FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING MHL071-027 03/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD RAINBOW FARMS **ROCKY POINT, NC 28457** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and complaint survey was completed March 1, 2022. The complaints were Please see attached POC. 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 consisted of audits of 3 current clients. For the purpose of this report: The "small bed" as referred to throughout this report was a small twin like bed with restraints which was located in client #1's bedroom positioned adjacent to a larger bed for sleeping and included 4 leather straps which fastened to client #1's wrists and ankles. Client #1's Behavior Support Plan dated 12/2/21 revealed: "...the very restrictive nature of the wrist band procedure... a specialized bed with leg and wrist restraints..." V 109 27G .0203 Privileging/Training Professionals V 109 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND RECEIVED ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for MAR 2 3 2022 qualified professionals or associate professionals. (b) Qualified professionals and associate **DHSR-MH Licensure Sect** professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.

Division of Health Service Regulation

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

(d) Competence shall be demonstrated by

Executive Director, BA/QP

(X6) DATE

3/21/2022

	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND FEAR OF CORRECTION ID	PENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
	MHL071-027	B. WING		03/	01/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
RAINBOW FARMS	200 ISLANI	CREEK RO	AD		
TAINDOW FAILING	ROCKY PO	INT, NC 284	57		
(X4) ID SUMMARY STATEMEN' PREFIX (EACH DEFICIENCY MUST I TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
v 109 Continued From page 1 exhibiting core skills includin (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; ar (7) clinical skills. (e) Qualified professionals at NCAC 27G .0104 (18)(a) are met the requirements of the employment system in the Standard met initiation of an individual plan upon hiring each associ (g) The associate profession supervised by a qualified propopulation served for the pespecified in Rule .0104 of this specified in Rule .0104 of this consultation of an individual plan upon hiring each associ (g) The associate profession supervised by a qualified propopulation served for the pespecified in Rule .0104 of this consultation of an individual plan upon hiring each associ (g) The associate profession supervised by a qualified propopulation served for the pespecified in Rule .0104 of this consultation of an individual plan upon hiring each associate profession supervised by a qualified propopulation served for the pespecified in Rule .0104 of this consultation of an individual plan upon hiring each associate profession supervised by a qualified propopulation served for the pespecified in Rule .0104 of this specified in Rule .0104 of this specifie	as specified in 10 A de deemed to have competency-based tate Plan for lach facility shall bies and procedures ualized supervision late professional. hal shall be ofessional with the uriod of time as s Subchapter. enced by: servation, and ofessional (QP)/ d to demonstrate the les required by the les requi	V 109			

Division of Health Service Regulation

PRINTED: 03/02/2022 FORM APPROVED

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING _ MHL071-027 03/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD PAINBOW FARMS

RAINBOW	FARMS 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 2	V 109		
	clients (#1).			
	Cross Reference: 10A NCAC 27G .5602 - Staff			
	(V290). Based on record reviews, observation,			
	and interviews the facility failed to ensure staff-client ratios above the minimum number to			
	enable staff to respond to individualized client			
	needs in the event of an emergency affecting 3 of			
	3 clients (#1, #2, #3).			
	Cross Reference: 10A NCAC 27G .0603 -			
	Incident Response Requirements for Category A			
	& B Providers (V366). Based on record reviews and interviews the facility failed to document their			
	response to level II incidents.			
	Cross Reference: 10A NCAC 27G .0604 -			
	Incident Reporting Requirements For Category A			
	& B Providers (V367). Based on record reviews and interview, the facility failed to report incidents			
	to the Local Management Entity/Managed Care			
	Organization (LME/MCO) as required.			
	Cross Reference: 10A NCAC 27E .0101 - Least			
	Restrictive Alternative (V513). Based on			
	interviews and record reviews the facility failed to provide services/supports that used the least			
	restrictive intervention procedure to reduce a			
	behavior for 1 of 3 audited clients (#1).			
	Cross Reference: 10A NCAC 27E .0102 -			
	Prohibited Procedures (V514). Based on record			
	reviews, and interviews, the facility failed to adhere to prohibited procedures administered to			
	the client for the purpose of reducing the			
	frequency or intensity of a behavior, affecting 1 of			
	3 clients (#1).			
	Cross Reference: 10A NCAC 27E .0104 -			
	Seclusion, Physical Restraint and Isolation			

Division of Health Service Regulation

	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03	3/01/2022
NAME	OF PROVIDER OR SUPPLIER		DRESS, CITY, ST			
RAIN	BOW FARMS		ND CREEK RO OINT, NC 284			
(X4) PRE TA	EIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V	reviews, observation, failed to ensure that so the physical and psycolient throughout the content process restrictive alternated attempted whenever process. The content of the content	ive Devices Used for 518). Based on record and interviews, the facility taff were present to monitor hological well-being of the duration of the restrictive d to ensure that positive and atives were considered and possible for 1 of 3 clients A NCAC 27E .0104 - estraint and Isolation we Devices Used for 521). Based on record s, the facility failed to documentation was in the estrictive intervention was ts (#1). A NCAC 27E .0104 - estraint and Isolation we Devices Used for 523). Based on record and interviews, the facility ic observation of the client inutes during a physical safety of the client, (#1). ANCAC 27E .0104 - estraint and Isolation we Devices Used for 523). Based on record and interviews, the facility ic observation of the client, (#1). ANCAC 27E .0104 - estraint and Isolation we Devices Used for 524). Based on record 524 is Based on record 525 is the facility failed to 525 is th	V 109			

Division of Health Service Regulation

PRINTED: 03/02/2022 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ B. WING 03/01/2022 MHL071-027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 ISLAND CREEK ROAD **RAINBOW FARMS ROCKY POINT, NC 28457** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 109 V 109 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 -Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V526). Based on record review and interviews, the facility failed to document the type of procedure used, effectiveness of procedures, length of time employed, and alternatives considered affecting 1 of 3 clients (#1). Cross Reference: 10A NCAC 27E .0104 -Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V528). Based on record reviews and interviews the facility failed to ensure that consent or approval for planned restrictive interventions shall be considered valid for no more than six months, and that the decision to continue a specific intervention shall be based on clear and recent behavioral evidence that the intervention is having a positive impact and continues to be needed, affecting 1 of 3 clients (#1).

Division of Health Service Regulation

Cross Reference: 10A NCAC 27E .0104 - Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V529). Based on record reviews and interview the facility failed to have documentation in the client file of description and

PRINTED: 03/02/2022 FORM APPROVED

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03	/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	200 ISLA	DDRESS, CITY, STATE ND CREEK ROAD POINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
	the planned interventithe planned intervention (client #1). Review on 1/5/22 of the record revealed: -Date of hire: 6/24/14 -Job Title: Qualified Properties of the planned plann	g, bi-monthly evaluations of on, and monthly review of on by the team affecting 1 of 3 clients are QP/ED's personnel arofessional (QP)/ Executive are Plan of Protection dated the QP/ED revealed: on will the facility take to be consumer's in your care? [client #1] will no longer are the purpose of a restraint are restraint or not. Otifying all ASAP (Autism as, Inc) staff via email today be been removed from the evailable for [client #1] to be informed in the email to Based Protective are and training to protect are #1] in the event that any is of aggression, property in jurious behaviors take	V 109				
	happens. All restraints removed from [client # bedroom and will not be purposes effective immembers will utilize EE redirect, and better mabehaviors which may be	/equipment have been 1's] small bed in his be utilized for restraint bediately. All team BPI techniques to prevent, bediated maladaptive					

Division of Health Service Regulation

Division o	f Health Service Regu	ation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		p.20040006 (2005203)00000000000000000000000000000000	B WING		00/0	4/2022
		MHL071-027	B. WING		03/0	1/2022
NAME OF BE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E. ZIP CODE		
NAIVIE OF PI	TOVIDER ON GUFFLIER					
RAINBOW	FARMS		ID CREEK ROAL			
		ROCKY P	OINT, NC 28457			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETE
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		DATE
TAG	REGULATORT OR	EGG IDENTIFICING ON ONNECTION	IAG	DEFICIENCY)		
			1			
V 109	Continued From page	e 6	V 109			
	manner [Programs F	Director], ASAP's Programs				
		aff immediately via email				
		lize the small bed as a				
1		ograms Director, who is also				
		orovide a refresher course to				
		aint techniques which will be		w		
1		#1] 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				
		losely monitor [client #1]				
	during behavioral ep					
1		ional (QP)/Executive				
	Director], ASAP's Ex	ecutive Director and				
		al contacted [client #1's] Care				
		n her of [client #1] requiring a				
		which ASAP is unable to				
	provide. [Care Coor					
		nt #1] spoke to [Local				*
	Management Entity's	s] Executive Team to				
		ere alternatives to him				
		erred to higher level of care.				
	[Programs Directo	or and QP/Executive Director]				
		pard of Director's (BOD)				
		/19/2022) to discuss the				
		D. agreed that [client #1]				
		el of care to address his				
		Director and QP/Executive				
		Care Coordinator] to inform				
		decision for as higher level of				
		ssed with her the need to				
	revise [client #1's] IS	SP (Individual Support Plan) to				
	reflect the discontinu	uation of using the small bed				
	for de-escalation. V	Ve also contacted [Behavior				
		nunity mental health business]				
	and requested he re	evise [client #1's] behavior				
		scontinuation of using the		4		
	1.5		1	I .		1

small bed for de-escalation .

