021. ated in any fire drills or				
	Director stated:	and 2/8/22 the Program				
V 118	27G .0209 (C) Medic	ation Requirements	V 118			
	alth Service Regulation					

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
Market OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2018LNBOW FARMS 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (M) ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EXCH CORRECTIVE ACTION NERSULD E (EXCH CORRECTIVE ACTION NERSULD E) (EXCH CORRECTIVE ACTION NERSULD E) (E) 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 drugs. (2) Medications shall be self-administered by clients only when authorized by law to prescribe drugs. (3) Medications shall be self-administered by clients only when authorized by law to prescribe drugs. (4) A Medication Administration. (5) Medications drainistered shall be recorded Immediately after administer medications. (4) A Medications administered shall be recorded Immediately after administration. The MAR is to include the following: (A) clients name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation Image: Strength and Quantity of the drug; (C) instructions for administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation							
BISIAD CREEK ROAD DOCUMENT NO. 28467 OWNER TWO SUMMARY STATEMENT OF DEFICIENCIES LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTRYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION MICOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OWNER DEFICIENCY V118 IOA NCAC 27G .0209 MEDICATION REGULARENTS (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 drugs. V118 IOA MEDICATION REGULARENTS (c) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (a) 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 Medications administered shall be recorded immediately after administered shall be recorded immediately after administered shall be current. Medications administering the drug; (a) client's name; (a) client's name; (b) client's name; (c) Client's			MHL071-027	B. WING		03	/01/2022
CANBOW FARMS ROCKY POINT, NC 28457 (Y4) ID PREFIX TAG Is JUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTIVA ACTION SNOLD BE (EACH CORRECTIVA ACTION SNOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMP DEFICIENCY V 118 Continued From page 20 V 118 V 118 Continued From page 20 V 118 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 drugs. V 118 V (2) Medications, including injections, shall be administered to a client on the vertiten order of a person strained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer dictions. (A) Addication Administration. Record (MAR) of all drugs administered to each client must be kept current. Medication 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 (E) name or initials of person administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug; (G) Client requests for medication changes or checks shall be recorded and kept with the MAR flie followed up by appointment or consultation	IAME OF PI	ROVIDER OR SUPPLIER					
PREFIX TAG IECAH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX TAG IECAH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE Come DEFICIENCY V118 Continued From page 20 V 118 10A NCAC 27G .0209 MEDICATION REQUIREMENTS V 118 (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized in writing by the clients only when authorized in writing by the clients only when authorized in writing by the clients only when authorized in writing by the clients 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. 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 administering the drug. (G) Client requests for medication changes or checks shall be appointment or consultation	RAINBOW	/ FARMS					
 10A NCAC 27G .0209 MEDICATION RECUIREMENTS (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 drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the clients 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 administering the 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 (E) name or initials of person administering the drug. (S) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	(X5) COMPLET DATE
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 drugs. (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 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 (E) name or initials of person administering the drug. (G) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation	V 118	Continued From page	Continued From page 20				
This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as		10A NCAC 27G .020 REQUIREMENTS (c) Medication admin (1) Prescription or no only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, inclu administered only by unlicensed persons t pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administere current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record file followed up by ap with a physician.	9 MEDICATION istration: In-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the uding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The e following: and quantity of the drug; drug is administered; and f person administering the r medication changes or rded and kept with the MAR pointment or consultation as evidenced by: ews and interviews, the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL071-027	B. WING		03	/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE	
V 118	Continued From page	e 21	V 118				
	competency with me	an, failed to demonstrate dications, and failed to keep ng 3 of 3 clients (#1,#2,#3).					
	Finding #1 Review on 1/5/22 and revealed: -31 year-old male -Admission date of 6.	d 1/6/22 of client #1's record					
	-Diagnoses of autism intellectual disability-	spectrum disorder and severe					
	revealed: 9/18/20	client #1's physician's orders eam, Apply to affected area					
		as twice daily and as needed					
		ram (mg), Take 1 tablet (tab) ery evening.					
	October 1, 2021 - Jai -There were no staff	client #1's MARs from nuary 5, 2022 revealed: initials to indicate am was applied on 11/9/21					
	at 7pm. -There were no staff	initials to indicate is administered on 10/6/21					
	revealed:	d 1/6/22 of client #2's record					
	-56 year-old male -Admission date of 9, -Diagnoses of autistic and intellectual disab	disorder, impulse control,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03/01/2022	
NAME OF PF	OVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page 22		V 118			
	Review on 1/5/22 of orevealed: FL2- 2/16/21: -Diazepam 10mg, Ta -Divalproex Sodium II 500mg, Take 1 tab th -Topiramate 200mg, Review on 1/5/22 of of October 1, 2021 - Jau -There were no staff 10mg, Divalproex So Topiramate 200mg v 10/17/21 at 7pm. Finding #3 Review on 1/5/22 and revealed: -21 year-old male -Admission date of 8/ -Diagnoses of autistic intellectual disability- Review on 1/5/22 of of revealed: -Progesterone 100mg every evening. -Clonidine 0.1mg, Ta daily. Review on 1/5/22 of of October 1, 2021 - Jau -There were no staff Progesterone 100mg 12/4/21 at 7pm.	client #2's physician's orders ke 1 tab twice daily. Delayed Release (DR) wice daily. Take 1 tab every evening. client #2's MARs from nuary 5, 2022 revealed: initials to indicate Diazepam dium DR 500mg, and vere administered on d 1/6/22 of client #3's record d 1/6/22 of client #3's record d 1/6/22 of client #3's record d 1/6/22 of client #3's record client #3's physician's orders g, Take 1 capsule (cap) ke 1 and ½ tabs 3 times client #3's MARs from nuary 5, 2022 revealed: initials to indicate g was administered on initials to indicate Clonidine				
	12/23/21 at 12pm.					
aion of Llog	Due to verbal and co Ith Service Regulation	gnitive limitations, interviews				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			B. WING			
		MHL071-027			03	8/01/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE AND CREEK ROAD			
RAINBOW	/ FARMS		POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 23	V 118			
		nd #3 on 1/5/22 and 1/6/22 determining medication				
	Interviews on 1/6/22, 1/10/22 and 2/7/22 staff #2 stated: -She had been employed with the agency for					
	approximately 1 year. -She did not pass medications. -She had witnessed medications pre-filled in medication cups and stored for clients to take at a					
	later time. -She had found loose bed.	e medications in client #1's				
	medications in the tra	ication cups with unused ash. ent approximately 2 weeks				
	earlier (interview date medications for the u	e of 2/7/22) where evening pcoming shift were signed t's MARs. The incoming staff				
	for the next shift iden the missing medication	itified the discrepancy with				
	Interview on 2/7/22 s	staff #6 stated:				
	August of 2021.	oyed with the agency since medications missing on a				
	shift approximately 2 she prepared noon n she witnessed the up	weeks earlier (2/7/22). As nedications for the clients, pocoming evening medications				
	MARs. In addition, th	as given in all 3 client's ne evening shift medications or in the medication blister				
	of the medication dis	s. She notified management crepancy. #2 as "moving a lot slower"				
	that particular afterno	-				
	Interview on 2/4/22 s	staff #8 stated:				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027			03	/01/2022
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW	FARMS		POINT, NC 28457			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AND OF DEFICIENCED TO CROSS-REFERENCED TO DEFICIENCED TO DEFICIENCED			ACTION SHOULD BE COMF TO THE APPROPRIATE DA		
V 118	Continued From page 24		V 118			
	approximately 1 year. -She had witnessed r medication cups and at later time. This had over the last 2 month -There had been a m 1/23/22. During the th the morning of 1/23/2 for 1/23/22 were adm The MARs had been 1/22/22 and 1/23/22 at initialed indicating a th QP/ED. On the aftern noticed the discrepant management. When the counted, the staff not packs for the evening missing for the 1/23/2 -She had passed alor Program Director.	nedications pre-filled in stored for the clients to take d occurred on two occasions s. edication error on 1/22/22 or ne evening of 1/22/22 and t2, the evening medications inistered for all 3 clients. completed for the shifts on and then crossed out and ranscription error by the noon shift of 1/23/22, staff ney and notified the medications were iced the medication blister g shift of 1/23/22 had pills t2 evening dose. Ing her concerns to the former staff #5 (FS #5) gency in December of 2021.				
		ongoing problems" with the the wrong boxes of MARs ne MARs after giving				
	2020. -She had witnessed s including medications and MARs filled out in	n agency since September of several medication errors, s given at the wrong time ncorrectly.				
		ner initials crossed out on I filled in by other staff.				
	Interview on 2/8/22 th	ne Qualified Professional				

STATE FORM

(EACH DEFICIENCY REGULATORY OR L continued From page QP)/ Executive Direc She had made a tran nd signed in the wron prrection. She had not made ar egards to administeri r 1/23/22. f medications were n ave been due to staf	200 ISLA ROCKY F ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 2 25 Ator (ED) stated: Isscription error on 1/23/22 Ing box but had initialed the hy additional errors with ing medications on 1/22/22	B. WING DDRESS, CITY, STATE, ND CREEK ROAD POINT, NC 28457 ID PREFIX TAG		CORRECTION ON SHOULD BE HE APPROPRIATE	01/2022 (X5) COMPLETE DATE
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L continued From page QP)/ Executive Direc She had made a tran nd signed in the wron porrection. She had not made ar egards to administeri r 1/23/22. f medications were n ave been due to staf	200 ISLA ROCKY F ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 2 25 Ator (ED) stated: Isscription error on 1/23/22 Ing box but had initialed the hy additional errors with ing medications on 1/22/22	ND CREEK ROAD POINT, NC 28457	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	COMPLETE
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L continued From page QP)/ Executive Direc She had made a tran nd signed in the wron porrection. She had not made ar egards to administeri r 1/23/22. f medications were n ave been due to staf	ROCKY F TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 2 25 etor (ED) stated: ascription error on 1/23/22 ng box but had initialed the hy additional errors with ing medications on 1/22/22	POINT, NC 28457	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	COMPLETE
(EACH DEFICIENCY REGULATORY OR L continued From page QP)/ Executive Direc She had made a tran nd signed in the wron prrection. She had not made ar egards to administeri r 1/23/22. f medications were n ave been due to staf	A MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 2 25 tor (ED) stated: scription error on 1/23/22 ng box but had initialed the ny additional errors with ing medications on 1/22/22	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	COMPLETE
REGULATORY OR L continued From page QP)/ Executive Direc She had made a tran nd signed in the wron prrection. She had not made ar egards to administeri r 1/23/22. f medications were n ave been due to staf	e 25 etor (ED) stated: uscription error on 1/23/22 ng box but had initialed the ny additional errors with ing medications on 1/22/22	PREFIX TAG	CROSS-REFERENCED TO TH	HE APPROPRIATE	COMPLETE
QP)/ Executive Direc She had made a tran nd signed in the wron prrection. She had not made ar egards to administeri r 1/23/22. f medications were n ave been due to staf	tor (ED) stated: scription error on 1/23/22 ng box but had initialed the ny additional errors with ing medications on 1/22/22	V 118			
She had made a tran nd signed in the wron prrection. She had not made ar egards to administeri r 1/23/22. f medications were n ave been due to staf	ng box but had initialed the ng additional errors with ng medications on 1/22/22				
nd signed in the wron prrection. She had not made ar egards to administeri r 1/23/22. f medications were n ave been due to staf	ng box but had initialed the ny additional errors with ing medications on 1/22/22				
orrection. She had not made ar egards to administeri r 1/23/22. f medications were n ave been due to staf	ny additional errors with ing medications on 1/22/22				
She had not made ar egards to administeri r 1/23/22. f medications were n ave been due to staf	ing medications on 1/22/22				
egards to administeri r 1/23/22. f medications were n ave been due to staf	ing medications on 1/22/22				
ave been due to staf	nissing on 1/23/22 it may				
	-If medications were missing on 1/23/22 it may				
	-				
	•				
e medication cabine	et for a later administering				
me.					
she was unaware of rrors.	any additional medication				
ue to the failure to a	ccurately document				
7G .5602 Supervised	d Living - Staff	V 290			
0A NCAC 27G .5602	2 STAFF				
•	d to individualized client				
	e staff member shall be				
•					
remises, except whe	n the client's treatment or				
•					
	-				
ousonnsri unes 7 oaufneorraais	art of another staff. S mplete an investigat ch events had occu he was unaware of om the medication be emedication cabine- ne. he was unaware of rors. ue to the failure to a edication administra- termined if clients r ordered by the phy G .5602 Supervised (A NCAC 27G .5602 () Staff-client ratios unbers specified in this Rule shall be d table staff to respon eeds. () A minimum of one esent at all times whe emises, except whe obilitation plan docu pable of remaining thout supervision.	he was unaware of any additional medication rors. Le to the failure to accurately document edication administration it could not be stermined if clients received their medications ordered by the physician. TG .5602 Supervised Living - Staff PA NCAC 27G .5602 STAFF) Staff-client ratios above the minimum umbers specified in Paragraphs (b), (c) and (d) this Rule shall be determined by the facility to hable staff to respond to individualized client teds.) A minimum of one staff member shall be essent at all times when any adult client is on the emises, except when the client's treatment or ibilitation plan documents that the client is pable of remaining in the home or community thout supervision. The plan shall be reviewed meeded but not less than annually to ensure	 art of another staff. She had not had a chance to implete an investigation to determine if any ich events had occurred. a was unaware of medications being removed on the medication blister packs and stored in e medication cabinet for a later administering ne. be was unaware of any additional medication rors. are to the failure to accurately document edication administration it could not be itermined if clients received their medications or ordered by the physician. arG .5602 Supervised Living - Staff be ANCAC 27G .5602 STAFF challe shall be determined by the facility to table staff to respond to individualized client seeds. challe shall be determined by the facility to table staff to respond to individualized client seeds. challe the client's treatment or bilitation plan documents that the client is pable of remaining in the home or community thout supervision. The plan shall be reviewed in enceded but not less than annually to ensure 	rt of another staff. She had not had a chance to mplete an investigation to determine if any ch events had occurred. he was unaware of medications being removed om the medication blister packs and stored in a medication cabinet for a later administering ne. he was unaware of any additional medication rors. ue to the failure to accurately document edication administration it could not be termined if clients received their medications ordered by the physician. G. 5602 Supervised Living - Staff V 290 A NCAC 27G .5602 STAFF) Staff-client ratios above the minimum mbers specified in Paragraphs (b), (c) and (d) this Rule shall be determined by the facility to iable staff to respond to individualized client teds.) A minimum of one staff member shall be essent at all times when any adult client is on the emises, except when the client's treatment or ibilitation plan documents that the client is pable of remaining in the home or community thout supervision. The plan shall be reviewed on needed but not less than annually to ensure	In to fanother staff. She had not had a chance to mplete an investigation to determine if any chevents had occurred. he was unaware of medications being removed on the medication bister packs and stored in a medication cabinet for a later administering ne. he was unaware of any additional medication rors. ue to the failure to accurately document edication administration it could not be termined if clients received their medications ordered by the physician. G. 5602 Supervised Living - Staff V 290 A NCAC 27G .5602 STAFF) Staff-Client ratios above the minimum mimbers specified in Paragraphs (b), (c) and (d) this Rule shall be determined by the facility to the staff to respond to individualized client eds. A minimum of one staff member shall be esent at all times when any adult client is on the emises, except when the client's treatment or community thout supervision. The plan shall be reviewed in ended but not less than annually to ensure