MALE OF PROVIDER OR SUPPLIER RAINBOW FARMS SIRRET ADDRESS, GITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD ROCKY POINT, NC 2847 (X4) D REDUCTION IN CREATED RECOLOR CONTROL OF DEPTICATIONS OF THE PROVIDERS PLAN OF CORRECTION DEPTICATION OF LIST DEPTICATIONS OF THE PROVIDER PLAN OF CORRECTION DEPTICATION OF LIST DEPTIFYING BARDAMATION) V 109 Continued From page 7 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 Protection dated 3/1/22 and signed by the OP/ED revealed: "What immediate action will the facility take to ensure the safety of the consumer's in your care? Effective immediately, [client #1] will no longer utilize his small bed for fire purpose of a restraint whether he requests the restraint or not. Management will be notifying all ASAP (Autism Support and Programs, Inc.) staff via email today that the restraints have been removed from the bed and is no longer available for [client #1] to utilize. Staff will also be informed in the email to utilize EBPI (Evidence Based Protective Interventions) techniques and client #1] in the event that any behavioral occurrences of aggression, property destruction, and/or self injurious behaviors take place." ""Describe your plans to make sure the above happens. All restraints/equipment have been removed from [client #1] in the event that any behavioral occurrences of aggression, property destruction, and/or self injurious behaviors take place." ""Describe your plans to make sure the above happens. All restraints/equipment have been removed from [client #1] in the event that any behavioral occurrences of aggression property destruction, and or self-injurious behavior and will not be utilized for restra		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
RAINBOW FARMS 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457			MHL071-027	B. WING		03	3/01/2022	
CM3 DID SUMMARY STATEMENT OF DEPICIENCIES PROVIDER'S PLAN OF CORRECTION (MST SE PRECEDED BY PLLE (EACH ODER CONTROL ACTION SHOULD BE PRECEDED BY PLLE (EACH ODER CONTROL ACTION SHOULD BE CROSS REFERENCE ACTION SHOULD BE CROSS REFERENCE. V 109	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
(M4) ID PRETEX TAG SUMMARY STATEMENT OF DEFICIENCISS (READ DEFICIENCY MUST BE PRECEDED BY PILL TAG REGULATORY OR LSC (IDENTIFYING INFORMATION) V 109 Continued From page 7 The Care Coordinator is actively looking for placement with a higher level of care for [client #1]. Once placement is attermined for [client #1] (outside of A. S.A.P.) and he has been officially discharge [client #1] from the organization. Until placement is determined for [client #1] (outside of A. S.A.P.) and he has been officially 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 31/22 of the Plan of Protection dated 31/1/22 and signed by the QP/ED revealed: "What immediate action will the facility take to ensure the safety of the consumer's in your care? Effective immediately, [client #1] will no longer utilize his small bed for the purpose of a restraint whether he requests the restraint for not. Management will be notifying all ASAP (Autism Support and Programs, Inc) staff via email today that the restraints have been removed from the bed and is no longer available for [client #1] to utilize. Staff will also be informed in the email to utilize EBPI (Evidence Based Protective Interventions) techniques and training to protect themselves and [client #1] in the event that any behavioral occurrences of aggression, property destruction, and/or self injurious behaviors take place." "Describe your plans to make sure the above happens. All restraints/equipment have been removed from [client #15] small bed in his bedrorom and will not be utilized for restraint purposes effective immediately. All team members will tillize EBPI techniques to prevent, redirect, and better manage mailadaptive behaviors which may be displayed in an aggressive and/or SIS (Self-injurious behavior)	RAINBOW	/ FARMS						
TAGE CANDESCIBENCY MUST BE PRECEDED BY FULL TAGE CROSS-REFERENCED TO THE APPROPRIATE OFFICIENCY V 109 Continued From page 7 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 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 Protection dated 3/1/22 and signed by the QP/ED revealed: "What immediate action will the facility take to ensure the safety of the consumer's in your care? Effective immediately, (client #1] will no longer utilize his small bed for the purpose of a restraint whether he requests the restraint for not. Management will be notifying all ASAP (Autism Support and Programs, Inc) staff via ermail today that the restraints have been removed from the bed and is no longer available for (client #1) to utilize. Staff will also be informed in the email to utilize EBPI (Evidence Based Protective Interventions) techniques and training to protect themselves and [client #1] in the event that any behavioral occurrences of aggression, property destruction, and/or self injurious behaviors take place." "Describe your plans to make sure the above happens. All restraints/equipment have been removed from [client #15] small bed in his bedrorom and will not be utilized for restraint purposes effective immediately. All team members will utilize EBPI techniques to prevent, redirect, and better manage maladaptive behaviors which may be displayed in an aggressive and/or SIS (self-injurious behavior)			ROCKY P	OINT, NC 284	57			
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 Protection dated 3/1/22 and signed by the QP/ED revealed: "What immediate action will the facility take to ensure the safety of the consumer's in your care? Effective immediately, [client #1] will no longer utilize his small bed for the purpose of a restraint whether he requests the restraint or not. Management will be notifying all ASAP (Autism Support and Programs, Inc) staff via email today that the restraints have been removed from the bed and is no longer available for [client #1] to utilize. Staff will also be informed in the email to utilize EBPI (Evidence Based Protective Interventions) techniques and training to protect themselves and [client #1] in the event that any behavioral occurrences of aggression, property destruction, and/or self injurious behaviors take place." ""Describe your plans to make sure the above happens. All restraints/equipment have been removed from [client #15] small bed in his bedroom and will not be utilized for restraint purposes effective immediately. All team members will utilize EBPI (Erinquerious prevent, redirect, and better manage maladaptive behaviors which may be displayed in an angressive and/or SBI (self-injurious behavior)	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETE	
Director, informed staff immediately via email	V 109	The Care Coordina placement with a high #1]. Once placement discharge [client #1] fr Until placement is (outside of A.S.A.P.) a discharged/transitione A.S.A.P. will continue shift." Review on 3/1/22 of th 3/1/22 and signed by t-"What immediate acti ensure the safety of the Effective immediately, utilize his small bed fo whether he requests the same that the restraints have bed and is no longer autilize. Staff will also be utilize EBPI (Evidence Interventions) technique themselves and [client behavioral occurrence destruction, and/or sel place." -"Describe your plans happens. All restraints removed from [client #bedroom and will not be purposes effective immembers will utilize EBPI (Evidence Interventions) technique themselves and [client behavioral occurrence destruction, and/or sel place."	tor is actively looking for er level of care for [client is arranged, ASAP will from the organization. Idetermined for [client #1] and he has been officially id into new placement, to schedule two staff per the Plan of Protection dated the QP/ED revealed: on will the facility take to be consumer's in your care? [client #1] will no longer in the purpose of a restraint the restraint or not. Offiying all ASAP (Autism is, Inc.) staff via email today is been removed from the evailable for [client #1] to be informed in the email to a Based Protective in the event that any is of aggression, property if injurious behaviors take to make sure the above dequipment have been the distribution of the entitized for restraint mediately. All team is applied to prevent, anage maladaptive one displayed in an (self-injurious behavior) rector], ASAP's Programs	V 109				

Division of Health Service Regulation

PRINTED: 03/02/2022 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 03/01/2022 MHL071-027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 ISLAND CREEK ROAD **RAINBOW FARMS ROCKY POINT, NC 28457** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 109 V 109 Continued From page 8 (1/17/2022) not to utilize the small bed as a restraint. ASAP's Programs Director, who is also the EBPI trainer will provide a refresher course to review all EBPI restraint techniques which will be used to keep [client #1] and all staff safe during behavioral episodes. In the event [client #1] falls to the floor or begins to bang his head, staff are to utilize gym mats to protect him from hurting his head/body on the floor, wall, etc. The mat will also add a protective barrier for staff to remain safe while continuing to closely monitor [client #1] during behavioral episodes. [Qualified Professional (QP)/Executive Director], ASAP's Executive Director and Qualified Professional contacted [client #1's] Care Coordinator to inform her of [client #1] requiring a higher level of care, which ASAP is unable to provide. [Care Coordinator], the Care Coordinator for [client #1] spoke to [Local Management Entity's] Executive Team to determine if there were alternatives to him needing to be transferred to higher level of care. [Programs Director and QP/Executive Director] held an emergent Board of Director's (BOD) meeting via zoom (1/19/2022) to discuss the matter and the B.O.D. agreed that [client #1] needs a higher level of care to address his needs. [Programs Director and QP/Executive Director] spoke to [Care Coordinator] to inform her of the B.O.D.'s decision for as higher level of care. we also discussed with her the need to revise [client #1's] ISP (Individual Support Plan) to

reflect the discontinuation of using the small bed for de-escalation. We also contacted [Behavior Analyst] with [community mental health business] and requested he revise [client #1's] behavior plan to reflect the discontinuation of using the

As of 3/1/2022, [client #1's] guardian does not

feel comfortable signing the updated ISP

small bed for de-escalation.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		MHL071-027	B. WING		03/	/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	FATE, ZIP CODE		
RAINBOV	LEADAR	200 ISLAN	D CREEK RO	AD		
KAINBUV	V FARIVIS	ROCKY PO	DINT, NC 284	57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 109	o o minara i i o m pago		V 109			
		an) which reflects that the				
	ISP has been change	emoved as a resource. The				
		s week. Once the team				
		y not have an updated and				
		g on the guardian's stance				
		e chooses not to sign, I will				
	request the unsigned					
		s our attempt to comply with				
	requests.	ator is actively looking for				
		er level of care for [client		1		
	(1.0)	is arranged, ASAP will				
	discharge [client #1] fr					
	Client #1 was a 31 year	ar-old male admitted				
	6/10/09 with diagnose:					
	disorder and severe in					
		ered from frequent bowel				
	The second of th	sues, neck pain issues, es. Client #1's diagnoses				
		anifested in the form of				
	physical assaults, prop					
		ing SIBs. His SIBs included				
		t floors and walls, punching				
	himself in the face, and	d punching his genitalia.				
		ehavior Support Plan dated				
	12/2/21, the facility util					
		s self-injurious behaviors.				
	The "small bed" was person had for clooping					
		and included 4 leather to client #1's wrists and				
		or staff monitoring were	1			
	documented observations					
	increments to ensure a					
	and the successful imp	elementation of the				1
	•	nall bed" intervention was				- 1
		ed in use from 2-30 times				- 1
	per month (depending	on the month and				- 1

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
RAINBOW	FARMS		D CREEK ROAD DINT, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 109	reporter), and lasted 8 hours in duration. The each shift with the QL occasionally working Staff failed to recogn #1 in 15 minute increwhile in the restrictive debriefing protocols, restrictive intervention prohibited procedure for the purpose of reintensity of behaviors staff-client ratios on documentation was in response/reporting, extended restrictive restrictive intervention time employed, and considered. In addit bi-monthly restrictive monthly team review #1's record of when implemented, bi-annintervention, treatment notifications, or a resupplemented of the pagencies, and maint documentation of incomplemented within 23 openalty of \$5,000.00 not corrected within administrative penalty.	approximately 10 minutes to There were 2 -3 staff working P/ED and male staff alone on overnight shifts. ize the observation of client aments, observe client #1 in interventions, complete implement the least inside available, adhere to substitute administered to client #1 ducing the frequency or so, and failed to maintain safe overnight shifts. Supporting insufficient with no level II intervention times, no data on an effectiveness, length of alternative interventions ion, there were no records of an intervention evaluations, as, documentation in client restrictive interventions were all approvals of the ent team/guardian strictive intervention log. The enth intervention intervention log. The enth intervention intervention in client are trictive intervention log. The enth intervention intervention log. The enth intervention log. The enth intervention intervention log. The enth intervention log.	V 109			

Division of Health Service Regulation STATE FORM

DIVISION	of fleatiff betvice Regu	iation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION		SURVEY
ANDILAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMP	PLETED
		MHL071-027	B. WING		03.	/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		*
DAINDON	/ F4 D340	200 ISLA	ND CREEK RO	AD		
RAINBOW	FARMS	ROCKY	POINT, NC 2845	57		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP		COMPLETE
		,	IAG	DEFICIENCY)	KOFKIATE	DATE
V 112	Continued From page	11	V 112			
			0000 200011 270			
V 112	27G .0205 (C-D) Assessment/Treatmen	at/Habilitation Plan	V 112			
	Assessment freatmen	IVHADIII(ation Flan				
	10A NCAC 27G .0205	ASSESSMENT AND				
	TREATMENT/HABILIT	TATION OR SERVICE				
	PLAN					
		developed based on the artnership with the client or				
		rson or both, within 30 days				
	of admission for client					
	receive services beyon	•				
	(d) The plan shall incl					
		that are anticipated to be				
	achieved by provision projected date of achie					
	(2) strategies;	sverilent,				
	(3) staff responsible;					
		riew of the plan at least				
		n with the client or legally				
	responsible person or (5) basis for evaluation					
	outcome achievement					
		agreement by the client or				
		written statement by the				
		uch consent could not be				1
	obtained.					
					Į.	
	This Rule is not met a	s evidenced by:				
	Based on record review					

Division of Health Service Regulation

findings are:

facility failed to implement strategies based on assessment affecting 1 of 3 clients (#1). The

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL071-027	B. WING		03/01/2022
NAME OF PE	ROVIDER OR SUPPLIER	200 ISLAN	DRESS, CITY, STATE OREEK ROAD OINT, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 112	Review on 1/5/22 and revealed: -31 year-old male -Admission date of 6Diagnoses of autism intellectual disabilityVocabulary is limited achieved through phisource -No documentation of checks presented Review on 1/5/22 an Individual Support Pi-"WHAT OTHERS N SUPPORT MELife staffing and supervisistaff at night for heal (currently have visual minutes to monitor for restroom needs, etc. behaviors which are	d 1/6/22 of client #1's record /10/09 n spectrum disorder and	V 112		
	SUPPORT MEMed behaviors are tracked monitored 24 hours 6 hours of 1:1 time a night with 15 minute controlled home enverage at home, and directI require direct suphoursI require extra at least 18 hours/da support is provided, medical attention or	dical/Behavioral: My ed every 15 minutes and a dayDuring the day I have and have awake staff over checksI require a specially vironment, direct supervision supervision in the community pervision during all waking tensive support 7 days/week, y (truly 24 hours/day). If no I may injure myself requiring hospitalization."			