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		MHL071-027	B. WING		03	/01/2022
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CO(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTIONREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 290	Continued From page 26		V 290			
	the home or communi- specified periods of ti- (c) Staff shall be pre- following client-staff r child or adolescent of (1) children or abuse disorders shall of one staff present for clients present. How present during sleepi emergency back-up p the governing body; of (2) children or developmental disabi- one staff present for present and two staff more clients present. need be present durin specified by the emer determined by the go (d) In facilities which diagnosis is substant (1) at least one duty shall be trained withdrawal symptoms secondary complicati-	sent in a facility in the ratios when more than one lient is present: adolescents with substance I be served with a minimum or every five or fewer minor vever, only one staff need be ng hours if specified by the procedures determined by or adolescents with ilities shall be served with every one to three clients i present for every four or However, only one staff ng sleeping hours if rgency back-up procedures overning body. serve clients whose primary ce abuse dependency: e staff member who is on in alcohol and other drug is and symptoms of ions to alcohol and other I be available on an				
	interviews, the facility ratios above the mini	as evidenced by: ews, observation, and / failed to ensure staff-client mum number to enable staff µalized client needs affecting				

STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL071-027	B. WING		03	8/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW		200 ISLA	AND CREEK ROAD			
		ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OI (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIENCY DEFICIENCE DEFICIENCE		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
V 290	Continued From page	e 27	V 290			
	3 of 3 clients (#1, #2,	#3). The findings are:				
	revealed: -31 year-old male -Admission date of 6,	spectrum disorder and				
	Individual Support PI revealed: -"WHAT OTHERS NE SUPPORT MELife staffing and supervis staff at night for healt (currently have visua minutes to monitor for restroom needs, etc.) behaviors which are -"WHAT OTHERS NE SUPPORT MESoci assistance and occas engage in behaviors. -"WHAT OTHERS NE SUPPORT MEMed injurious behaviors (S time, but I have used staffing last year and full support to avoid b	EED TO KNOW TO BEST lical/Behavioral: my severe SIB) have lessened over crisis services with 2:1 my SIB continuesI need nealth and safety hazards -				
	for me and help me t traffic, using safety ra smoke detectors/cart alarms, storing chem signs regarding haza doors)I require mo moving about - I mov	be aware of safety hazards hrough them (walking in ails, nonslip mats, using bon monoxide detectors/fire icals, reading safety danger rds and poisons, locking nitoring with ambulating and re independently but I may et up and go somewhere,				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:			E SURVEY PLETED	
		MHL071-027	L071-027 B. WING		03	03/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE				
			AND CREEK ROAD				
RAINBOW	FARMS	ROCKY	POINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
V 290	Continued From page	e 28	V 290				
	and just need monitoring for safetyI need full support with learning how to access emergency services - I have no awareness of emergency skills, using a personal emergency response system, planning access to emergency services, and planning/practicing response to emergencies." Review on 1/11/22 of client #1's Behavior Support						
 Plan dated 12/2 -"Reason for Rebehavior consult frequency and in as well as the reinterventions (fm Programs, Inc). restrictions impacts community and environments an -"Interventions aryear (Oct 2020) elevated levels to thereby indication Observation on approximately 1 -Staff #1 was provide alone light off. -Client #1 was ly the small bed) with the small bed with the second bed white "big bed " which -Client #1 did not second bed white" 	behavior consultative frequency and intens as well as the restrict interventions (from A Programs, Inc). Thes restrictions impair his community and funct environments and to -"Interventions and ra year (Oct 2020 - Sep elevated levels for bo	I[Client #1] was referred for e services due to the high ity of his problem behaviors, tive nature of the current SAP) (Autism Support and e problem behaviors and s ability to integrate into the ion safely across reach his ISP goals." ationalesData for the past					
	approximately 11:45a -Staff #1 was providin -While staff #1 was in observed alone in his light off. -Client #1 was lying i the small bed) with 4 from the bed and cor wrists and ankles. -The "small bed" was second bed which wa "big bed " which clien	ng 1:1 services with client #1. In the kitchen, client #1 was s bedroom with the bedroom In a bed (identified by staff as leather straps extending Innected to both of client #1's is positioned adjacent to a as identified by staff as the Int #1 used for sleeping. Dear in distress and was					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SUR COMPLETE	
		MHL071-027	B. WING		03	6/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
		200 ISLA	ND CREEK ROAD			
RAINBOW	FARWIS	ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COI EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION EGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY) DEFICIENCY		CTION SHOULD BE	(X5) COMPLET DATE	
V 290	Continued From page	e 29	V 290			
	Finding #2: Review on 1/5/22 and revealed: -56 year-old male -Admission date of 9/ -Diagnoses of autistic and intellectual disab Review on 1/5/22 and dated 2/1/21 revealed -"WHAT OTHERS NE SUPPORT MELife hour supervisionI n choices when at hom well as support to eva the event of a fire."	d 1/6/22 of client #2's record /1/11 c disorder, impulse control, ility-moderate d 1/6/22 of client #2's ISP				
	•	/4/17 c disorder, impulse control, moderate, and non-verbal				
	Review on 1/5/22 and dated 7/1/21 revealed -"Important People /T assistance and super and safety in all settir -"My Choices & Supp	d 1/6/22 of client #3's ISP d: 'hings - Having enough staff rvision to ensure his health ngs is important." ports - Where I choose to				
	deal of supervision. H home or any other loo -"My Support Needs needs: [Client #3] doo danger, will walk fast sometimes without pa going. He is a very fa	y active and needs a good le cannot be left alone at cation." - Behavioral health support es not have a good sense of and will get away from you aying attention to where he is ust walker. [Client #3] does o requests made of him or				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BOILDING.			
		MHL071-027	B. WING		03	/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
04015	SUMMARY ST		,			0(5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY DEFICIENCY			CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 290	Continued From page 30 follow rules or boundaries." -"When I may need Extra Help - Things that may create stress. Situations where I'll need extra help? - Target behaviors are more likely to occur:		V 290			
	a) when he is denied a preferred item or activity					
	(e.g. preferred food), b) when he is redirected to					
	participate in an activ	vity he's not interested in, c)				
	when a routine or ritu	ual (e.g. placing items in				
		interrupted d) when the				
	environment is noisy					
		e (e.g. an item of his is				
		his tolerance level for that				
		ded. h) staff and routine				
	changes"					
	-	Extra Help - What you can do				
		head? - Noisy environments				
		[client #3] (when he doesn't				
	behaviors.") could lead to negative				
		: [Client #3] will decrease his				
	anxiety, agitation, fru					
		elf and othersWhere am I				
		ires one on one staffing to				
	help address his hea	-				
	Review on 1/5/22 an	d 1/6/22 of client #3's				
		Assessment dated 7/1/21				
	revealed:					
	"Safety Supports in	n Home and				
		es support to evacuate home				
		ribe: [Client #3] does not				
	understand conseque					
	yes)Requires supp					
		be: [Client #3] does not know				
	how to get help. (ma	rked yes)"				
	Interviews on 1/5/22	and 2/4/22 staff #1 stated:				
	-She had been rehire	ed with the agency as of				
	January 3, 2022.					
	-She had previously					

STATE FORM

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL071-027	B. WING		03	8/01/2022	
NAME OF PR	OVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, STATE	, ZIP CODE			
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC	HE APPROPRIATE	COMPLET DATE	
V 290	Continued From pag	le 31	V 290				
	approximately 3 years. -She was working 1:1 with client #1 on 1/5/22. -The afternoon of 1/5/22 was the first afternoon she had used the " small bed " intervention with						
	client #1 since her re	ehire.					
	Interviews on 1/6/22,	, 1/10/22, and 2/7/22 staff #2					
	stated:						
		oyed with the agency for					
	approximately 1 year						
	-She primarily worke						
		client #1 using the "small					
	bed" intervention on two separate occasions during the overnight shift.						
	-She had worked alone on one overnight shift.						
		ssional (QP)/ Executive					
		ale staff were the only					
	. ,	o work alone on overnight					
	shifts.						
	-She did not believe	anyone working alone would					
		et all 3 clients out of the home					
	in the event of a fire.						
	-Client #3 was espec	cially difficult to arouse once					
	he was asleep.						
	Interview on 2/4/22 s						
		oyed with the agency for					
	approximately 1 year						
	-She primarily worke						
		client #1 using the "small					
		two separate occasions					
	during the overnight						
		one on one overnight shift. le staff were the only other					
		aware of who had worked					
	alone on overnight s						
	-	any staff working alone could					
		ts out of the home in the					
	event of a fire.						
		2 and client #3 would have					
/ision of Hea	-Evacuating client #2	2 and client #3 would have					

STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:		(X3) DATE SURVEY COMPLETED 03/01/2022		
		MHL071-027	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	1	ADDRESS, CITY, STATE, 2	ZIP CODE		<i></i>	
RAINBOW	/ FARMS		AND CREEK ROAD				
	-		POINT, NC 28457				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PLAN OF CORRECTION TIVE ACTION SHOULD BE COM CED TO THE APPROPRIATE E FFICIENCY)		
V 290	Continued From pag	e 32	V 290				
	proven especially difficult during a fire due to client #2's balance issues and client #3's difficulty waking up. Interview on 2/4/22 staff #9 stated: -She had been employed with the agency since September of 2020. -Only the QP/ED, male staff, and "seasoned staff"						
-S Se -O							
	were allowed to work	alone on overnight shifts.					
	stated:	former staff #5 (FS#5)					
	-She resigned from agency in December of 2021. -The QP/ED and male staff had worked alone on overnight shifts.						
	-She would not have been able to safely assist all 3 clients in exiting the home had a fire started while she was working alone.						
		kly would have proven very ficulty of waking client #3 vith client #2.					
	Interviews on 2/7/22 stated:	and 2/8/22 the QP/ED					
		ormer male staff had been ad worked overnight shifts					
		ors for the agency had g more than 1 staff on it had not been a					
		shifts since 1/14/22 had ff.					
	NCAC 27G .0203 Co Professionals and As	oss referenced into 10A ompetencies of Qualified ssociate Professionals rule violation and must be					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL071-027	B. WING		03	/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD			
			POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIEN		TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 291	Continued From page	e 33	V 291			
V 291	27G .5603 Supervise	d Living - Operations	V 291			
	six clients when the of developmental disabi- on June 15, 2001, an than six clients at tha provide services at no licensed capacity. (b) Service Coordinal maintained between to qualified professional treatment/habilitation (c) Participation of the Responsible Person. provided the opportur relationship with her of means as visits to the the facility. Reports a annually to the paren legally responsible per Reports may be in wr conference and shall progress toward mee (d) Program Activities needs and the treatment Activities shall be desi inclusion. Choices mo or legal system is invi- safety issues become This Rule is not met Based on record revie	ty shall serve no more than lients have mental illness or lities. Any facility licensed d providing services to more t time, may continue to o more than the facility's tion. Coordination shall be the facility operator and the s who are responsible for or case management. e Family or Legally Each client shall be nity to maintain an ongoing or his family through such e facility and visits outside shall be submitted at least t of a minor resident, or the erson of an adult resident. iting or take the form of a focus on the client's ting individual goals. s. Each client shall have based on her/his choices, ent/habilitation plan. signed to foster community way be limited when the court olved or when health or e a primary concern.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL071-027	B. WING		03	8/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
RAINBOW	/ FARMS		ND CREEK ROAD POINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 291	Continued From pag	e 34	V 291				
	-	responsible for the client's treatment affecting 2 of 3 clients (#2 and #3). The findings are:					
	Finding #1: Review on 1/5/22 and 1/6/22 of client #2's record revealed: -56 year-old male						
	-Admission date of 9 -Diagnoses of autisti and intellectual disat	c disorder, impulse control, pility-moderate					
	-No documentation c podiatrist following 8	•					
	Individual Support Pl " Medical/Behavioral maintaining my toena help keep them trimr - " I require support t	d 1/6/22 of client #2's an dated 2/1/21 revealed: - I have a hard time ails and I see a podiatrist to ned and manageable" o promote skin integrity - ance with lotion, toenail					
	Review on 2/4/22 of from podiatry appoin revealed:	client #2's physician notes tment dated 8/30/21					
	with debridement of toenails 1-5 left and nippers. I then smoo	patient wishes to proceed painful toenails. I debrided 6-10 right with toenail thed each toenail with the prided the fissures of his					
	electric debriderPa	and smoothed with an atient to RTO (return to a follow up evaluation or					
	Finding #2: Review on 1/5/22 an revealed: -21 year-old male	d 1/6/22 of client #3's record					
ision of He	-Admission date of 8 alth Service Regulation	/4/17					