-"Time in small Bed with Restraints - duration of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	MHL071-027	B. WING		03/	01/2022
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE		
RAINBOW FARMS	200 ISLA	ND CREEK ROAD			
TAINDOW I ARMS	ROCKY	POINT, NC 28457			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
ASAP (Autism Supprestraints for severe-"Estimated Function BehaviorsWhen [a bed the procedure is minutes asking him small bed Sometim during this procedure sooner or later than -"Interventions and receive interaction of (noncongruent reinfolds) for entire this motivation for entire the behaviors that are resultant and the control of the behavior that are resultant and the control of the behavior occur monthly." -"Behavior Support ForeventiveProvide every 2-3 minutes in behaviorsStaff shot [client #1]." Review on 1/5/22 and Interval Recording Source and the control of the co	pecifically and only used by cort and Programs, Inc.) for a problem behavior." Ins of Problem client #1] is placed in the small is to check on him every 15 if he is ready to get out of the es his yes/no cards are used and sometimes he is asked 15 minutes." Rationales[Client #1] will every 3 minutes orcement) to help decrease gaging in undesired einforced by attention." DeceduresStaff will be using asheets that track occurrence rading) of each behavior every I be calculated as percentage inutes intervals during which red, and analyzed at least Plan Procedures - social interaction at least the absence of target uld be able to see and hear In 1/6/22 of client #1's Partial heet dated 9/13/21 - 1/2/22 Is were listed in 16 daily a sam - 11pm, and one single I the hours of 11pm - 7am. The separated into two is and recorded using tick was identified as navior #2 was identified was navior #2 was identified	V 112			

Division of Health Service Regulation

PRINTED: 03/02/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL071-027	B. WING	03/01/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RAINBOW FARMS

200 ISLAND CREEK ROAD **ROCKY POINT, NC 28457**

KAINBOW	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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	hoursStaff 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. 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 yearStaff were to check on client #1 every 2 hours to ensure that he was able to use the bathroom and to ensure his safetyThere were no specific requirements for observation checks with regards to time observed on day shiftObservations of client #1 were to be recorded in log book at the end of each shift but were not completed by all staff regularly and were not accurate. Interview on 1/11/22 staff #3 stated: -She had been employed with the agency for over a yearThere were no specific requirements with regards to observation times for client #1 when he was in his roomObservation of client #1 was dependent on the staff working and the "mood" of the client.	V 112		
	Interviews on 1/4/22, 1/12/22 and 2/4/22 staff #4			

Division	of Health Service Regu	lation			FORI	VIAPPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		MHL071-027	B. WING		03/0	01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
RAINBOV	V FARMS	200 ISLA	ND CREEK ROA	/D		
			OINT, NC 2845	57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	Continued From page	15	V 112			
	November of 2021Supervision requirem remain in line of sight awakeThere were no specific regards to observation he was in bedThere were no specific requirements for observation he was in bedThere were no specific requirements for observation when he used his "smill line line in several months, but shagency previouslyStaff were to be chect 15-30 minutesClient #1 was able to unattended but should when in his room.	ic documentation rvations of client #1. client #1 every 30 minutes all bed." aff #7 stated: yed with the agency for ne had been employed with king on client #1 every remain in his room I have had an open door				

- -She had never been educated on specific observation requirements for client #1.
- -Observations of client #1 were to be recorded in a log book but were not completed by all staff regularly and were not accurate.

Interview on 1/11/22 former staff #5 (FS #5) stated:

- -She resigned from the agency in December of 2021.
- -Management "never pushed" how often client #1 was to be observed.
- -Observations were to be recorded in a log book.

Division of Health Service Regulation

STATE FORM

PRINTED: 03/02/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE S	URVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	75 January 11 10 10 10 10 10 10 10 10 10 10 10 10		COMPLE	
		MHL071-027	B. WING		03/0	1/2022
				5 7ID CODE		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STAT			
RAINBOW	FARMS		ND CREEK ROAD POINT, NC 28457			
					ON	(1/5)
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 112	Continued From page	e 16	V 112			
	-There were no speci	ific observation requirements				
	for client #1.					
		with client #1 when he was				
		ff would "just place him in his				
	"having a bad day."	im" when he was upset or				
	Tiaving a bad day.					
	Interview on 1/18/22	the local managment entity				
		e organization (MCO) Care				
Coordinator stated:						
		have been using 15-minute				
		n client #1 and recording				
	observations approp	riately. ve been under line of sight				
	The state of the s	wake hours due to the				
		elf-injurious behaviors.				
	Interview on 1/11/22	the behavior analyst stated:				
		receiving services since				
	2014.					
		eviously used 15-minute				
	February 2021.	stopped recording those in				
		ed to their own observation				
	The state of the s	itor behaviors on an hourly				
	basis.	have been checking and				
		I have been checking and ient #1 every 15 minutes				
		restraint, including the "small				
	bed" restraint.	3				
	The state of the s	the Qualified Professional				
	(QP)/ Executive Dire					
1		l:1 supervision and should e of sight when he was				
	awake.	e or signit when he was				
	6777 (1901) (1901) (1901) (1901) (1901) (1901) (1901) (1901) (1901) (1901) (1901) (1901) (1901) (1901) (1901)	eviously employed 15 minute				
		#1 was using his small bed.				

Division of Health Service Regulation

15-minute checks.

However, staff stopped documenting the

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION ::		(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03/	01/2022	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE	1 03/1	01/2022	
RAINBOV	V EADMS		ND CREEK RO				
RAINBOV	V PARINS	ROCKY F	OINT, NC 284	157			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 112	-Observation of client had not been docume -Staff were required to ensure he was not we "small bed." -Staff were to be check minutes during sleep 1-She was responsible completed client docu. This deficiency is cross NCAC 27G .0203 Corprofessionals and Assa (V109) for a Type A1 recorrected within 23 data 27G .0207 Emergency 10A NCAC 27G .0207 AND SUPPLIES (a) A written fire plan for area-wide disaster plashall be approved by the authority. (b) The plan shall be mand evacuation proceed in the facility. (c) Fire and disaster dishall be held at least of repeated for each shift under conditions that see the staff of the staff of the shift under conditions that see the staff of the staff	#1 in 15-minute increments ented. O check on client #1 to et when he was using the eking on client #1 every 30 hours. for ensuring staff mentation. It is referenced into 10 A inpetencies of Qualified excitate Professionals rule violation and must be eys. If Plans and Supplies EMERGENCY PLANS Or each facility and in shall be developed and the appropriate local enade available to all staff dures and routes shall be rills in a 24-hour facility	V 112				
	This Rule is not met a Based on record review						

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL071-027	B. WING	03/01/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RAINBOW FARMS

200 ISLAND CREEK ROAD ROCKY POINT, NC 28457

RAINBOW	AINBOW FARMS ROCKY		CKY 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE			
	regularly when the facility had employed Team Leads. Interview on 2/4/22 staff #3 stated: -She had been employed with the agency for over a yearShe worked all shiftsFire and disaster drills were completed "periodically," but she had not participated in any fire or disaster drills. Interviews on 1/4/22, 1/12/22 and 2/4/22 staff #4 stated: -She had been employed with the agency since November of 2021.						

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		_ETED
		MHL071-027	B. WING		03/0	01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE		
RAINBOV	FARMS	200 ISLAN	D CREEK RO	AD		
		ROCKY PO	DINT, NC 284	57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 114	Continued From page	19	V 114			
	-Fire and disaster drill	s were to be completed not personally participated				
	Interview on 2/7/22 star-She had been employ August of 2021She had not participal drills.					
	approximately 1 yearShe primarily worked	yed with the agency for the overnight shifts. ted in fire or disaster drills				
	Interview on 2/4/22 star-She had been employ September of 2020Fire and disaster drills monthly, but she could participating in any fire since "it got cold."	yed with the agency since s were to be completed I not remember				
	Interview on 1/11/22 for stated: -She was hired in Febriary from the agency in Der-She had not participate disaster drills.	ruary of 2020 and resigned cember of 2021.				
	Interview on 1/14/22 at Director stated: -Agency would address drills.	nd 2/8/22 the Program s the fire drills and disaster				
V 118	27G .0209 (C) Medicat	tion Requirements	V 118			

Division of Health Service Regulation

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL071-027	B. WING		03/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 118	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 to pharmacist or other I privileged to prepare (4) A Medication Adm all drugs administered current. Medications recorded immediatel MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for a (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recorded.	istration: in-prescription drugs shall to a client on the written thorized by law to prescribe be self-administered by thorized in writing by the uding injections, shall be licensed persons, or by trained by a registered nurse, tegally qualified person and and administer medications. Ininistration Record (MAR) of the dot each client must be kept administered shall be by after administration. The te following: and quantity of the drug; the drug is administering the to medication changes or orded and kept with the MAR topointment or consultation	V 118		
		riews and interviews, the inister medications as			

-		OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
-			MHL071-027	B. WING		0:	3/01/2022	
THE RESERVE AND ADDRESS OF THE PERSON NAMED IN COLUMN 2 IS NOT THE	NAME OF P	ROVIDER OR SUPPLIER	200 ISLA	DDRESS, CITY, STAND CREEK ROAPOINT, NC 2845	.D			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
		ordered by a physiciar competency with medi MARs current affecting The findings are: Finding #1 Review on 1/5/22 and revealed: -31 year-old male -Admission date of 6/1 -Diagnoses of autism sintellectual disability-se Review on 1/5/22 of clirevealed: 9/18/20 -Clotrimazole 1% Crea and surrounding areas for itching. 3/25/21 -Clonazepam 1 milligra at noon and 1 tab ever Review on 1/5/22 of cli October 1, 2021 - Janu-There were no staff ini Clotrimazole 1% Crean at 7pmThere were no staff ini Clotrimazole 1% Crean at 7pmThere were no staff ini Clonazepam 1mg was and 10/8/21 at 12pm. Finding #2: Review on 1/5/22 and revealed: -56 year-old male -Admission date of 9/1/	n, failed to demonstrate ications, and failed to keep g 3 of 3 clients (#1,#2,#3). 1/6/22 of client #1's record 0/09 spectrum disorder and evere ient #1's physician's orders m, Apply to affected area twice daily and as needed am (mg), Take 1 tablet (tab) y evening. ent #1's MARs from lary 5, 2022 revealed: itials to indicate in was applied on 11/9/21 itials to indicate administered on 10/6/21 1/6/22 of client #2's record 11 lisorder, impulse control,	V 118				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY	
	F CORRECTION	IDENTIFICATION NUMBER:			COMPLE	TED
		MHL071-027	B. WING		03/01	1/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STAT	E, ZIP CODE		
		200 ISLAN	D CREEK ROA	D		
RAINBOW	FARMS	ROCKY PO	DINT, NC 28457	7		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	e 22	V 118			
		client #2's physician's orders				
	revealed: FL2- 2/16/21:					
	-Diazepam 10mg, Ta	ke 1 tab twice daily.				
		Delayed Release (DR)				
	500mg, Take 1 tab to	wice daily. Take 1 tab every evening.				
	- Topiramate 200mg,	Take I tab every everning.				
	Review on 1/5/22 of client #2's MARs from					
		nuary 5, 2022 revealed: initials to indicate Diazepam				
		odium DR 500mg, and				
		were administered on				
	10/17/21 at 7pm.					
	Finding #3					
		d 1/6/22 of client #3's record				
	revealed:					
	-21 year-old male -Admission date of 8	3/4/17				
	-Diagnoses of autisti	c disorder, impulse control,				
	intellectual disability	-moderate, and non-verbal				
	Review on 1/5/22 of revealed:	client #3's physician's orders				
		ng, Take 1 capsule (cap)				
	every evening.	aliand and 17 table 2 times				
	-Clonidine 0.1mg, 1a daily.	ake 1 and ½ tabs 3 times				
	Review on 1/5/22 of	client #3's MARs from				
		anuary 5, 2022 revealed:				
	-There were no staff	finitials to indicate				
		g was administered on				
	12/4/21 at 7pmThere were no staff	finitials to indicate Clonidine				
		ered on 10/17/21 and				
	12/23/21 at 12pm.					

Due to verbal and cognitive limitations, interviews

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	E CONSTRUCTION		E SURVEY IPLETED	
		MHL071-027	B. WING		03	3/01/2022
NAME OF F	PROVIDER OR SUPPLIER	200 ISLAN	DRESS, CITY, ST ID CREEK RO OINT, NC 284	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETE DATE
V 118	with clients #1, #2, an were unsuccessful in regimen. Interviews on 1/6/22, stated: -She had been employ approximately 1 yearShe did not pass medication cups and slater timeShe had found loose bedShe had found medic medications in the trast-There was an incident earlier (interview date medications for the up as given in all 3 client's for the next shift identified the missing medication management of the medications for the medication for the medication management of the medication management of the medication shift approximately 2 with the missing medication management of the medication management of the medication medication medication medication medication, the were unaccounted for it packs for all 3 clients. Sof the medication discrete.	d #3 on 1/5/22 and 1/6/22 determining medication 1/10/22 and 2/7/22 staff #2 //ed with the agency for lications. edications pre-filled in stored for clients to take at a medications in client #1's ation cups with unused sh. t approximately 2 weeks of 2/7/22) where evening coming shift were signed s MARs. The incoming staff fied the discrepancy with as and notified edication discrepancy. off #6 stated: red with the agency since medications missing on a reeks earlier (2/7/22). As dications for the clients, coming evening medications a given in all 3 client's evening shift medications on the medication blister She notified management epancy. 2 as "moving a lot slower" n.	V 118			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
AND FLANC	O CONNECTION	JEHI IOANOH HOMBER	A. BUILDING:			
		MHL071-027	B. WING		03/0	1/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
RAINBOW	FARMS		D CREEK ROAL			
	CLIMMADV CT		DINT, NC 28457	PROVIDER'S PLAN OF CORRECTION	N I	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETE DATE
V 118	Continued From page	e 24	V 118			
	-She had been emploapproximately 1 year -She had witnessed redication cups and at later time. This had over the last 2 monthThere had been a moderate had been a moderate had been a moderate had been at 1/23/22. During the the morning of 1/23/22 for 1/23/22 were adm. The MARs had been 1/22/22 and 1/23/22 initialed indicating at QP/ED. On the aftern noticed the discrepar management. When counted, the staff not packs for the evening missing for the 1/23/2-she had passed also Program Director. Interview on 1/11/22 stated: -She resigned from a she had witnessed agency staff filling in and not completing to medications. Interview on 2/4/22 she had worked wit 2020She had witnessed including medication and MARs filled out she had witnessed including medication and MARs filled out she had witnessed including medication and MARs filled out she had witnessed	medications pre-filled in stored for the clients to take doccurred on two occasions s. edication error on 1/22/22 or me evening of 1/22/22 and 22, the evening medications ministered for all 3 clients. completed for the shifts on and then crossed out and ranscription error by the moon shift of 1/23/22, staff may and notified the medications were ticed the medication blister go shift of 1/23/22 had pills 22 evening dose. In the moon shift of 1/23/22 had pills 22 evening dose.				

Interview on 2/8/22 the Qualified Professional

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
MHL071-027		B. WING		03/01/2022		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST			
RAINBOV	/ FARMS		DINT, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	(QP)/ Executive Directorshe had made a transand signed in the wrote correction. -She had not made arregards to administerior 1/23/22If medications were not have been due to staff part of another staff. Scomplete an investigation such events had occurshe was unaware of from the medication between timeShe was unaware of errors. Due to the failure to accomedication administration.	tor (ED) stated: scription error on 1/23/22 Ing box but had initialed the Iny additional errors with Ing medications on 1/22/22 Inissing on 1/23/22 it may If theft or an error on the Ishe had not had a chance to Ition to determine if any Irred. Imedications being removed Initiation it for a later administering Item and additional medication Intercurately document Ition it could not be Intercurated in the could not be intercur	V 118			
V 290	of this Rule shall be de enable staff to respond needs. (b) A minimum of one present at all times who premises, except when habilitation plan docun capable of remaining in without supervision. T	STAFF above the minimum Paragraphs (b), (c) and (d) etermined by the facility to d to individualized client staff member shall be en any adult client is on the in the client's treatment or	V 290			

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMITEE	120	
		MHL071-027	B. WING		03/01/2022	
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	re, ZIP CODE		
DAINDOM	FADAGE	200 ISLANI	CREEK ROA	D		
RAINBOW	FARING.	ROCKY PO	INT, NC 2845	7		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 290	the home or communispecified periods of ti (c) Staff shall be prefollowing client-staff richild or adolescent of (1) children or abuse disorders shall of one staff present for clients present. How present during sleep emergency back-up the governing body; (2) children or developmental disabone staff present for present and two staff more clients present meed be present during specified by the emedetermined by the go (d) In facilities which diagnosis is substant (1) at least one duty shall be trained withdrawal symptom secondary complicated drug addiction; and (2) the services	be capable of remaining in a bity without supervision for time. 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 every five or fewer minor every, only one staff need be ing hours if specified by the procedures determined by or adolescents with illities shall be served with every one to three clients of present for every four or thousand the fing sleeping hours if the gency back-up procedures everning body. In serve clients whose primary to eabuse dependency: The staff member who is on the in alcohol and other drug as and symptoms of the staff of a certified substance all be available on an	V 290			
	This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, the facility failed to ensure staff-client ratios above the minimum number to enable staff					