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	8/01/2022
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
AINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID					F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		TION SHOULD BE THE APPROPRIATE	COMPLET
V 291	Continued From page 35		V 291			
-Diagnoses of autistic disorder, intellectual disability-moderate, -Last documented dental visit w evaluation of previous wisdom t on 1/22/20.		moderate, and non-verbal ntal visit was for an				
Risk/S (start -"Phys App -"Su Requi comm -"Su Daily appoi Revie for clie for clien follow 5/28/2	Risk/Support Needs / (start date) revealed: -"Physician Supports Approximate Date of -"Supports for Com Requires full assistar communicate most of -"Supports Needed	- Dentist - twice yearly of Last Visit- 1/2021." municating Needs - nce from familiar persons to r all essential needs" to Complete Activities of es Support for making				
	for client #3 dated 1/ [,] -Client #3 was "Due f	d 1/6/22 of physician's note 14 /21 - 11/19/21 revealed: for dental visit " on the /21, 1/30/21, 3/25/21, 7/21, 10/14/21, and				
	Program Director rev -Client #3 had a dent December, 2021 white -He had been workin appointment following -Regular appointment	al appointment scheduled in ch had been canceled. g on scheduling another				
V 366	27G .0603 Incident R	esponse Requirments	V 366			
	10A NCAC 27G .060 RESPONSE REQUIF CATEGORY A AND E	REMENTS FOR				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONS A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03	/01/2022
NAME OF PR	OVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIF	P CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 366	Continued From page	e 36	V 366			
	implement written pol response to level I, II shall require the prov (1) attending to of individuals involved (2) determining (3) developing measures according timeframes not to exc (4) developing to prevent similar inci- specified timeframes (5) assigning p for implementation of preventive measures (6) adhering to set forth in G.S. 75, A 42 CFR Parts 2 and 3 164; and (7) maintaining Subparagraphs (a)(1) (b) In addition to the Paragraph (a) of this shall address inciden regulations in 42 CFF (c) In addition to the Paragraph (a) of this providers, excluding I develop and implement their response to a le while the provider is c or while the client is c The policies shall req by: (1) immediately by:	or III incidents. The policies ider to respond by: the health and safety needs d in the incident; the cause of the incident; and implementing corrective to provider specified ceed 45 days; and implementing measures dents according to provider not to exceed 45 days; erson(s) to be responsible the corrections and ; confidentiality requirements article 2A, 10A NCAC 26B, 3 and 45 CFR Parts 160 and documentation regarding) through (a)(6) of this Rule. requirements set forth in Rule, ICF/MR providers ts as required by the federal R Part 483 Subpart I. requirements set forth in Rule, Category A and B ICF/MR providers, shall ent written policies governing vel III incident that occurs delivering a billable service on the provider's premises. uire the provider to respond y securing the client record e client record;				

Division of Health Service Regulation STATE FORM

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
		MHL071-027			03	8/01/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 366	Continued From page	e 37	V 366			
	 (D) transferring review team; (2) convening a review team within 24 internal review team within 24 internal review team shall correview the facts a and make recommen occurrence of future if (B) gather other (C) issue writtee within five working da preliminary findings of LME in whose catched and to the LW if different; and (D) issue a final owner within three models owner within three models and to the LW if different; and (D) issue a final owner within three models and to the LW if different; and downer within three models are the plume where the client final written report shall be sected. And shall material documents needed available within three 	he copy's completeness; and the copy to an internal a meeting of an internal 4 hours of the incident. The shall consist of individuals d in the incident and who for the client's direct care or al oversight of the client's of the incident. The internal mplete all of the activities as copy of the client record to nd causes of the incident dations for minimizing the incidents; er information needed; en preliminary findings of fact ays of the incident. The of fact shall be sent to the nent area the provider is Me where the client resides, I written report signed by the onths of the incident. The ent to the LME in whose rovider is located and to the resides, if different. The all address the issues nal review team, shall uments pertinent to the ake recommendations for rence of future incidents. If d for the report are not months of the incident, the ovider an extension of up to				
	three months to subm (3) immediately	nit the final report; and notifying the following: ponsible for the catchment				

ND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027				8/01/2022
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			5/01/2022
			ND CREEK ROAD			
RAINBOW	FARMS	ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 366	Continued From page	e 38	V 366			
	area where the servic Rule .0604; (B) the LME wh different; (C) the provide for maintaining and u treatment plan, if diffe provider; (D) the Departm (E) the client's applicable; and	ces are provided pursuant to here the client resides, if er agency with responsibility updating the client's erent from the reporting				
	failed to document th incidents. The finding Review on 1/5/22 of Improvement System	ew and interview, the facility eir response to level II gs are: Incident Response n (IRIS) from January 1, 22 revealed no documented				
	Review on 1/5/22 and revealed: -31 year-old male -Admission date of 6/ -Diagnoses of autism intellectual disability- -No documentation o	d 1/6/22 of client #1's record /10/09 n spectrum disorder and				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	8/01/2022
NAME OF PF	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD			
		ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 366	Continued From pag	e 39	V 366			
	-	heet dated 9/13/21 - 1/2/22				
	revealed:					
		were listed in 16 daily				
		n 8am - 11pm, and one single				
		the hours of 11pm - 7am.				
		ere separated into two				
		s and recorded using tick				
		as identified as "Aggression"				
		identified as "Self-Injurious				
	Behavior (SIB)."	in a in a fan 100 in dividwal blaak				
		issing for 192 individual block				
	hours.	incing for 2 blocks which				
		issing for 2 blocks which				
	- 7am (9/28/21 and 1	n between the hours of 11pm 11/26/21).				
		and 2/4/22 staff #1 stated:				
	January 3, 2022.	ed with the agency as of				
	-She had previously approximately 3 year	worked with the agency for rs.				
		5/22 was the first afternoon				
		mall bed " intervention with				
	client #1 since her re					
		or had shown her how to use				
	-	s with client #1 by ensuring				
		ired properly and maintaining				
	his safety throughout					
	Interviews on 1/6/22,	, 1/10/22, and 2/7/22 staff #2				
	stated:					
	-She had worked wit	h the agency for				
	approximately 1 year	r.				
	-Client behaviors we in a log book.	re supposed to be recorded				
	•	n the log book was not				
		led to record data on a				
	regular basis.					
	-	small bed" intervention for				
	as little as "30 minute		1			1

STATE FORM

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If continuation sheet 40 of 100

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING			8/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	1	ADDRESS, CITY, STATE		03	5/01/2022
			AND CREEK ROAD	,		
RAINBOW	FARMS	ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 366	Continued From pag	e 40	V 366			
	"small bed" intervent	client #1 may have used the ion an average of "15-30 er the "last few months."				
	-She had been empl approximately 1 year -Client behaviors we	, and 1/11/22 staff #3 stated: oyed with the agency for r. re recorded in a black and				
	as little as 30 minute	small bed" intervention for s and as long as 1 hour. t #1 had used the "small bed"				
	intervention up to 2-3 December of 2021.	3 times per week in				
	stated:	, 1/12/22 and 2/4/22 staff #4 oyed with the agency since				
	-Documentation requ	ed after a 1 year absence. uirements for client #1's				
	book. -Client #1 used the "	rded in a black and white log small bed" intervention for				
	hours."	es" and as long as "1-2 t #1 had used the "small bed"				
		s in December of 2021 and				
	Interview on 2/7/22 s -She had been empl August of 2021.	staff #6 stated: oyed with the agency since				
	-She estimated clien	t #1 had used the "small bed" verage of 1 time per week in				
	-Client #1 used the "	small bed" intervention for nutes" at a minimum.				
	Interview on 2/4/22 s	staff #8 stated:				

Division of Health Service Regulation STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03	8/01/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 366	Continued From page	e 41	V 366			
	-She had been emplo approximately 1 year -She had witnessed of bed" intervention on a during the overnight -The data recorded in accurate, as staff fail regular basis. Interview on 2/4/22 s -She had been emplo September of 2020. -Documentation requi- behaviors were recor- book. -Client #1 used the "s as little as "25-30 min day." -She estimated client intervention 2-3 times Interview on 1/12/22 -Her employment wit December 2021. -Behaviors were doct documented consiste -Client #1 used the "s as little as "15-20 min "maybe 8 hours." -She estimated client intervention approxin full month she worke	byed with the agency for c. client #1 using the "small two separate occasions shift. In the log book was not ed to record data on a taff #9 stated: byed with the agency since tirements for client #1's rded in a black and white log small bed" intervention for nutes" and as long as "all t #1 had used the "small bed" is in December of 2021. former staff (FS #5) stated: In the agency ended in umented in a logbook but not ently by staff. small bed" intervention for nutes" and as much as t #1 had used the "small bed" is the agency ended in umented in a logbook but not ently by staff. small bed" intervention for nutes" and as much as t #1 had used the "small bed" hately 10 times for the last d (October). 1/5/22, 1/6/22, 1/10/22, and Professional (QP)/				
	-The facility had with the implementation o and would continue t	f the "small bed" intervention o use the method as a peutic intervention moving				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COI A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03	8/01/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, 2	ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(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 THE APPROPRIATE	(X5) COMPLET DATE
V 366	Continued From page	e 42	V 366			
	varied depending on where it was impleme where it was impleme -She believed that a was not required due plan with the interver -She was responsible incident reports. This deficiency is cro NCAC 27G .0203 Co Professionals and As	e for completing all level II ss referenced into 10A impetencies of Qualified isociate Professionals rule violation and must be				
V 367	27G .0604 Incident F	Reporting Requirements	V 367			
	level II incidents, exc the provision of billab consumer is on the p incidents and level II to whom the provider 90 days prior to the in responsible for the ca services are provided becoming aware of th be submitted on a for Secretary. The report in person, facsimile co means. The report so information:	REMENTS FOR B PROVIDERS B providers shall report all ept deaths, that occur during ble services or while the roviders premises or level III deaths involving the clients rendered any service within holdent to the LME atchment area where d within 72 hours of he incident. The report shall rm provided by the rt may be submitted via mail, or encrypted electronic hall include the following				

Division of Health Service Regulation STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MUI 071 027				04/2022
	ROVIDER OR SUPPLIER	MHL071-027	ADDRESS, CITY, STATE,		03	/01/2022
NAIVIE OF Pr	COUDER OR SUPPLIER		AND CREEK ROAD	ZIF CODE		
RAINBOW	FARMS		POINT, NC 28457			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE
V 367	Continued From page	e 43	V 367			
	(2) client identi	fication information;				
	(3) type of incid					
	(4) description					
		e effort to determine the				
	cause of the incident	; and				
	(6) other individual or responding.	duals or authorities notified				
		3 providers shall explain any				
	missing or incomplete	e information. The provider				
		ted report to all required				
		ne end of the next business				
	day whenever:					
		r has reason to believe that				
	information provided					
		g or otherwise unreliable; or				
		r obtains information ent form that was previously				
	unavailable.	ent form that was previously				
		3 providers shall submit,				
		LME, other information				
	obtained regarding th					
		cords including confidential				
	information;	C C				
	(2) reports by a	other authorities; and				
		r's response to the incident.				
		3 providers shall send a copy				
		reports to the Division of				
		opmental Disabilities and				
		rvices within 72 hours of				
	•	ne incident. Category A				
	providers shall send	client death to the Division of				
	-	lation within 72 hours of				
	-	ne incident. In cases of				
	-	ven days of use of seclusion				
		der shall report the death				
	-	ired by 10A NCAC 26C				
	.0300 and 10A NCAC	-				
	(e) Category A and E					1

MHL071-027 B. WING 03/01/2022 AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 03/01/2022 AMBOW FARMS 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECIDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECIDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECIDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECIDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECIDED BY FULL PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 00/01/2022 V 367 Continued From page 44 V 367 V 367 Continued From page 44 V 367 V 367 Continued From page 44 V 367 Image: Continued From page 44 V 367 Image: Continued From page 44 V 367 V 367 Continued From page 44 V 367 Image: Continued From page 44 V 367 Image: Continued From page 44 V 367 V 367 Continued From page 41 Image: Continued From page 44 V 367 Image: Continued From page 44 V 367 V 367 Continued From page 41 Image: Continued From page 44 V 367 Image: Continued From page 44 V 367 (3) searches of a client on a for bruing area; (4) seizures of client or his living area; (5) the total number of level III incident;		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AINBOW FARMS 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (X4) ID PREFIX TAG V 367 V 367 Continued From page 44 V 367 V 367 Continued From page 44 V 367 V 367 Continued From page 44 V 367 V 367 V 367 Continued From page 44 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 III 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 incident; (6) a statement indicating that there have been no reportable incidents whenever no							
20 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (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 ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE V 367 Continued From page 44 V 367 V 367 V 367 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 incidating that there have been no reportable incidents whenever no Here is a statement incidation get the have been no reportable incidents whenever no			MHL071-027	B. WING		03	8/01/2022
IDENTIFY ROCKY POINT, NC 28457 (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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) COMPLET DATE V 367 Continued From page 44 V 367 V sector 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 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	iame of Pf	ROVIDER OR SUPPLIER			ZIP CODE		
(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 CORRECTIVE ACTION SHOULD BE (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) (COMPLET TAG V 367 Continued From page 44 V 367 The 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	RAINBOW	FARMS					
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	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TC	CTION SHOULD BE THE APPROPRIATE	COMPLET
		report quarterly to the catchment area when The report shall be su by the Secretary via a include summary info (1) medication definition of a level II (2) restrictive in the definition of a level (3) searches of (4) seizures of the possession of a c (5) the total nu- incidents that occurre (6) a statement	e LME responsible for the re services are provided. ubmitted on a form provided electronic means and shall ormation as follows: errors that do not meet the or level III incident; interventions that do not meet el II or level III incident; f a client or his living area; client property or property in slient; mber of level II and level III ed; and t indicating that there have ncidents whenever no				
		Based on record revis facility failed to report Management Entity/N (LME/MCO) as requis Review on 1/5/22 and	ews and interviews, the t incidents to the Local Managed Care Organization red. The findings are: d 1/6/22 of facility records				
This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report incidents to the Local Management Entity/Managed Care Organization (LME/MCO) as required. The findings are: Review on 1/5/22 and 1/6/22 of facility records and Incident Response Improvement System		(IRIS) from January 1	I, 2021 - January 6, 2022 Inted incident reports for				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MUI 074 027	B. WING			2/04/2022
NAME OF P	ROVIDER OR SUPPLIER	MHL071-027	DDRESS, CITY, STATE, 2		03	3/01/2022
RAINBOW	FARMS		POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 367	Continued From page	e 45	V 367			
	Review on 1/5/22 and revealed: -31 year-old male -Admission date of 6/ -Diagnoses of autism intellectual disability- -No documentation of being employed betw 1/5/22 Review on 1/5/22 and Interval Recording SF revealed: -Observation periods one-hour blocks from block which captured -Individual blocks we observable behaviors marks. Behavior-1 wa and behavior-2 was i Behavior (SIB)." -Staff initials were mi captured observation - 7am (9/28/21 and 1 Interviews on 1/5/22 -She had been rehire January 3, 2022. -She had previously wa approximately 3 year -The afternoon of 1/5 she had used the " si client #1 since her re -The Program Director the "small bed" straps	d 1/6/22 of client #1's record (10/09) spectrum disorder and severe f any restrictive interventions reen the dates of 1/1/21 - d 1/6/22 of client #1's Partial heet dated 9/13/21 - 1/2/22 were listed in 16 daily 8 am - 11pm, and one single the hours of 11pm - 7am. re separated into two is and recorded using tick as identified as "Aggression" dentified as "Self-Injurious ssing for 192 individual block ssing for 2 blocks which between the hours of 11pm 1/26/21). and 2/4/22 staff #1 stated: d with the agency as of worked with the agency for s. /22 was the first afternoon mall bed " intervention with hire. or had shown her how to use is with client #1 by ensuring red properly and maintaining				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	8/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 367	Continued From page	e 46	V 367			
	stated: -She had worked with approximately 1 year -Client behaviors were in a log book. -The data recorded in accurate, as staff fail regular basis. -Client #1 used the "s as little as "30 minute -She estimated that of "small bed" interventit times per month" over Interviews on 1/5/22 -She had been employ approximately 1 year -Client behaviors were white notebook. -Client #1 used the "s as little as 30 minutes	The supposed to be recorded in the log book was not ed to record data on a small bed" intervention for es to all day." client #1 may have used the ion an average of "15-30 er the "last few months." and 1/11/22 staff #3 stated: byed with the agency for				
	intervention up to 2-3 December of 2021.					
	-She had been emplo November of 2021.	byed with the agency since				
	-Documentation requ	irements for client #1's ded in a black and white log				
	as little as "30 minute hours."	small bed" intervention for es" and as long as "1-2				
		#1 had used the "small bed" s in December of 2021 and er of 2021.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	8/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 THE APPROPRIATE	(X5) COMPLET DATE
V 367	Continued From page	e 47	V 367			
	August of 2021. -She estimated client intervention on an av December of 2021. -Client #1 used the "s as little as "15-20 min Interview on 2/4/22 s -She had been emplo approximately 1 year -She had witnessed bed" intervention on during the overnight -The data recorded in	byed with the agency since t #1 had used the "small bed" rerage of 1 time per week in small bed" intervention for nutes" at a minimum. taff #8 stated: byed with the agency for t. client #1 using the "small two separate occasions				
	September of 2020. -Documentation required behaviors were recombook. -Client #1 used the "s as little as "25-30 minday." -She estimated client intervention 2-3 times Interview on 1/12/22 -Her employment with December 2021.	taff #9 stated: byed with the agency since irrements for client #1's rded in a black and white log small bed" intervention for nutes" and as long as "all t #1 had used the "small bed" s in December of 2021. former staff (FS #5) stated: h the agency ended in umented in a logbook but not				
	documented consister -Client #1 used the "s					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING	B. WING		3/01/2022
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 367	Continued From page	e 48	V 367			
	-She estimated client #1 had used the "small bed" intervention approximately 10 times for the last full month she worked (October).					
	the Qualified Profess Director (ED) stated: -The facility had with the implementation o and would continue to primary form of thera forward. -Client #1's use of the varied depending on where it was impleme -She believed that lev not required due to the with the intervention	1/5/22, 1/6/22, and 1/10/22 ional (QP)/ Executive essed positive results with f the "small bed" intervention o use the method as a peutic intervention moving e "small bed" intervention his mood. There were times ented daily and other times ented daily and other times ented once a week, or less. vel II incident reporting was ne established behavior plan listed. e for completing all level II				
	NCAC 27G .0203 Co Professionals and As (V109) for a Type A1 corrected within 23 d					
V 513	27E .0101 Client Rig Alternative	hts - Least Restictive	V 513			
	that promote a safe a These include: (1) using the le appropriate settings a	l provide services/supports and respectful environment. east restrictive and most				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MUL 074 007	B. WING		00/04/0000	
	ROVIDER OR SUPPLIER	MHL071-027	ADDRESS, CITY, STATE		03	8/01/2022
			AND CREEK ROAD	,		
RAINBOW	/ FARMS	ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 513	Continued From page	e 49	V 513			
	 V 513 Continued From page 49 skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. 					
	facility failed to provid used the least restric to reduce a behavior findings are: Review on 1/5/22 and revealed: -31 year-old male -Admission date of 6, -Diagnoses of autism intellectual disability-	ews and interviews, the de services/supports that tive intervention procedure for 1 of 3 clients (#1). The d 1/6/22 of client #1's record /10/09 n spectrum disorder and severe vailable to support the use of				
	Review on 1/5/22 and Individual Support Pl revealed: -"WHAT OTHERS N					

STATE FORM

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
		A. BUILDING:			
	MHL071-027	B. WING		03	8/01/2022
AME OF PROVIDER OR SUPPLIE	R STREET	ADDRESS, CITY, STATE,	ZIP CODE		
AINBOW FARMS		AND CREEK ROAD			
		POINT, NC 28457			
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 513 Continued From	page 50	V 513			
engage in behar -"WHAT OTHEF SUPPORT ME injurious behavit time, but I have staffing last year Review on 1/11/ Plan dated 12/2 -"Background Im restrictive nature well as his prefe specialized bed 'small bed'), one increase time ou eventually leadin ASAP (Autism S preferred to kee (Human Rights that are outside Support Plan)." -"Clinical Formu use the restraint in SIB or physic frequently), as v onset of precurs [Program Direct additional strate Review on 2/4/2 dates of 10/6/21 -There were ove citing the use of -There were 30 whether a restra	RS NEED TO KNOW TO BEST Medical/Behavioral: my severe ors (SIB) have lessened over used crisis services with 2:1 r and my SIB continues." 22 of client #1's Behavior Support /21 revealed: formation Due to the very e of the wrist band procedure (as erred activity of staying in a with leg and wrist restraints (aka e of [client #1's] goals has been to at of wrist bands/small bed ng to discarding the wrist band. Support and Programs) staff have p the small bed as per their HRC Committee) recommendations the scope of this BSP (Behavior lation They are continuing to a bed as well if [client #1] engages al aggression (SIB most vell as PRN (as needed) at the for behaviors. At the current time, or] does not feel like they need gies"				

STATE FORM

STATEMENT OF DEFICIENC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY IPLETED
			A. BUILDING:			
		MHL071-027	B. WING		0:	3/01/2022
NAME OF PROVIDER OR S	JPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW FARMS			AND CREEK ROAD POINT, NC 28457			
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 513 Continued	From page	e 51	V 513			
use of the restraints i -There was the use an "small bed -There was of less resi Interviews stated: -She had b interventio when addr -She had b used the "s didn't want Interview of stated: -She was h and resign -Staff woul happy" and listen for h -She had v interventio	"small bed n the bed. a 1 shift wird d non-use " interventi s no docum rictive inter on 1/6/22, been emploided tely 1 year been trained n was to be essing clie been inform small bed" to deal" w an 1/11/22 hired by the ed in Dece d interact w d would "pi im" when h vitnessed s n as a way or 2/3/22 s vorked with previously w re. used the "s tely 4 time I been son	nentation identifying the use rventions. 1/10/22 and 2/7/22 staff #2 byed with the agency for d that the "small bed" e utilized as a "last resort"				

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STATEMENT	of Health Service Regure OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		MHL071-027	B. WING		03/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	FCORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETI
V 513	Continued From page	e 52	V 513			
	"aggressive behavior	s."				
	approximately 1 year -Sometimes, the "sm	byed with the agency for all bed" intervention was ciplinary action by staff who				
	(QP)/ Executive Direct -All data pertaining to bed" intervention wer logbook. -She was responsible	the Qualified Professional ctor (ED) stated: o the details of the "small re recorded in client #1's e for reviewing all client nsuring it was implemented.				
	NCAC 27G .0203 Co Professionals and As	ss referenced into 10A mpetencies of Qualified sociate Professionals rule violation and must be ays.				
V 514	27E .0102 Client Rigl	hts - Prohibited Procedures	V 514			
	shall be prohibited: (1) those intervention prohibited by statute (a) any intervention considered corporal provides 122C-59; (b) the contingentiation contact; (c) substances	lowing types of procedures ventions which have been or rule which shall include: ntion which would be punishment under G.S. ent use of painful body administered to induce				
	(c) substances painful bodily reaction	administered to induce ns, exclusive of Antabuse; ck (excluding medically				

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If continuation sheet 53 of 100

	of Health Service Regu OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	INSTRUCTION		E SURVEY
and plan (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		MHL071-027	B. WING		03	8/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
RAINBOW		200 ISL/	AND CREEK ROAD			
KAINDOW	FARMIS	ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 514	Continued From pag	e 53	V 514			
	(g) contingent substances which ind noise, bad smells or (h) any potenti procedure, excluding stimulus which is adr purpose of reducing a behavior.	ck; tasting foodstuffs; application of any noxious clude but are not limited to splashing with water; and ally physically painful prescribed injections, or ninistered to the client for the the frequency or intensity of ventions determined by the e unacceptable for or				
	facility failed to adhe administered to the c reducing the frequen	as evidenced by: ews and interviews, the re to prohibited procedures lient for the purpose of cy or intensity of a behavior, s (#1). The findings are:				
	revealed: -31 year-old male -Admission date of 6	n spectrum disorder and				
	Individual Support PI revealed: -"WHAT OTHERS NI SUPPORT MESoc assistance and occa engage in behaviors. -"WHAT OTHERS NI	d 1/6/22 of client #1's an (ISP) dated 6/1/21 EED TO KNOW TO BEST ial Network: I need 1:1 sional 2:1 supports if I EED TO KNOW TO BEST lical/Behavioral: my severe				

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If continuation sheet 54 of 100

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		MHL071-027	B. WING		03	/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
RAINBOW	FARMS		AND CREEK ROAD				
			POINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
V 514	Continued From pag	e 54	V 514				
	time, but I have used staffing last year and	d crisis services with 2:1 I my SIB continues."					
	Review on 1/11/22 of client #1's Behavior Support Plan dated 12/2/21 revealed:						
	-"Background Information Due to the very						
	restrictive nature of the wrist band procedure (as well as his preferred activity of staying in a						
	specialized bed with	leg and wrist restraints (aka					
	, -	client #1's] goals has been to					
		wrist bands/small bed discarding the wrist band.					
		ort and Programs) staff have					
	preferred to keep the small bed as per their HRC (Human Rights Committee) recommendations						
	that are outside the s	mittee) recommendations scope of this BSP (Behavior					
	Support Plan)."	n They are continuing to					
		as well if [client #1] engages					
	frequently), as well a	s PRN (as needed) at the					
		ehaviors. At the current time,					
	additional strategies.	oes not feel like they need "					
		with client #1 on 1/5/22 and					
		cessful due to verbal #1's detachment from the					
	interview process.						
	Interviews on 1/6/22 stated:	, 1/10/22 and 2/7/22 staff #2					
	-She had been empl approximately 1 year	oyed with the agency for r					
		client #1 may have used the					
		ion 15-30 times per month					
	on average over the						
		upon hire that the "small s only to be used as a last					
						1	

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		MHL071-027	B. WING		03	/01/2022
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		ND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 514	Continued From page	e 55	V 514			
	-She had been informed by co-workers that they used the "small bed" intervention when "they didn't want to deal" with client #1.					
	 didn't want to deal" with client #1. Interview on 1/11/22 former staff #5 (FS #5) stated: -She was hired by the agency in February of 2020 and resigned in December of 2021. -She estimated client #1 had used the "small bed" intervention approximately 10 times for the last full month she worked (October). -Staff would interact with client #1 when "he was happy" and would "put him in his room and just listen for him" when he was "having a bad day." -She witnessed staff use the "small bed" intervention" to avoid client #1 when he was upset and displaying problematic behaviors and aggression. Interview on 2/3/22 staff #7 stated: -She had worked with the agency since October of 2021. -She had previously worked with the agency prior to her rehire. -Client #1 used the "small bed" intervention approximately 4 times per month. -There had been some staff, who were no longer working with the agency, that had used the "small 					
	Interview on 2/4/22 s -She had been emplo approximately 1 year -She had witnessed to used as a form of "di	"aggressive behaviors." Interview on 2/4/22 staff #8 stated: -She had been employed with the agency for approximately 1 year. -She had witnessed the "small bed" intervention used as a form of "disciplinary" action by staff as means of avoiding interactions with client #1.				
	Interview on 1/10/22 (QP)/ Executive Dire alth Service Regulation	the Qualified Professional ctor (ED) stated:				