Division of Health Service Regulation

to respond to individualized client needs affecting

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
MHL071-027			03/01/2022	
STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
200 ISLAND	CREEK RO	AD		
ROCKY PO	INT, NC 2845	57		
PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
	V 290			
finalinan aug				
findings are:				
NOW TO BEST I need close 1:1 ed 24-hour awake ety concerns I least every 15 ke cycles, safety, in extreme I life threatening NOW TO BEST I need 1:1 supports if I NOW TO BEST ioral: my severe essened over rices with 2:1 entinuesI need safety hazards m (walking in mats, using ide detectors/fire ing safety danger isons, locking				
	STREET ADD	STREET ADDRESS, CITY, ST. 200 ISLAND CREEK RO. ROCKY POINT, NC 2849 F DEFICIENCIES PRECEDED BY FULL PYING INFORMATION) f client #1's record f client #1's record f client #1's ated 6/1/21 NOW TO BEST I need close 1:1 red 24-hour awake rety concerns t least every 15 ricke cycles, safety, rin extreme d life threatening NOW TO BEST x: I need 1:1 supports if I NOW TO BEST ricral: my severe ressened over rices with 2:1 rottinuesI need safety hazards rim (walking in ro mats, using ride detectors/fire ring safety danger risons, locking th ambulating and	STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 F DEFICIENCIES PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) (EACH CORRECTIVE ACTION SHOULD) F Client #1's record I disorder and I disorder and I disorder and I disorder and I reed close 1:1 I need	

Division of Health Service Regulation

need prompting to get up and go somewhere,

PRINTED: 03/02/2022 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 03/01/2022 MHL071-027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 ISLAND CREEK ROAD RAINBOW FARMS **ROCKY POINT, NC 28457** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) V 290 V 290 Continued From page 28 and just need monitoring for safety ... I 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 12/2/21 revealed: -"Reason for Referral...[Client #1] was referred for behavior consultative services due to the high frequency and intensity of his problem behaviors, as well as the restrictive nature of the current interventions (from ASAP) (Autism Support and Programs, Inc). These problem behaviors and restrictions impair his ability to integrate into the community and function safely across environments and to reach his ISP goals." -"Interventions and rationales...Data for the past year (Oct 2020 - Sept 2021) show slightly elevated levels for both SIB and aggression, thereby indicating regression from baseline." Observation on 1/5/22 of client #1's bedroom at approximately 11:45am revealed: -Staff #1 was providing 1:1 services with client #1. -While staff #1 was in the kitchen, client #1 was observed alone in his bedroom with the bedroom

Division of Health Service Regulation

light off.

wrists and ankles.

unresponsive to dialogue.

-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

-The "small bed" was positioned adjacent to a second bed which was identified by staff as the "big bed" which client #1 used for sleeping.
-Client #1 did not appear in distress and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:					
		MHL071-027	B. WING		03	3/01/2022		
	OF PROVIDER OR SUPPLIER	200 ISLA	AND CREEK ROAD POINT, NC 28457					
	FIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
	revealed: -56 year-old male -Admission date of 9Diagnoses of autistic and intellectual disable Review on 1/5/22 and dated 2/1/21 revealed -"WHAT OTHERS NE SUPPORT MELife hour supervisionI in choices when at home well as support to every the event of a fire." Finding #3 Review on 1/5/22 and revealed -21 year-old male -Admission date of 8/-Diagnoses of autistic intellectual disability-intellectual disab	d 1/6/22 of client #2's record /1/11 c disorder, impulse control, illity-moderate d 1/6/22 of client #2's ISP d: EED TO KNOW TO BEST Situation- I do require 24 eed support to make safe e and in the community as acuate my home or area in d 1/6/22 of client #3's record //// / disorder, impulse control, moderate, and non-verbal d 1/6/22 of client #3's ISP d: hings - Having enough staff vision to ensure his health logs is important." orts - Where I choose to y active and needs a good le cannot be left alone at	V 290					

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED		
		MHL071-027	B. WING		03/	01/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STAT	E, ZIP CODE			
DAINDO	FADME	200 ISLAN	D CREEK ROAD)			
RAINBOW	FARMS	ROCKY PO	DINT, NC 28457				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 290	PROVIDER OR SUPPLIER PROVIDER OR SUPPLIER 200 ISLAND ROCKY POIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 290				
	January 3, 2022She had previously	worked with the agency for					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		to anyther wastern	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
	construction of the second	MHL071-027	B. WING		03/01/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
RAINBOV	V FARMS		ND CREEK ROA		
	7	ROCKY P	OINT, NC 2845	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 290	approximately 3 years -She was working 1:1 -The afternoon of 1/5/ she had used the "sn client #1 since her ren Interviews on 1/6/22, stated: -She had been emplo approximately 1 yearShe primarily worked -She had witnessed of bed" intervention on to during the overnight s -She had worked alon -The Qualified Profess Director (ED) and mal individuals allowed to shiftsShe did not believe a have been able to get in the event of a fireClient #3 was especia he was asleep. Interview on 2/4/22 sta -She had been employ approximately 1 yearShe primarily worked -She had witnessed of bed" intervention on to during the overnight sl -She had worked alon -The QP/ED and male individuals she was av alone on overnight shi -She did not believe as safely exit all 3 clients event of a fire.	with client #1 on 1/5/22. 22 was the first afternoon hall bed " intervention with hire. 1/10/22, and 2/7/22 staff #2 yed with the agency for overnight shifts. lient #1 using the "small wo separate occasions hift. e on one overnight shift. sional (QP)/ Executive e staff were the only work alone on overnight nyone working alone would all 3 clients out of the home ally difficult to arouse once aff #8 stated: yed with the agency for overnight shifts. ient #1 using the "small wo separate occasions hift. e on one overnight shift. staff were the only other ware of who had worked fts. hy staff working alone could	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMI	PLETED	
		MHL071-027	B. WING		03	/01/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
RAINBOV	N FARMS		ND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 290	proven especially difficient #2's balance is waking up. Interview on 2/4/22 s -She had been emplo September of 2020Only the QP/ED, may were allowed to work Interview on 1/11/22 stated: -She resigned from a -The QP/ED and male overnight shiftsShe would not have 3 clients in exiting the while she was working -Escaping a fire quick difficult due to the difficult one of the only ones that he aloneThe Board of Direct recommended having overnight shifts, but requirementAll of the overnight stincluded multiple stated. This deficiency is crown NCAC 27G .0203 Compressionals and Assertices.	taff #9 stated: byed with the agency since alle staff, and "seasoned staff" alone on overnight shifts. If alone on December of 2021. It is staff had worked alone on been able to safely assist all the home had a fire started and alone. If would have proven very ficulty of waking client #3 with client #2. and 2/8/22 the QP/ED If ormer male staff had been and 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 off. obs referenced into 10 A competencies of Qualified associate Professionals If rule violation and must be	V 290			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
MHL071-027		B. WING		03	03/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE		
RAINBOV	V FARMS		D CREEK RO DINT, NC 284			
	CUMMADVOTA		T			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE	(X5) COMPLETE DATE
V 291	Continued From page	33	V 291			
V 291	27G .5603 Supervised	Living - Operations	V 291			
	six clients when the cl developmental disabili on June 15, 2001, and than six clients at that provide services at no licensed capacity. (b) Service Coordinat maintained between the qualified professionals treatment/habilitation of (c) Participation of the Responsible Person. provided the opportunit relationship with her or means as visits to the the facility. Reports shannually to the parent legally responsible per Reports may be in writt conference and shall for progress toward meetif (d) Program Activities activity opportunities beneeds and the treatme Activities shall be designed.	y shall serve no more than ients have mental illness or tites. Any facility licensed if providing services to more time, may continue to more than the facility's ion. Coordination shall be ne facility operator and the who are responsible for or case management. Family or Legally Each client shall be the total the maintain an ongoing or his family through such facility and visits outside neall be submitted at least of a minor resident, or the son of an adult resident. In ing or take the form of a cocus on the client's no individual goals. Each client shall have ased on her/his choices, nt/habilitation plan. In great to foster community by be limited when the court wed or when health or				