TATEMENT OF DEFICIEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027			03	8/01/2022
AME OF PROVIDER OR	SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
AINBOW FARMS			AND CREEK ROAD POINT, NC 28457			
	CH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 514 Continued	I From page	56	V 514			
dangerou sensory s -The "sma requested This defic NCAC 27	s self-injurio timulation. all bed" inter by client #1 iency is cros G .0203 Cor	vention was used to prevent us behaviors and to provide vention was sometimes I to help calm him. ss referenced into 10A mpetencies of Qualified sociate Professionals				
(V109) for corrected	a Type A1 within 23 da	rule violation and must be	V 518			
PHYSICA TIME-OU FOR BEH (e) Within may be us in accorda (1) restrictive attempted more rest (2) physical a during an- interventio (A) the client' conducted health his assessme pre-existin and limita	TAND PRO AVIORAL C a facility while sed, the politic ance with the the requirent alternatives whenever prictive intervi- consideration after utilization, including review of the s comprehend tory or comp- ent shall inclu- ing medical con- tions that wo	INT AND ISOLATION TECTIVE DEVICES USED CONTROL here restrictive interventions cy and procedures shall be e following provisions: ment that positive and less a are considered and possible prior to the use of entions; on is given to the client's pojical well-being before, ation of a restrictive				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	8/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN ((X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLET
V 518	Continued From pag	e 57	V 518			
	 V 518 Continued From page 57 of the physical and psychological well- being of the client and the safe use of restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions; (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention; 					
	interviews, the facility were present to mon psychological well-be the duration of the re failed to ensure that alternatives were cor	ews, observation, and y failed to ensure that staff				
	revealed: -31 year-old male -Admission date of 6, -Diagnoses of autism intellectual disability- -No documentation of	n spectrum disorder and severe of alternatives to restrictive mployed between the dates				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		
			A. BUILDING:		COMPLETED	
		MHL071-027	B. WING		03/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 518	Continued From pag	e 58	V 518			
	physical and psychological well-being throughout the duration of the restrictive interventions employed between the dates of 1/1/21 - 1/5/22 -No documentation that the least restrictive intervention alternatives were considered					
	intervention alternatives were considered Review on 1/5/22 and 1/6/22 of client #1's Individual Support Plan (ISP) dated 6/1/21 revealed: -"WHAT OTHERS NEED TO KNOW TO BEST SUPPORT MESocial Network: I need 1:1 assistance and occasional 2:1 supports if I					
	SUPPORT MEMed injurious behaviors (S	EED TO KNOW TO BEST lical/Behavioral: my severe SIB) have lessened over l crisis services with 2:1				
	Plan dated 12/2/21 re -"Background Inform restrictive nature of the well as his preferred specialized bed with 'small bed'), one of [c increase time out of v eventually leading to ASAP (Autism Suppor preferred to keep the (Human Rights Commit that are outside the sis Support Plan)." -"Clinical Formulation use the restraint bed in SIB or physical ago frequently), as well a onset of precursor be	ation Due to the very he wrist band procedure (as activity of staying in a leg and wrist restraints (aka client #1's] goals has been to wrist bands/small bed discarding the wrist band. ort and Programs) staff have e small bed as per their HRC mittee) recommendations scope of this BSP (Behavior h They are continuing to as well if [client #1] engages				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL071-027	MHL071-027 B. WING		03	8/01/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
0(4) 15				PROVIDER'S PLAN C		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AU CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 518	Continued From page	e 59	V 518			
	dates of 10/6/21 - 2/2 -There were over 30 citing the use of the " -There was no docum restrictive interventio the dates of 1/1/21 - -There was no docum the physical and psyo throughout the durati intervention. -There was no docum restrictive interventio considered. Observation on 1/5/2 revealed: -Staff #1 was providin -Client #1 was observ with the bedroom ligh -Client #1 was lying i the small bed) with 4 from the bed and cor wrists and ankles. -The "small bed" was second bed which was "big bed " which clien -Client #1 did not app unresponsive to dialo	shifts with specific entries 'small bed" intervention. nentation of alternatives to ns being employed between 1/5/22 nentation of staff monitoring chological well-being on of the restrictive nentation that the least n alternatives were 2 at approximately 11:45am ng 1:1 services with client #1. ved alone in his bedroom nt out. n a bed (identified by staff as leather straps extending nected to both of client #1 's a positioned adjacent to a as identified by staff as the nt used for sleeping. bear in distress and was ogue.				
	stated: -She estimated that o	1/10/22 and 2/7/22 staff #2 client #1 may have used the ion 15-30 times per month				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:				
		MHL071-027	B. WING		03	8/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE			
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 518	Continued From pag	e 60	V 518				
	on average over the last "few months." -There were no specific observation times for monitoring client #1 while using the "small bed" intervention. Interviews on 1/6/22 and 1/11/22 staff #3 stated: -She estimated client #1 had used the "small bed"intervention 2-3 times per week in December of 2021. -Staff were required to watch client #1 for "5 - 10						
	minutes" when using to ensure that client the restraints. -Staff returned to che	the "small bed" intervention, #1 did not wriggle free from eck on client #1 "when he					
	was ready." -There were no addit requirements when o intervention.	tional observation client #1 used the "small bed"					
	stated:	, 1/12/22 and 2/4/22 staff #4 client #1 had used the "small					
	bed" intervention 3 - 2021, and 2 -3 times -There were no spec	5 times in December of in November of 2021. ific observation requirements #1 while using the "small					
	bed" intervention. -She was not require	ed to remain in the room with as utilizing the "small bed"					
		red use of the restrictive I bed" approximately once					
	to check on him ever -The observation req	uirements for client #1 when					
ision of Ho		ed" intervention were to more often" than normal					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03	/01/2022
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 518	Continued From page	e 61	V 518			
	observation periods.					
	Interview on 2/3/22 staff #7 stated: -Client #1 used the "small bed" intervention approximately 4 times per month. -Staff were not required to be in the room to observe client #1 while using the "small bed" intervention.					
	#1 had used the "sma -There were no speci	vernight shifts where client				
	stated: -Client #1 used the "s as little as 15-20 min hours. -She estimated client intervention approxim full month she worked -There were no speci	former staff #5 (FS #5) small bed" intervention for utes and as much as 8 #1 had used the "small bed" hately 10 times for the last d (October). ific observation requirements #1 while using the "small				
	approximately 2 -3 tir -When utilizing the "s would return to check	he "small bed" intervention nes in December of 2021. mall bed" intervention, staff				
	(QP)/ Executive Direct -All data pertaining to	the Qualified Professional ctor (ED) stated: the details of the "small re recorded in client #1's				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL071-027	027 B. WING		03	03/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
		200 ISLA	ND CREEK ROAD				
RAINBOW		ROCKY	POINT, NC 28457				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF		(X5) COMPLETE	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE	
V 518	Continued From page	9 62	V 518				
		e for reviewing all client nsuring it was implemented.					
		ss referenced into 10A					
	Professionals and As	mpetencies of Qualified					
		rule violation and must be					
	corrected within 23 da	ays.					
V 521	27E .0104(e9) Client	Rights - Sec. Rest. & ITO	V 521				
	10A NCAC 27E .0104	-					
	PHYSICAL RESTRA						
	TIME-OUT AND PRC						
		here restrictive interventions					
		icy and procedures shall be					
		e following provisions:					
		ctive intervention is utilized,					
		be made in the client record					
	to include, at a minim						
	(A) notation of the clie psychological well-be						
	(B) notation of the fre						
	duration of the behav						
		precipitating circumstance					
	contributing to the on						
		ne use of the intervention,					
	the positive or less re						
		and the inadequacy of less					
		n techniques that were used; ne intervention and the date,					
	time and duration of i						
	(E) a description of a						
	methods of intervention						
		e debriefing and planning					
		e legally responsible person,					
		mergency use of seclusion,					
	physical restraint or is	solation time-out to eliminate	1				

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If continuation sheet 63 of 100

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:				
		MHL071-027	B. WING		03	8/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)	
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	D THE APPROPRIATE	COMPLET DATE	
V 521	Continued From pag	e 63	V 521				
	or reduce the probability of the future use of						
	restrictive interventio	-					
		he debriefing and planning					
		e legally responsible person,					
		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						
		the employee who further					
	authorized, the use of						
	This Rule is not met as evidenced by: Based on record reviews and interviews, the						
	facility failed to ensur	n the client record when a					
		n was utilized for 1 of 3					
	clients (#1). The find						
		d 1/6/22 of client #1's record					
	revealed:						
	-31 year-old male -Admission date of 6	/10/09					
		n spectrum disorder and					
	intellectual disability-	-					
		of client's physical and					
	psychological well-be	eing following following a					
	restrictive interventio						
		of the frequency, intensity,					
	intervention	ehavior which led to the					
		of the rationale for the use of					
		ention, and the alternative					
	interventions conside						
	-No documentation of	of a description, date, time,					
	and duration of the ir						
	-No documentation of	of debriefing					
	Review on 1/5/22 an alth Service Regulation	d 1/6/22 of client #1's					

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED	
		A. BUILDING:				
	MHL071-027	B. WING		03	3/01/2022	
AME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE			
AINBOW FARMS		AND CREEK ROAD POINT, NC 28457				
			PROVIDER'S PLAN C		0(5)	
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
V 521 Continued From page	e 64	V 521				
Individual Support PI revealed: -"WHAT OTHERS NE SUPPORT MESocia assistance and occase engage in behaviors. -"WHAT OTHERS NE SUPPORT MEMed injurious behaviors (Stime, but I have used staffing last year and Review on 1/11/22 of Plan dated 12/2/21 re -"Background Informa restrictive nature of th well as his preferred specialized bed with 'small bed'), one of [c increase time out of v eventually leading to ASAP (Autism Suppor preferred to keep the (Human Rights Comu- that are outside the s Support Plan)." -"Clinical Formulatior use the restraint bed in SIB or physical age frequently), as well a onset of precursor be [Program Director] do additional strategies. Review on 2/4/22 of of dates of 10/6/21 - 2/2 -There were over 30	an (ISP) dated 6/1/21 EED TO KNOW TO BEST ial Network: I need 1:1 sional 2:1 supports if I EED TO KNOW TO BEST lical/Behavioral: my severe SIB) have lessened over crisis services with 2:1 my SIB continues." f client #1's Behavior Support evealed: ation Due to the very ne wrist band procedure (as activity of staying in a leg and wrist restraints (aka client #1's] goals has been to wrist bands/small bed discarding the wrist band. ort and Programs) staff have small bed as per their HRC mittee) recommendations cope of this BSP (Behavior n They are continuing to as well if [client #1] engages gression (SIB most s PRN (as needed) at the ehaviors. At the current time, bes not feel like they need "					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		03/01/2022	
		MHL071-027	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID SUMMARY S				PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
V 521	Continued From pag	e 65	V 521			
	following following a restrictive intervention, frequency, intensity, and duration of the behavior which led to the intervention, rationale for the use of the restrictive intervention, alternative interventions considered, description, date, time, and duration of the intervention, and debriefing following the intervention. Interviews on 1/6/22, 1/10/22 and 2/7/22 staff #2 stated: -She documented the dates of behaviors and					
	that led to the interve -There were no debri use of "small bed."	f interventions, and factors ention in client #1's logbook. iefing requirements following and 2/4/22 staff #3 stated:				
	"small bed" intervent	ny client #1 needed the ion, what caused the need and how he felt after the #1's logbook.				
	stated: -Staff were required to used the "small bed" -There were no spect requirements with re- #1 when he finished intervention.					
	causal factors leadin #1's logbook. The log staff often failed to co requirements approp	d to record behaviors and g to the behaviors in client gbook was not accurate, as complete documentation				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL071-027	B. WING		03/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		ND CREEK ROAD			
	1		POINT, NC 28457			
(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 THE APPROPRIATE	(X5) COMPLETI DATE
V 521	Continued From page	e 66	V 521			
	use of "small bed."					
	the"small bed" interve	taff #9 stated: actions leading to the use of ention in client #1's logbook. stently recording data in				
	(QP)/ Executive Direct -All data pertaining to bed" intervention wer logbook. -She was responsible	the Qualified Professional ctor (ED) stated: • the details of the "small re recorded in client #1's • for reviewing all client nsuring it was implemented.				
	NCAC 27G .0203 Co Professionals and As	rule violation and must be				
V 523	27E .0104(e11) Clien	t Rights - Sec. Rest. & ITO	V 523			
	TIME-OUT AND PRC FOR BEHAVIORAL C (e) Within a facility w may be used, the poli in accordance with th (11) The following pre be employed whenev (A) seclusion or phys protective device whe with the intent of cont behavior: periodic ob	INT AND ISOLATION DECTIVE DEVICES USED CONTROL where restrictive interventions icy and procedures shall be e following provisions: ecautions and actions shall er a client is in: ical restraint, including a en used for the purpose or trolling unacceptable oservation of the client shall 5 minutes, or more often as				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03	/01/2022
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 523	Continued From page	e 67	V 523			
V 523	Continued From page 67 attention shall be paid to the provision of regular meals, bathing and the use of the toilet; and such observation and attention shall be documented in the client record; (B) isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the client who is placed in isolation time-out; there shall be continuous observation and verbal interaction with the client when appropriate; and such observation shall be documented in the client record; and (C) physical restraint and may be subject to injury: a facility employee shall remain present with the client continuously.					
	interviews, the facility observation of the cli minutes during a phy	as evidenced by: ews, observation, and / failed to ensure periodic ent for at least every 15 rsical restraint to assure the ffecting 1 of 3 clients (#1).				
	revealed: -31 year-old male -Admission date of 6/ -Diagnoses of autism intellectual disability- -No documentation o	n spectrum disorder and severe f 15 minute observation se of a restrictive intervention				
	Individual Support Pla revealed: -"WHAT OTHERS NE	d 1/6/22 of client #1's an (ISP) dated 6/1/21 EED TO KNOW TO BEST ial Network: I need 1:1				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	8/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW	FARMS		ND CREEK ROAD POINT, NC 28457			
				PROVIDER'S PLAN O		(275)
(X4) ID PREFIX TAG	(EACH DEFICIENC	STEMENT OF DEFINITION BEINGLES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 523	Continued From page	e 68	V 523			
	engage in behaviors. -"WHAT OTHERS NE SUPPORT MEMed injurious behaviors (S time, but I have used staffing last year and Review on 1/11/22 of Plan dated 12/2/21 re -"Background Information restrictive nature of th well as his preferred specialized bed with 'small bed'), one of [of increase time out of v eventually leading to ASAP (Autism Suppor preferred to keep the (Human Rights Comp that are outside the s Support Plan)." -"Clinical Formulation use the restraint bed in SIB or physical age frequently), as well as onset of precursor be [Program Director] do additional strategies. Observation on 1/5/2 revealed: -Staff #1 was providin	EED TO KNOW TO BEST lical/Behavioral: my severe SIB) have lessened over l crisis services with 2:1 my SIB continues." f client #1's Behavior Support evealed: ation Due to the very he wrist band procedure (as activity of staying in a leg and wrist restraints (aka client #1's] goals has been to wrist bands/small bed discarding the wrist band. ort and Programs) staff have e small bed as per their HRC mittee) recommendations cope of this BSP (Behavior h They are continuing to as well if [client #1] engages gression (SIB most s PRN (as needed) at the ehaviors. At the current time, pes not feel like they need				
	the small bed) with 4	nt out. n a bed (identified by staff as leather straps extending nnected to both of client #1 '				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL071-027	B. WING		03	8/01/2022	
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 523	Continued From pag	e 69	V 523				
	"big bed " which clier	opear in distress and was					
	Attempted interviews with client #1 on 1/5/22 and 1/6/22 proved unsuccessful due to verbal limitations and client #1's detachment from the interview process.						
	stated: -She estimated that of "small bed" intervent on average over the -She estimated that of intervention from "30 "all day."	1/10/22 and 2/7/22 staff #2 client #1 may have used the ion "15-30 times" per month last "few months." client #1 used the "small bed" minutes" at a minimum to ific observation times for					
	•	while using the "small bed"					
	-She estimated client	and 1/11/22 staff #3 stated: t #1 had used the "small times per week in December					
	minutes" when using to ensure that client the restraints.	to watch client #1 for "5 - 10 the "small bed" intervention, #1 did not wriggle free from eck on client #1 "when he					
	Interviews on 1/4/22, stated:	, 1/12/22 and 2/4/22 staff #4					
	bed" intervention 3 - 2021, and 2 -3 times	client #1 had used the "small 5 times in December of in November of 2021. ific observation times for					
		while using the "small bed"					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL071-027	B. WING		03	8/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE			
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 523	Continued From pag	e 70	V 523				
	intervention.						
Interview on 2/7/22 staff #6 s -Client #1 only required use of straps with his "small bed" ap per week during December o -The observation requiremen to check on him every 30 min -The observation requiremen utilizing the "small bed" intervicheck on him a "little more of observation periods. Interview on 2/3/22 staff #7 s -Client #1 used the "small bed" approximately 4 times per mod -Staff were not required to be observe client #1 while using intervention.		eed use of the restrictive l bed" approximately once ember of 2021. uirements for client #1 were y 30 minutes. uirements for client #1 when ed" intervention were to more often" than normal staff #7 stated: small bed" intervention is per month. red to be in the room to ile using the "small bed"					
	stated: -Client #1 used the ": as little as 15-20 min hours. -She estimated client intervention approxim full month she worke -There were no spec	former staff #5 (FS #5) small bed" intervention for utes and as much as 8 t #1 had used the "small bed" nately 10 times for the last d (October of 2021). ific observation times for while using the "small bed"					
ision of Hos		taff #9 stated: he "small bed" intervention mes in December of 2021.					

Division of Health Service Regulation

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		SURVEY PLETED
		MHL071-027	B. WING		03/01/2022	
	ROVIDER OR SUPPLIER	1	ADDRESS, CITY, STATI		03	/01/2022
			AND CREEK ROAD			
RAINBOW	/ FARMS		POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE # DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 523	Continued From pag	e 71	V 523			
	-When utilizing the "s	small bed" intervention, staff				
	would return to chec					
	approximately 15 mi	nutes to assess his progress.				
		the behavior analyst stated:-				
		have been checking and ent #1 every 15 minutes				
	when he was in a res					
		that staff remained within				
		lient #1 was using the "small				
	bed" intervention.	-				
		the Qualified Professional				
	(QP)/ Executive Dire					
	-	:1 supervision and should be				
	within line of sight wi					
		/iously employed 15-minute 1 was using his small bed.				
		nger completed 15-minute				
		t #1 in 15-minute increments				
	had not been docum					
		to check on client #1 to				
		et when he was using the				
		e for reviewing all client				
		ensuring it was implemented.				
		oss referenced into 10A				
		ompetencies of Qualified				
		ssociate Professionals				
		rule violation and must be				
	corrected within 23 c	lays.				
V 524	27E .0104(e12-16) C ITO	Client Rights - Sec. Rest. &	V 524			
	10A NCAC 27E .010 PHYSICAL RESTR/	4 SECLUSION, AINT AND ISOLATION				
	l alth Service Regulation					1
ATE FORM			6899 60	G0T11	If continua	tion sheet 72

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		MHL071-027	B. WING 03/01/2022				
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, Z AND CREEK ROAD	ZIP CODE			
RAINBOW	/ FARMS		POINT, NC 28457				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT		CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETI DATE	
V 524	Continued From page	e 72	V 524				
	FOR BEHAVIORAL ((e) Within a facility w may be used, the pol in accordance with th (12) The use of a res discontinued immedia to the client's health of the client gains behav unable to gain behav frame specified in the intervention, a new a obtained. (13) The written appr governing body shall original order for a re renewed for up to a to accordance with the I Subparagraph (e)(10 (14) Standing orders used to authorize the restraint or isolation t (15) The use of a res considered a restriction specified in G.S. 1220 documentation require satisfy the requireme 122C-62(e) for rights (16) When any restrict for a client, notification follows: (A) those to be notified within 24 hours of the include: (i) the treatment or has designee, after each (ii) a designee of the (B) the legally respond	where restrictive interventions icy and procedures shall be ue following provisions: trictive intervention shall be ately at any indication of risk or safety or immediately after vioral control. If the client is ioral control within the time e authorization of the uthorization must be oval of the designee of the be required when the strictive intervention is otal of 24 hours in limits specified in Item (E) of) of this Rule. or PRN orders shall not be use of seclusion, physical imeout. trictive intervention shall be on of the client's rights as C-62(b) or (d). The rements in this Rule shall nts specified in G.S. restrictions. ctive intervention is utilized on of others shall occur as ed as soon as possible but e next working day, to abilitation team, or its use of the intervention; and					

STATEMENT	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		MHL071-027	B. WING		03/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS	200 ISLA	AND CREEK ROAD			
		ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 524	Continued From pag	e 73	V 524			
	notified immediately not to be notified.	unless she/he has requested				
	facility failed to docu treatment team and I following each restric	as evidenced by: iews and interviews, the ment notification of the legally responsible person ctive intervention as required, ts (#1). The findings are:				
	revealed: -31 year-old male -Admission date of 6 -Diagnoses of autism intellectual disability- -No documentation of notifications following -No documentation of	n spectrum disorder and severe of treatment team g each restrictive intervention of the notification of parties or client #1 following each				
	Individual Support Pl revealed: -"WHAT OTHERS NI SUPPORT MESoc assistance and occa engage in behaviors -"WHAT OTHERS NI SUPPORT MEMec injurious behaviors (5	EED TO KNOW TO BEST dical/Behavioral: my severe SIB) have lessened over d crisis services with 2:1				
	dates of 10/6/21 - 2/2 -There were over 30	client #1's logbook for the 2/22 revealed: shifts with specific entries "small bed" intervention.				

Division of Health Service Regulation STATE FORM

6899

If continuation sheet 74 of 100

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 524	Continued From pag	e 74	V 524			
	notifications following intervention. -There was no docur of parties legally resp following each restrice Attempted interviews 1/6/22 proved unsuce limitations and client interview process. Interviews on 1/6/22, stated: -She estimated that of "small bed" intervention on average over the Interviews on 1/6/22, stated: -She initially estimate "small bed" intervention December of 2021. -Client #1 would only about 50% of the tim Interviews on 1/4/22, stated: -She estimated that of bed" intervention 3-5 and 2-3 times in Nov	 mentation of the notification ponsible for client #1 etive intervention. with client #1 on 1/5/22 and cessful due to verbal #1's detachment from the 1/10/22 and 2/7/22 staff #2 client #1 may have used the ion 15-30 times per month last "few months." 1/11/22, and 2/4/22 staff #3 ed client #1 had used the on 2-3 times per week in y utilize the straps in his bed e the bed was used. 1/12/22 and 2/4/22 staff #4 client #1 had used the "small times in December of 2021 ember of 2021. staff #6 stated: red use of the restrictive I bed" approximately 1 time 				
	Interview on 2/3/22 s	staff #7 stated: small bed" intervention				

STATE FORM

6G0T11

If continuation sheet 75 of 100

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING	B. WING		8/01/2022
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,		00	5/01/2022
RAINBOW	/ FARMS		AND CREEK ROAD			
		ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
V 524	Continued From pag	e 75	V 524			
	#1 had used the "sm Interview on 1/11/22 stated: -She estimated client intervention approxim full month she worke Interview on 2/4/22 s -Client #1 had used t approximately 2 -3 til Interview on 2/7/22 o -Agency staff notified significant concerns. -He did not feel it wa to notify him following intervention.	vernight shifts where client all bed" intervention. former staff #5 (FS #5) t #1 had used the "small bed" nately 10 times for the last d (October of 2021). taff #9 stated: the "small bed" intervention mes in December of 2021. tient #1's guardian stated: I him when there were any s necessary for agency staff				
	(QP)/ Executive Dire -Client #1 had been of intervention approxim -Team reviews were but were completed ' COVID 19 emergend -She was responsible documentation and e This deficiency is cro NCAC 27G .0203 Co Professionals and As	using the "small bed" nately once per week of late. completed prior to COVID 19 'when we can" since the se. e for reviewing all client ensuring it was implemented. oss referenced into 10A ompetencies of Qualified esociate Professionals rule violation and must be				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		DENTIFICATION NOMBER.	A. BUILDING:				
		MHL071-027	B. WING		03/01/2022		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
RAINBOW	/ FARMS		ND CREEK ROAD				
			POINT, NC 28457				
(X4) ID PREFIX TAG					PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE
V 525	Continued From page	e 76	V 525				
V 525	27E .0104(e17) Clien	t Rights - Sec. Rest. & ITO	V 525				
	10A NCAC 27E .0104 SECLUSION,						
	PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED						
	FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions						
	•	here restrictive interventions icy and procedures shall be					
		e following provisions:					
		conduct reviews and reports					
	on any and all use of including:	restrictive interventions,					
	(A) a regular review by a designee of the						
	governing body, and review by the Client Rights						
	Committee, in compliance with confidentiality						
	rules as specified in f						
	(B) an investigation unwarranted patterns	of any unusual or possibly					
	-	f the following shall be					
	maintained on a log:						
	(i) name of the clier	nt;					
		oonsible professional;					
	(iii) date of each inte	-					
	(iv) time of each inte						
	(v) type of interventi(vi) duration of each						
	(vii) reason for use of						
	. ,	less restrictive alternatives					
		t were considered but not					
	, ,	alternatives were not used;					
		anning conducted with the					
		sible person, if applicable,					
	· ·	d in Parts (e)(9)(F) and (G) ate or reduce the probability					
		estrictive interventions; and					
		of the restrictive intervention,					
	if any, on the physica						
	well-being of the clier						
	1		1			1	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	8/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
V 525	Continued From page	e 77	V 525			
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain a log of restrictive interventions performed at the facility and conduct regular reviews of restrictive interventions as required, affecting 1 of 3 clients (#1). The findings are: Review on 1/5/22 and 1/6/22 of client #1's record revealed: -31 year-old male					
	intellectual disability- -No documentation o to reflect the restrictiv dates of 1/1/21 - 1/5/ -No documentation to	a spectrum disorder and severe f restrictive intervention log ve interventions between the 22 o accurately reflect the ns performed at the facility				
	Individual Support PI revealed: -"WHAT OTHERS NE SUPPORT MESoci assistance and occas engage in behaviors. -"WHAT OTHERS NE SUPPORT MEMed injurious behaviors (S time, but I have used staffing last year and Review on 1/11/22 of	EED TO KNOW TO BEST lical/Behavioral: my severe SIB) have lessened over crisis services with 2:1 my SIB continues." f client #1's Behavior Support				
	restrictive nature of the	evealed: ation Due to the very ne wrist band procedure (as activity of staying in a				