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU			MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		JOWN EL		
		MHL071-027	B. WING		03/01/2022		
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE			
RAINBOW	FARMS		CREEK ROAL				
RAINBOW	PARINIS	ROCKY PO	INT, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
V 291	3 clients (#2 and #3). Finding #1: Review on 1/5/22 and revealed: -56 year-old male -Admission date of 9 -Diagnoses of autistic and intellectual disable. No documentation of podiatrist following 8. Review on 1/5/22 and Individual Support Plandividual Support	ient's treatment affecting 2 of The findings are: d 1/6/22 of client #2's record /1/11 c disorder, impulse control, bility-moderate of follow-up visit with /30/21 appointment. d 1/6/22 of client #2's lan dated 2/1/21 revealed: - I have a hard time ails and I see a podiatrist to med and manageable" to promote skin integrity - ance with lotion, toenail	V 291				
	revealed: -21 year-old male						

-Admission date of 8/4/17

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03/01/2	2022
	PROVIDER OR SUPPLIER	200 ISLA	DDRESS, CITY, S' ND CREEK RO POINT, NC 284	DAD	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
V 291	-Diagnoses of autistic intellectual disability-n-Last documented der evaluation of previous on 1/22/20. Review on 1/5/22 and Risk/Support Needs A (start date) revealed: -"Physician SupportsApproximate Date of -"Supports for Comm Requires full assistance communicate most or -"Supports Needed to Daily Living Requires appointments(market appointment) Interviews on 1/5/22 and for client #3 dated 1/14-Client #3 was "Due for following dates: 1/14/25/28/21, 7/23/21, 8/27/11/19/21. Interviews on 1/14/22, Program Director reveal-Client #3 had a dental December, 2021 which-He had been working appointment following appointments	disorder, impulse control, noderate, and non-verbal ntal visit was for an wisdom tooth extractions 1/6/22 of client #3 's sesessment dated 7/1/21 Dentist - twice yearly f Last Visit - 1/2021." nunicating Needs - tee from familiar persons to all essential needs" o Complete Activities of s Support for making ed yes)." 1/6/22 of physician's note 1/21 - 11/19/21 revealed: r dental visit " on the 1, 1/30/21, 3/25/21, 1/21, 10/14/21, and 1/19/22, and 2/8/22 the aled: appointment scheduled in a had been canceled. on scheduling another the cancellation.	V 291			
V 366	27G .0603 Incident Res 10A NCAC 27G .0603 RESPONSE REQUIRE CATEGORY A AND B F	INCIDENT EMENTS FOR	V 366			

Division of Health Service Regulation

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:		(X3) DATE SU COMPLE	
		MHL071-027	B. WING		03/01	1/2022
NAME OF PRO	VIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
RAINBOW F	ARMS		D CREEK ROAI DINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
	mplement written policies providers, excluding to Subparagraph (a) of this shall address incider regulations in 42 CFI (c) In addition to the Paragraph (a) of this providers, excluding develop and implements in the policies shall recibility: (1) mediate the provider is or while the provider is policies shall recibility: (2) determining to developing the developing to prevent similar incomplementation of preventive measures (b) assigning provider measures (c) adhering to set forth in G.S. 75, A42 CFR Parts 2 and 164; and (c) maintaining Subparagraphs (a) (1) (b) In addition to the Paragraph (a) of this shall address incider regulations in 42 CFI (c) In addition to the Paragraph (a) of this providers, excluding develop and implementation in the provider is or while the client is The policies shall recibility: (1) immediate by: (1) immediate by:	s providers shall develop and icies governing their or III incidents. The policies ider to respond by: the health and safety needs in the incident; the cause of the incident; and implementing corrective to provider specified seed 45 days; and implementing measures idents according to provider not to exceed 45 days; the corrections and implementing measures idents according to provider not to exceed 45 days; the confidentiality requirements article 2A, 10A NCAC 26B, 3 and 45 CFR Parts 160 and and 45 CFR Parts 160 and 45 CFR Parts	V 366			

Division of Health Service Regulation			lation				
		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY MPLETED
			MHL071-027	B. WING		0	3/01/2022
	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST.	ATE ZIP CODE		
				ND CREEK RO			
	RAINBOW	FARMS		POINT, NC 284			
-	/V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES			CORRECTION	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	V 366	Continued From page	37	V 366			
		(C) certifying the (D) transferring to review team; (2) convening a review team within 24 internal review team swho were not involved were not responsible to with direct professional services at the time of review team shall comfollows: (A) review the condetermine the facts and make recommend occurrence of future in (B) gather other (C) issue writter within five working day preliminary findings of LME in whose catchmolocated and to the LMB if different; and (D) issue a final wowner within three modinal report shall be secatchment area the procurrence of the courrence of the course of the cour	meeting of an internal hours of the incident. The hall consist of individuals in the incident and who for the client's direct care or al oversight of the client's the incident. The internal inplete all of the activities as opy of the client record to ad causes of the incident dations for minimizing the incidents; information needed; in preliminary findings of fact as of the incident. The fact shall be sent to the ent area the provider is where the client resides, written report signed by the into the LME in whose ovider is located and to the resides, if different. The all address the issues all review team, shall ments pertinent to the the recommendations for ince of future incidents. If for the report are not months of the incident, the yider an extension of up to				
			notifying the following:				
	J.	(A) the I MF resp.	onsible for the catchment	1			1

Division of Health Service Regulation

Division o	Division of Health Service Regulation								
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SU				
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	IED			
		MHL071-027	B. WING		03/0	1/2022			
		CTREET AR	DRESS, CITY, STAT	E ZIR CODE					
NAME OF PE	ROVIDER OR SUPPLIER								
RAINBOW	FARMS		ND CREEK ROAL						
			OINT, NC 28457		.,				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE			
PREFIX TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE			
				DEFICIENCY)					
V 366	Continued From page	- 38	V 366						
1 000									
		ces are provided pursuant to							
	Rule .0604;	have the elient resides of							
	` '	here the client resides, if							
	different; (C) the provide	er agency with responsibility							
	for maintaining and u								
		erent from the reporting							
	provider;								
	(D) the Department;								
	(E) the client's legal guardian, as								
	applicable; and								
	(F) any other a	authorities required by law.							
	This Rule is not met	as evidenced by:							
		iew and interview, the facility							
		neir response to level II							
	incidents. The finding	gs are:							
	D : 4/5/00 of	Insident December							
	Review on 1/5/22 of	n (IRIS) from January 1,							
	2021 - January 6, 20	22 revealed no documented							
	incident reports for o								
	moldent reports for a								
	Review on 1/5/22 an	nd 1/6/22 of client #1's record							
	revealed:								
	-31 year-old male								
	-Admission date of 6								
		n spectrum disorder and							
	intellectual disability								
		of any restrictive interventions							
		ween the dates of 1/1/21 -							
1	1/5/22		1						

Review on 1/5/22 and 1/6/22 of client #1's Partial

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL071-027	B. WING	44	03/	01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
RAINBOV	/ FARMS	200 ISLANI	CREEK RO	AD		
		ROCKY PO	INT, NC 284	57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 366	Continued From page	39	V 366			
	Interval Recording Sh revealed: -Observation periods one-hour blocks from block which captured -Individual blocks were observable behaviors marks. Behavior-1 wa and behavior-2 was id Behavior (SIB)." -Staff initials were mis hoursStaff initials were mis captured observation is captured observation is 7am (9/28/21 and 11 Interviews on 1/5/22 a -She had been rehired January 3, 2022She had previously wapproximately 3 years -The afternoon of 1/5/2 she had used the "sm client #1 since her rehired -The Program Director the "small bed" straps the straps were secure his safety throughout to Interviews on 1/6/22, 1 stated: -She had worked with approximately 1 yearClient behaviors were in a log bookThe data recorded in accurate, as staff failed.	were listed in 16 daily 8am - 11pm, and one single the hours of 11pm - 7am. e separated into two and recorded using tick s identified as "Aggression" entified as "Self-Injurious sing for 192 individual block sing for 2 blocks which between the hours of 11pm /26/21). Ind 2/4/22 staff #1 stated: I with the agency for . 22 was the first afternoon all bed " intervention with ire. I had shown her how to use with client #1 by ensuring ad properly and maintaining the process. /10/22, and 2/7/22 staff #2 the agency for supposed to be recorded the log book was not	V 366			
	approximately 1 yearClient behaviors were in a log bookThe data recorded in accurate, as staff failed regular basis.	supposed to be recorded the log book was not d to record data on a				