OVIDER OR SUPPLIER FARMS SUMMARY ST		A. BUILDING: B. WING						
FARMS	STREET							
FARMS		DDRESS, CITY, STATE.	710.0005					
	200 1314		, ZIP CODE					
SUMMARY ST	ROCKY	AND CREEK ROAD POINT, NC 28457						
`	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
Continued From page	e 78	V 525						
'small bed'), one of [c increase time out of v eventually leading to ASAP (Autism Suppor preferred to keep the (Human Rights Comit that are outside the s Support Plan)." -"Clinical Formulation use the restraint bed in SIB or physical age frequently), as well a onset of precursor be [Program Director] do additional strategies. Review on 2/4/22 of notes) for the dates of -There were over 30 citing the use of the " -There was no docum restrictive interviews 1/6/22 proved unsuo	wrist bands/small bed discarding the wrist band. ort and Programs) staff have e small bed as per their HRC mittee) recommendations scope of this BSP (Behavior h They are continuing to as well if [client #1] engages gression (SIB most s PRN (as needed) at the ehaviors. At the current time, bes not feel like they need " client #1's log book (shift of 10/6/21 - 2/2/22 revealed: shifts with specific entries small bed" intervention. nentation detailing the use of ns.							
stated:								
"small bed" interventi on average over the -She documented wh "small bed" interventi for the intervention, a	ion 15-30 times per month last "few months." ny client #1 needed the ion, what caused the need and how he felt after the							
	'small bed'), one of [c increase time out of v eventually leading to ASAP (Autism Suppor preferred to keep the (Human Rights Comit that are outside the s Support Plan)." -"Clinical Formulation use the restraint bed in SIB or physical ag frequently), as well a onset of precursor be [Program Director] do additional strategies. Review on 2/4/22 of notes) for the dates of -There were over 30 citing the use of the " -There was no docur restrictive intervention Attempted interviews 1/6/22 proved unsuce limitations and client interview process. Interviews on 1/6/22, stated: -She estimated that of "small bed" intervent on average over the -She documented wf "small bed" intervent for the intervention, a intervention in client	'small bed'), one of [client #1's] goals has been to increase time out of wrist bands/small bed eventually leading to discarding the wrist band. ASAP (Autism Support and Programs) staff have preferred to keep the small bed as per their HRC (Human Rights Committee) recommendations that are outside the scope of this BSP (Behavior Support Plan)." -"Clinical Formulation They are continuing to use the restraint bed as well if [client #1] engages in SIB or physical aggression (SIB most frequently), as well as PRN (as needed) at the onset of precursor behaviors. At the current time, [Program Director] does not feel like they need additional strategies" Review on 2/4/22 of client #1's log book (shift notes) for the dates of 10/6/21 - 2/2/22 revealed: - There were over 30 shifts with specific entries citing the use of the "small bed" intervention. - There was no documentation detailing the use of restrictive interventions. Attempted interviews with client #1 on 1/5/22 and 1/6/22 proved unsuccessful due to verbal limitations and client #1's detachment from the interview process. Interviews on 1/6/22, 1/10/22 and 2/7/22 staff #2 stated: -She estimated that client #1 may have used the "small bed" intervention 15-30 times per month on average over the last "few months." -She documented why client #1 needed the "small bed" intervention, and how he felt after the interviews on 1/6/22, 1/11/22, and 2/4/22 staff #3	'small bed'), one of [client #1's] goals has been to increase time out of wrist bands/small bed eventually leading to discarding the wrist band. ASAP (Autism Support and Programs) staff have preferred to keep the small bed as per their HRC (Human Rights Committee) recommendations that are outside the scope of this BSP (Behavior Support Plan)." -"Clinical Formulation They are continuing to use the restraint bed as well if [client #1] engages in SIB or physical aggression (SIB most frequently), as well as PRN (as needed) at the onset of precursor behaviors. 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ASAP (Autism Support and Programs) staff have preferred to keep the small bed as per their HRC (Human Rights Committee) recommendations that are outside the scope of this BSP (Behavior Support Plan)." -"Clinical Formulation They are continuing to use the restraint bed as well if [client #1] engages in SIB or physical aggression (SIB most frequently), as well as PRN (as needed) at the onset of precursor behaviors. At the current time, [Program Director] does not feel like they need additional strategies" Review on 2/4/22 of client #1's log book (shift notes) for the dates of 10/6/21 - 2/2/22 revealed: -There were over 30 shifts with specific entries citing the use of the "small bed" intervention. -There was no documentation detailing the use of restrictive interventions. Attempted interviews with client #1 on 1/5/22 and 1/6/22 proved unsuccessful due to verbal limitations and client #1's detachment from the interview process. 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At the current time, [Program Director] does not feel like they need additional strategies" Review on 2/4/22 of client #1's log book (shift notes) for the dates of 10/6/21 - 2/2/22 revealed: -There were over 30 shifts with specific entries citing the use of the "small bed" intervention. -There was no documentation detailing the use of restrictive interventions. Attempted interviews with client #1 on 1/5/22 and 1/6/22 proved unsuccessful due to verbal limitations and client #1's detachment from the interview process. Interviews on 1/6/22, 1/10/22 and 2/7/22 staff #2 stated: -She estimated that client #1 may have used the "small bed" intervention 15-30 times per month on average over the last "few months." -She documented why client #1 needed the "small bed" intervention, what caused the need for the intervention, and how he felt after the interviews on 1/6/22, 1/11/22, and 2/1/22 staff #3			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03	8/01/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN) THE APPROPRIATE	COMPLET
V 525	Continued From pag	e 79	V 525			
	stated:.					
	-She initially estimate	ed client #1 had used the				
	-	on 2-3 times per week in				
	December of 2021.					
	-Client #1 would only	v utilize the straps in his bed				
	about 50% of the tim					
		ny client #1 needed the				
		ion, what caused the need				
	intervention in client	and how he felt after the #1's logbook.				
	Interviews on 1/4/22, stated:	, 1/12/22 and 2/4/22 staff #4				
	-She estimated that of	client #1 had used the "small				
	bed" intervention 3 -	5 times in the month of				
	December, 2021 and November. 2021.	1 2 -3 times in the month of				
	•	to document when client #1				
	used the "small bed"					
	-There were no spec					
		gards to follow-up with client the use of the "small bed"				
		recorded in client #1's				
	logbook.					
	Interview on 2/7/22 s	staff #6 stated:				
		all bed" intervention was				
	recorded in client #1					
		red use of the restrictive				
		l bed" approximately 1 time				
	per week during Dec					
	Interview on 2/3/22 s	staff #7 stated:				
		Il bed" intervention was				
	recorded in client #1	-				
		not always logged in the				
		re "generally" logged in the				
	book.					
	-Client #1 used the " alth Service Regulation	small bed" intervention				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		00/04/0000	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			3/01/2022
			AND CREEK ROAD			
RAINBOW	FARMS	ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 525	Continued From page	e 80	V 525			
	approximately 4 time	s per month.				
	recorded in the logbo -She had worked 2 o #1 had used the "sm -Staff were supposed causal factors leading #1's logbook. The log staff often failed to co requirements approp Interview on 1/11/22 stated: -Behaviors were doc documented consiste -Client #1 used the "s as little as "15-20 min hours." -She estimated client	 b use of the "small bed" were book. vernight shifts where client all bed" intervention. d to record behaviors and g to the behaviors in client gbook was not accurate, as complete documentation riately. former staff #5 (FS #5) umented in a logbook but not ently by staff. small bed" intervention for nutes" and as much as "8 t #1 had used the "small bed" mately 10 times for the last 				
	the "small bed" interv -Staff were not consis- client #1's logbook. -Client #1 had used t approximately 2 -3 tin Interview on 1/10/22 (QP)/ Executive Dire- -All data pertaining to bed" intervention were logbook. -She was responsible	actions leading to the use of vention in client #1's logbook. stently recording data in the "small bed" intervention mes in December. the Qualified Professional				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				/ DOLDING.		
		MHL071-027	B. WING		03	8/01/2022
IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD			
		ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 525	Continued From page	e 81	V 525			
	NCAC 27G .0203 Co Professionals and As	ss referenced into 10A mpetencies of Qualified sociate Professionals rule violation and must be ays.				
V 526	26 27E .0104(e18-19) Client Rights - Sec. Rest. & ITO		V 526			
	TIME-OUT AND PRO FOR BEHAVIORAL ((e) Within a facility w may be used, the pol in accordance with th (18) The facility shall the use of seclusion a data collected and ar incident: (A) the type of proceed time employed; (B) alternatives consi (C) the effectiveness alternative employed The facility shall anal quarterly basis to mo determine trends and where necessary. Th data available to the (19) Nothing in this F prohibit the use of vo interventions at the c procedures in this Ru	AINT AND ISOLATION DTECTIVE DEVICES USED CONTROL where restrictive interventions icy and procedures shall be the following provisions: collect and analyze data on and physical restraint. The halyzed shall reflect for each dure used and the length of dered or employed; and of the procedure or yze the data on at least a nitor effectiveness, I take corrective action he facility shall make the Secretary upon request. Rule shall be interpreted to				
	This Rule is not met Based on record revi	as evidenced by: ews and interviews, the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL071-027	B. WING		03/01/2022	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			5/01/2022
			AND CREEK ROAD			
RAINBOW	/ FARMS		POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
V 526	Continued From page	e 82	V 526			
	used, effectiveness c	ment the type of procedure of procedures, length of time natives considered affecting 1 e findings are				
	revealed: -31 year-old male -Admission date of 6, -Diagnoses of autism intellectual disability- -No documentation o procedures, length of alternatives to the res- bed) being employed Review on 1/5/22 and Individual Support PI revealed: -"WHAT OTHERS NE SUPPORT MESoci assistance and occas engage in behaviors. -"WHAT OTHERS NE SUPPORT MEMed injurious behaviors (S	a spectrum disorder and severe if the effectiveness of f time employed, and strictive intervention (small l. d 1/6/22 of client #1's an (ISP) dated 6/1/21 EED TO KNOW TO BEST ial Network: I need 1:1 sional 2:1 supports if I				
	staffing last year and Review on 1/11/22 of Plan dated 12/2/21 re -"Background Informa- restrictive nature of th well as his preferred specialized bed with 'small bed'), one of [c increase time out of v eventually leading to	my SIB continues." f client #1's Behavior Support				

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			MHI 071-027 B. WING				
		MHL071-027			03	6/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, AND CREEK ROAD	, ZIP CODE			
RAINBOW	FARMS		POINT, NC 28457				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (E		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 526	Continued From page 83		V 526				
	that are outside the s Support Plan)." -"Clinical Formulation use the restraint bed in SIB or physical ago frequently), as well as onset of precursor be [Program Director] do additional strategies Review on 2/4/22 of of dates of 10/6/21 - 2/2 -There were over 30 s citing the use of the " -There was no docum effectiveness of the p employed, and altern	s PRN (as needed) at the haviors. At the current time, bes not feel like they need ." client #1's Logbook for the 22 revealed: shifts with specific entries small bed" intervention. hentation of the rocedures, length of time atives considered for over ies where the "small bed"					
	1/6/22 proved unsucc	with client #1 on 1/5/22 and cessful due to verbal #1's detachment from the					
	stated: -She documented the interventions, time of that led to the interve -She estimated that of	1/10/22 and 2/7/22 staff #2 e dates of behaviors and interventions, and factors ntion in client #1's logbook. lient #1 may have used the on "15-30 times" per month ast "few months."					
	-She estimated client	and 2/4/22 staff #3 stated: #1 had used the "small times per week in December					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	8/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD			
			POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 THE APPROPRIATE	(X5) COMPLET DATE
V 526	Continued From pag	e 84	V 526			
		ion, what caused the need and how he felt after the #1's logbook.				
- - - - - - - - - - - - - - - - - - -	stated: -She estimated that o bed" intervention 3 - 2021 and 2 -3 times	-She estimated that client #1 had used the "small bed" intervention 3 - 5 times in December of 2021 and 2 -3 times in November of 2021.				
	-Staff were required to document when client #1 used the "small bed" intervention. -There were no specific documentation requirements with regards to follow-up with client #1 when he finished the use of the "small bed" intervention.					
		recorded in client #1's				
	straps with his "smal per week during Dec -Precursors to the us	red use of the restrictive I bed" approximately 1 time ember of 2021. se of the "small bed" and the small bed" was employed				
	approximately 4 time -The use of the "sma recorded in client #1	small bed" intervention es per month. Ill bed" intervention was				
	causal factors leadin #1's logbook. -The logbook was no	staff #8 stated: d to record behaviors and g to the behaviors in client ot accurate, as staff often ocumentation requirements				

STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	8/01/2022
AME OF PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE		
	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 526	Continued From pag	e 85	V 526			
	appropriately.					
	stated: -She estimated clien intervention approxim full month she worke -Staff documented al "small bed" intervent -Documentation was all staff. Interview on 2/4/22 s -Client #1 had used to approximately 2 -3 tii -She documented all "small bed" intervent	Il actions related to use of the ion in client #1's logbook. not recorded accurately by staff #9 stated: the "small bed" intervention				
	(QP)/ Executive Dire -All data pertaining to bed" intervention we logbook. -She was responsible	the Qualified Professional ctor (ED) stated: o the details of the "small re recorded in client #1's e for reviewing all client ensuring it was implemented.				
	NCAC 27G .0203 Co Professionals and As	oss referenced into 10A ompetencies of Qualified sociate Professionals rule violation and must be ays.				
V 528	27E .0104(g1-2) Clie	ent Rights - Sec. Rest. & ITO	V 528			
	-	4 SECLUSION, AINT AND ISOLATION DTECTIVE DEVICES USED				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		MHL071-027	B. WING		03	/01/2022
iame of Pi	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 528	Continued From pag	e 86	V 528			
	FOR BEHAVIORAL (CONTROL				
	(g) When a restrictiv	e intervention is used as a				
		, facility policy shall specify:				
		hat a consent or approval				
		valid for no more than six				
		decision to continue the				
	specific intervention shall be based on clear and recent behavioral evidence that the intervention is					
		pact and continues to be				
	needed;					
		on or continued use of any				
	planned intervention,	•				
	notifications, consent	ts and approvals shall be				
		ented in the client record:				
		lan by the responsible				
	•	treatment and habilitation				
	team, if applicable, s					
		ient and a review of the red by Subparagraph (e)(9)				
	and (e)(14) of this Ru					
		ent or legally responsible				
	()	ation in treatment planning				
	and after the specific	intervention and the reason				
		ained in accordance with 10A				
	NCAC 27D .0201;					
		advocate/client rights				
		ne specific intervention has				
	utilization of the inter	client and the rationale for				
		al, after an initial medical				
	· · · ·	ne plan includes a specific				
		sonably foreseeable physical				
		uch cases, periodic planned				
		ician shall be incorporated				
	into the plan.					
	This Rule is not met					
		ews and interviews, the				
	alth Service Regulation	re that consent or approval				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 528	Continued From pag	e 87	V 528			
	considered valid for r and that the decision intervention shall be behavioral evidence having a positive imp needed, affecting 1 c are: Review on 1/5/22 an revealed: -31 year-old male -Admission date of 6 -Diagnoses of autism intellectual disability- -No documentation c	n spectrum disorder and				
	Individual Support PI -"WHAT OTHERS NI SUPPORT MELife need a break, I will w small bed and for the gesture) that legs be sensory needs I have -" WHAT OTHERS N SUPPORT MEMe	d 1/6/22 of client #1's an dated 6/1/21 revealed: EED TO KNOW TO BEST s/Situation: When asked if I valk in my room toward my e most part I only request (by strapped. This is due to a had for many years." IEED TO KNOW TO BEST dical/Behavioral: I have ons in place related to these behavior plan."				
	Plan dated 12/2/21 rd -"Background Inform restrictive nature of ti well as his preferred specialized bed with 'small bed'), one of [d	f client #1's Behavior Support evealed: ation Due to the very he wrist band procedure (as activity of staying in a leg and wrist restraints (aka client #1's] goals has been to wrist bands/small bed				

D STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BUILDING.			
		MHL071-027	B. WING		0;	3/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
	SUMMARY ST			PROVIDER'S PLAN C		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 528	Continued From page	e 88	V 528			
	ASAP (Autism Suppor preferred to keep the (Human Rights Commit that are outside the sissing the sissing the sissing the sissing the "Clinical Formulation use the restraint bed in SIB or physical age frequently), as well a onset of precursor be [Program Director] do additional strategies. Review on 1/5/22 and Rights Committee (H dated 5/24/17 - 5/26/ -HRC members appr "prescribed hospital B only used upon [client" 'yes'/'no' cards."	s PRN (as needed) at the ehaviors. At the current time, bes not feel like they need " d 1/6/22 of ASAP Human (RC) document signed and 17 revealed: oved the use of a bed with safe straps that are at #1's] request using oved the use of "arm bands				
	Review on 1/14/22 of notes/emails dated 1 -There was no docun client #1.	f 5 HRC meeting 0/28/19 - 8/10/21 revealed: nentation present identifying nentation present identifying				
	(QP)/ Executive Direct -Client #1's behavior by HRC and were ind support plan and indi -She was not certain due to COVID 19. -She was responsible	interventions were approved cluded in his behavior				

Division of Health Service Regu STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		MHL071-027	B. WING		03	6/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
		200 ISLA	AND CREEK ROAD			
RAINBOW	/ FARMS	ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 528	Continued From page	e 89	V 528			
	NCAC 27G .0203 Co Professionals and As	rule violation and must be				
V 529	27E .0104(g3-6) Clie	nt Rights - Sec. Rest. & ITO	V 529			
	TIME-OUT AND PRO FOR BEHAVIORAL ((g) When a restrictive planned intervention, (3) within 30 days of planned intervention, Committee established	NINT AND ISOLATION				
	or may abstain from r (4) within any time du intervention, if reques Advisory Committee	shall be given the				
	plan; (5) if any of the perso in Subparagraphs (h)	the treatment/habilitation ons or committees specified (2) or (h)(3) of this Rule do I use or continued use of a				
	planned intervention, initiated or continued resolution of any disa	the intervention shall not be Appeals regarding the greement over the use of				
	accordance with gove (6) documentation in the use of a planned	ion shall be handled in erning body policy; and the client record regarding intervention shall indicate:				
	the client, legally resp	equency of debriefing with ponsible person, if if determined to be clinically				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL071-027	B. WING		03	8/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG	(EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 529	Continued From page	Continued From page 90				
	the level of cognitive (B) bi-monthly evaluative responsible profession planned intervention; (C) review, at least m	nonthly, by the I team that approved the				
	facility failed to have file of description and bi-monthly evaluation intervention, and mon intervention by the tree	ews and interviews, the documentation in the client d frequency of debriefing,				
	revealed: -31 year-old male -Admission date of 6, -Diagnoses of autism intellectual disability- -No documentation of of debriefing -No documentation of the planned intervent -No documentation of	n spectrum disorder and severe of description and frequency of bi-monthly evaluations of				
	Individual Support PI -"WHAT OTHERS NE SUPPORT MELife need a break, I will w	d 1/6/22 of client #1's an dated 6/1/21 revealed: EED TO KNOW TO BEST e/Situation: When asked if I valk in my room toward my e most part I only request (by				

STATE FORM

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If continuation sheet 91 of 100

	of Health Service Regunder FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON	NSTRUCTION		E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		MHL071-027	B. WING		03	3/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, Z	ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD			
		ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 THE APPROPRIATE	(X5) COMPLETE DATE
V 529	Continued From page	e 91	V 529			
	sensory needs I have -"WHAT OTHERS NE SUPPORT MESch beside supports with bands and supports with bands and supports of I'd like the small bed needed for me to eng specific item or main cannot physically put myself in the small be must physically assis those coping strategi -" WHAT OTHERS N SUPPORT MEMed staff keep data sheet following activities: m behaviors, sleep, wri- in small bed, leisure private time, choices injuries, and behavio	EED TO KNOW TO BEST dical/Behavioral: Support is to track/document the neals, bowels, urination, st cuff removals, time spent time activities, personal of activities, body scan for r chartsI have documented elated to these risks in my				
	Plan dated 12/2/21 re -"Background Informa- restrictive nature of the well as his preferred specialized bed with 'small bed'), one of [c increase time out of v eventually leading to ASAP (Autism Suppor preferred to keep the (Human Rights Commit that are outside the s Support Plan)." -"Clinical Formulation	f client #1's Behavior Support evealed: ation Due to the very he wrist band procedure (as activity of staying in a leg and wrist restraints (aka client #1's] goals has been to wrist bands/small bed discarding the wrist band. ort and Programs) staff have e small bed as per their HRC mittee) recommendations scope of this BSP (Behavior n They are continuing to as well if [client #1] engages				

Division of Health Service Regulation STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		MHL071-027	B. WING		03	/01/2022
iame of Pi	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 529	Continued From page	e 92	V 529			
	onset of precursor be	s PRN (as needed) at the ehaviors. At the current time, bes not feel like they need				
	Review on 2/4/22 of client #1's Logbook for the dates of 10/6/21 - 2/2/22 revealed: -There were over 30 shifts with specific entries citing the use of the "small bed" intervention. -There was no description and frequency of debriefing for over 30 recorded shift entries where the "small bed" intervention was recorded.					
	Rights Committee do 5/24/17 - 5/26/17 rev -Board members app "prescribed hospital I only used upon [clien 'yes'/'no' cards."	proved the use of a bed with safe straps that are nt #1's] request using proved the use of "arm bands				
	-There was no docun client #1.	0/28/19 - 8/10/21 revealed: nentation present identifying nentation present identifying				
	1/6/22 proved unsuce	with client #1 on 1/5/22 and cessful due to verbal #1's detachment from the				
	stated:	1/10/22 and 2/7/22 staff #2				

STATE FORM

MHL071-027 B. WING O3/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
Week of PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE_ZIP CODE 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (M) ID PRETIX ISLAND CREEK ROAD ROCKY POINT, NC 28457 ID PRETIX (M) ID PRETIX ISLAND CREEK ROAD ROCKY POINT, NC 28457 ID PRETIX (M) ID PRETIX ISLAND CREEK ROAD ROCKY POINT, NC 28457 ID PRETIX (M) ID PRETIX ISLAND CREEK ROAD ROCKY POINT, NC 28457 ID PRETIX (M) ID PRETIX ISLAND CREEK ROAD ROCKY POINT, NC 28457 ID PRETIX (M) ID PRETIX ISLAND CREEK ROAD ROCKY POINT, NC 28457 ID PRETIX (M) ID PRETIX ISLAND CREEK ROAD ROCKY POINT, NC 28457 ID PRETIX (M) ID PRETIX ISLAND CREEK ROAD ROCKY POINT, NC 28457 ID PRETIX (M) ID PRETIX ISLAND CREEK ROAD ROCKY POINT, NC 28457 ID PRETIX (M) ID PRETIX ISLAND CREEK ROAD ROCKY POINT, NC 28457 ID PRETIX (M) ID SUBMERTING INFORMATION WEEK ROAD ROKKY POINT, NC 28457 ID PRETIX (M) ID SUBMERTING INFORMATION INFORMATION ID PRETIX ID PRETIX (M) ID SUBMERTING INFORMATION INFORM							
NUMBER Subscription Description PROVIDER STATE			MHL071-027	B. WING		03	8/01/2022
NAME ROCKY POINT, NC 28457 (M) ID PRETX TAC SUMMARY STATEMENT OF DEFICIENCES ID RESULTION OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE Comparing CROSS-REFERENCE TO THE APPROPRIATE Comparing CROSS-REFERENCE ID PRETX RESULTION OF USC IDENTIFYING INFORMATION) PRETX PRETX TAG PROVIDERS FLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE Comparing CROSS-REFERENCE ID PROVIDERS FLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE ID PROVIDERS FLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE Comparing CROSS-REFERENCE ID PROVIDERS FLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE Comparing CROSS-REFERENCE ID PROVIDERS FLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE Comparing CROSS-REFERENCE Comparing CRO	NAME OF PR	ROVIDER OR SUPPLIER					
Vision (EACH OBERICIENCY MUST BE PRECEDED BY PULL REGULTORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORECTIVE ACTION SHOULD BE OROSS-REFERENCE TO THE APPROPRIATE Coling DEFICIENCY) V 529 Continued From page 93 V 529 -Observations of client #1 were to be recorded in client #1's logbook at the end of each shift but were not accurate. V 529 Interviews on 1/4/22, 1/12/22 and 2/4/22 staff #4 stated:	RAINBOW	FARMS					
- Observations of client #1 were to be recorded in client #1's logbook at the end of each shift but were not completed by all staff regularly and were not accurate. Interviews on 1/4/22, 1/12/22 and 2/4/22 staff #4 stated: - There were no specific documentation requirements with regards to follow-up with client #1 when he finished the use of the "small bed" intervention. Interview on 2/4/22 staff #8 stated: - All actions related to use of the "small bed" were recorded in client #1's logbook. - There were no debriefing requirements following use of "small bed." Interview on 1/10/22 and 1/12/22 the Qualified Professional (QPV) Executive Director (ED) stated: - Client #1's behavior interventions were approved by a board and were included in his behavior support plan and individual support plan. - She was not certain when board last gathered due to COVID 19. - Team reviews were completed prior to COVID 19 but were completed "when we can" since the COVID 19 emergence. This deficiency is cross referenced into 10A NCAC 27G. 0203 Competencies of Qualified Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days. V 537	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
vient #1's logbook at the end of each shift but were not completed by all staff regularly and were not accurate. Interview on 1/4/22, 1/12/22 and 2/4/22 staff #4 stated: -There were no specific documentation requirements with regards to follow-up with client #1 when he finished the use of the "small bed" intervention. Interview on 2/4/22 staff #8 stated: -All actions related to use of the "small bed" were recorded in client #1's logbook. -There were no debriefing requirements following use of "small bed." Interview on 1/10/22 and 1/12/22 the Qualified Professional (QP) Executive Director (ED) stated: -Client #1's behavior interventions were approved by a board and were included in his behavior support plan and individual support plan. -She was not certain when board last gathered due to COVID 19. -Team reviews were completed prior to COVID 19 but were completed "when we can" since the COVID 19 emergence. This deficiency is cross referenced into 10A NCAC 27G. 0.203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days. V 537 27E. 0.108 Client Rights - Training in Sec Rest & V 537	V 529	Continued From pag	e 93	V 529			
V 53727E.0108Client Rights - Training in Sec Rest &V 537		client #1's logbook at were not completed I not accurate. Interviews on 1/4/22, stated: -There were no spec requirements with re- #1 when he finished intervention. Interview on 2/4/22 s -All actions related to recorded in client #1'	t the end of each shift but by all staff regularly and were 1/12/22 and 2/4/22 staff #4 ific documentation gards to follow-up with client the use of the "small bed" staff #8 stated: o use of the "small bed" were 's logbook.				
NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days. V 537 27E .0108 Client Rights - Training in Sec Rest & V 537		Interview on 1/10/22 Professional (QP)/ E stated: -Client #1's behavior by a board and were support plan and ind -She was not certain due to COVID 19. -Team reviews were but were completed '	xecutive Director (ED) interventions were approved included in his behavior ividual support plan. when board last gathered completed prior to COVID 19 "when we can" since the				
		NCAC 27G .0203 Co Professionals and As (V109) for a Type A1	ompetencies of Qualified ssociate Professionals rule violation and must be				
	V 537	-	hts - Training in Sec Rest &	V 537			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MUL 074 007					
	ROVIDER OR SUPPLIER	MHL071-027	DDRESS, CITY, STATE,		03	3/01/2022	
	ROVIDER OR SUFFLIER		AND CREEK ROAD	, ZIF CODE			
RAINBOV	V FARMS		POINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
V 537	Continued From page	94	V 537				
	 ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the pr to these procedures. staff authorized to emp procedures are retrai competence at least at (b) Prior to providing disabilities whose treating includes restrictive in service providers, emp volunteers shall comp seclusion, physical retraining is completed demonstrated. (c) A pre-requisite for demonstrating competentiating in preventing the need for restrictive (d) The training shall include measurable testing (w behavior) on those of methods to determine course. (e) Formal refresher by each service proviation of MH/DI Paragraph (g) of this 	CAL RESTRAINT AND JT cal restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that inploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including uployees, students or obtet training in the use of estraint and isolation time-out se interventions until the and competence is r taking this training is betence by completion of , reducing and eliminating e interventions. be competency-based, earning objectives, written and by observation of objectives and measurable e passing or failing the training must be completed der periodically (minimum ining that the service bloy must be approved by D/SAS pursuant to Rule. ng programs shall include,					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL071-027			03	3/01/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN (OF CORRECTION	(X5)
PRÉFIX TAG	1	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLETI DATE
V 537	Continued From page	e 95	V 537			
	(1) refresher in	formation on alternatives to				
	the use of restrictive					
	(2) guidelines of	on when to intervene				
	(understanding imminent danger to self and others);					
		on safety and respect for the				
		all persons involved (using				
		trictive interventions and				
	incremental steps in a					
	., .	or the safe implementation				
	of restrictive interven (5) the use of e	emergency safety				
	interventions which in					
		assessment and monitoring of the physical and				
	psychological well-being of the client and the safe					
		ghout the duration of the				
	restrictive intervention	n;				
	(6) prohibited p	procedures;				
		strategies, including their				
	importance and purp					
		tion methods/procedures.				
	(h) Service providers					
	at least three years.	ial and refresher training for				
	,	tion shall include:				
		pated in the training and the				
	outcomes (pass/fail);	•				
		where they attended; and				
	(C) instructor's	name.				
		n of MH/DD/SAS may				
	-	ocumentation at any time.				
	(i) Instructor Qualific	ation and Training				
	Requirements:	all domonstrato competence				
		all demonstrate competence testing in a training program				
		reducing and eliminating the				
	need for restrictive in					
		all demonstrate competence				
		testing in a training program				
	-	· ·				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING				
	MHL071-027			03	/01/2022	
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE			
RAINBOW FARMS		AND CREEK ROAD POINT, NC 28457				
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	ACTION SHOULD BE COMP TO THE APPROPRIATE DA		
V 537 Continued From pag	Continued From page 96					
teaching the use of a and isolation time-ou (3) Trainers sl by scoring a passing instructor training pr (4) The trainin competency-based, objectives, measura observation of behar measurable method failing the course. (5) The conten- service provider plan approved by the Div to Subparagraph (j)((6) Acceptable shall include, but no of: (A) understance (B) methods fr course; (C) evaluation (D) documenta (7) Trainers sl annually and demon of seclusion, physica time-out, as specifie Rule. (8) Trainers sl CPR. (9) Trainers sl in teaching the use of	seclusion, physical restraint ut. hall demonstrate competence g grade on testing in an ogram. Ig shall be include measurable learning ble testing (written and by vior) on those objectives and s to determine passing or ht of the instructor training the ns to employ shall be ision of MH/DD/SAS pursuant					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED	
		MHL071-027			0,	3/01/2022	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			5/01/2022	
			AND CREEK ROAD				
RAINBOW	/ FARMS	ROCKY	POINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	ACTION SHOULD BE COMP TO THE APPROPRIATE DAT		
V 537	 ⁷ Continued From page 97 (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (I) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. 		V 537				
	interviews, the facility audited staff (#1 and update in seclusion, p isolation time out. Th Review on 1/5/22 of s revealed: -Date of Hire: 1/3/22 -Job Title: Paraprofes -EBPI (Evidence Bas training dated 9/3/20,	ews, observation, and / failed to ensure 2 of 8 #3) received annual training physical restraint and he findings are: staff #1's personnel record ssional bed Protective Interventions)					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 03/01/2022	
		MHL071-027				
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	/ FARMS		AND CREEK ROAD POINT, NC 28457			
	SUMMARY ST		,	PROVIDER'S PLAN OF	E CORRECTION	(¥5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 537	Continued From page 98		V 537			
	Review on 1/5/22 of revealed: -Date of Hire: 10/8/20 -Job Title: Paraprofes					
	-EBPI dated 11/6/20, expired 11/6/21 -No documentation of updated EBPI training					
	Observation on 1/5/22 at approximately 11:45am revealed: -Staff #1 was providing 1:1 services with client #1. -Client #1 was observed alone in his bedroom with the bedroom light out. -Client #1 was lying in a bed (identified by staff as the small bed) with 4 leather straps extending from the bed and connected to both of client #1 ' s wrists and ankles. -The "small bed" was positioned adjacent to a					
	second bed which wa "big bed " which clier	as identified by staff as the nt used for sleeping. opear in distress and was				
	-She had been rehire January 3, 2022.	and 2/4/22 staff #1 stated: ed with the agency as of worked with the facility for rs.				
	she had used the " si client #1 since her re					
	the "small bed" strap	or had shown her how to use s with client #1 by ensuring red properly and maintaining t the process.				
	stated:	1/11/22, and 2/4/22 staff #3 oyed with the agency for over				
ision of Hea	•	ed client #1 had used the				

STATE FORM

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL071-027			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		03/01/2022		
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
RAINBOW	FARMS		AND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	ACTION SHOULD BE COMP TO THE APPROPRIATE DAT	
V 537	Continued From page 99		V 537			
	month of December, -Client #1 would only about 50% of the tim Interviews on 1/14/22 Professional (QP)/ E	utilize the straps in his bed				