Division of Health Service Regulation

STATE FORM

Division of Health Service Regulation						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03/01/2022	
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	E, ZIP CODE		
RAINBOW	EADMS	200 ISLAN	D CREEK ROAL			
RAINBOW	PARINIS	ROCKY P	OINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 366	Continued From page -She estimated that of "small bed" interventitimes per month" ove Interviews on 1/5/22, -She had been emplorated approximately 1 year -Client behaviors were white notebookClient #1 used the "sas little as 30 minutesShe estimated client intervention up to 2-3. December of 2021. Interviews on 1/5/22, stated: -She had been emplorated with the state of the	elient #1 may have used the on an average of "15-30 or the "last few months." and 1/11/22 staff #3 stated: byed with the agency for and as long as 1 hour. If #1 had used the "small bed" it it it is it is it is in December of 2021 and it is in December of 2021. It #1 had used the "small bed" intervention for es and as long as "1-2 it is in December of 2021 and i	V 366	DEFICIENCY)		
	as little as "15-20 mi	nutes" at a minimum.				

Interview on 2/4/22 staff #8 stated:

PRINTED: 03/02/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING MHL071-027 03/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD **RAINBOW FARMS ROCKY POINT, NC 28457** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 366 Continued From page 41 V 366 -She had been employed with the agency for approximately 1 year. -She had witnessed client #1 using the "small bed" intervention on two separate occasions during the overnight shift. -The data recorded in the log book was not accurate, as staff failed to record data on a regular basis. Interview on 2/4/22 staff #9 stated: -She had been employed with the agency since September of 2020. -Documentation requirements for client #1's behaviors were recorded in a black and white log -Client #1 used the "small bed" intervention for as little as "25-30 minutes" and as long as "all day." -She estimated client #1 had used the "small bed" intervention 2-3 times in December of 2021. Interview on 1/12/22 former staff (FS #5) stated: -Her employment with the agency ended in December 2021. -Behaviors were documented in a logbook but not documented consistently by staff. -Client #1 used the "small bed" intervention for as little as "15-20 minutes" and as much as "maybe 8 hours." -She estimated client #1 had used the "small bed" intervention approximately 10 times for the last full month she worked (October).

Division of Health Service Regulation

During interviews on 1/5/22, 1/6/22, 1/10/22, and

-The facility had witnessed positive results with the implementation of the "small bed" intervention and would continue to use the method as a primary form of therapeutic intervention moving

1/19/22 the Qualified Professional (QP)/

Executive Director (ED) stated:

Division o	Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE S		
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		MHL071-027	B. WING		03/0	1/2022	
NAME OF B	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E. ZIP CODE			
NAME OF P	NOVIDER OR SUPPLIER		ND CREEK ROAL				
RAINBOW	FARMS		OINT, NC 28457				
OUR MARRY OTATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE	
				DEFICIENCY)			
V 366	Continued From page	e 42	V 366				
	forward						
	forward.	e "small bed" intervention					
		his mood. There were times					
		ented daily and other times					
		ented once a week, or less.					
		level II incident response					
		to the established behavior					
	plan with the interver	ntion listed.					
	-She was responsible	e for completing all level II					
	incident reports.						
		ss referenced into 10A					
		ompetencies of Qualified ssociate Professionals					
		rule violation and must be					
	corrected within 23 d						
1	001100100 11111111111111111111111111111	,					
V 367	27G .0604 Incident F	Reporting Requirements	V 367				
		, ,					
	10A NCAC 27G .060	4 INCIDENT					
	REPORTING REQU	IREMENTS FOR					
	CATEGORY A AND						
		B providers shall report all					
		cept deaths, that occur during					
		ole services or while the					
		providers premises or level III					
		deaths involving the clients					
	90 days prior to the i	r rendered any service within					
		atchment area where					
	services are provide						
		he incident. The report shall					
	be submitted on a fo						
		ort may be submitted via mail,					
		or encrypted electronic					

(1)

information:

identification information;

means. The report shall include the following

reporting provider contact and

PRINTED: 03/02/2022 FORM APPROVED

Division of Health Service Regulation

MML071-027 MAME OF PROVIDER OR SUPPLIER RAINBOW FARMS 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 201 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (PA) ID PROVIDERS PLAN OF CORRECTION (EACH DEPOISENCES) (EACH DEPOISENCY MUST SE PRECEDED BY FULL RESULATION OR LOSS REFERENCE TO THE APPROPRIATE DEPOISE OF THE PROVIDER SHALL OF CORRECTIVE ACTION SHOULD BE COMMETTE AND CREEK ROAD (CROSS-REFERENCE) TO THE APPROPRIATE DEPOISE OF THE PROVIDER SHALL SHAL		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A CONTRACTOR OF THE PARTY OF TH	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AMALE OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (A4) ID PREFEX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 43 (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident, and (6) other individuals or authorities notified or responding, (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider of the incident, upon required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) nospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall submit information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of							
RAINBOW FARMS SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 43 (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident, and information provided in the report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider shall submit an updated report that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including; (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B providers shall capping of the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (d) Category A and B provider's response to the incident. (e) Category A and B provider's response to the incident. (e) Category A and B provider's response to the incident. (e) Category A and B provider's response to the incident. (e) Category A			MHL071-027	B. WING		03/	01/2022
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION FRESULATORY OR LSC IDENTIFYING INFORMATION) V 367 V 367 Continued From page 43 (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including; (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall acopy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of	NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE		
(Y4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 43 (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including; (1) hospital records including confidential information. (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of	RAINBOV	V FARMS	200 ISLAN	D CREEK RO	AD		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 43 (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident, and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including; (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of	TOAINDOV	VIARMO	ROCKY PO	DINT, NC 284	57		
(2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level Ill incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of	PREFIX	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
(3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of	V 367	Continued From page	43	V 367			
becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C		(2) client identife (3) type of incide (4) description of (5) status of the cause of the incident; (6) other individe or responding. (b) Category A and B missing or incomplete shall submit an update report recipients by the day whenever: (1) the provider information provided in erroneous, misleading (2) the provider required on the incider unavailable. (c) Category A and B upon request by the Lieutobtained regarding the (1) hospital recomposition; (2) reports by of (3) the provider's did Category A and B of all level III incident in Mental Health, Develo Substance Abuse Service Substance Abuse Service Regula becoming aware of the client death within severor restraint, the provider	ication information; lent; of incident; of effort to determine the and luals or authorities notified providers shall explain any information. The provider of report to all required of end of the next business has reason to believe that in the report may be of or otherwise unreliable; or obtains information int form that was previously providers shall submit, ME, other information of incident, including: ords including confidential ther authorities; and of response to the incident, providers shall send a copy reports to the Division of prepental Disabilities and vices within 72 hours of of incident. Category A copy of all level III lient death to the Division of of incident. In cases of of en days of use of seclusion of er shall report the death	V 367			

Division of Health Service Regulation

PRINTED: 03/02/2022

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 03/01/2022 MHL071-027 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 ISLAND CREEK ROAD **RAINBOW FARMS ROCKY POINT, NC 28457** PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 367 Continued From page 44 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: medication errors that do not meet the (1) definition of a level II or level III incident; restrictive interventions that do not meet (2)the definition of a level II or level III incident; searches of a client or his living area; (3)seizures of client property or property in (4)the possession of a client; the total number of level II and level III incidents that occurred; and a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to 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, 2021 - January 6, 2022

client #1.

revealed no documented incident reports for

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X6 COMPILE) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPILED.)	1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second second	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
ANAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (A4) ID PREPIX REQUALIDED THE PRECEDED BY FULL TAGY (A4) ID PREPIX REQUALIDED THE PRECEDED BY FULL TAGY (A5) ID PREPIX REQUALIDED THE PRECEDED BY FULL TAGY (A6) ID PREPIX REQUALIDED THE PRECEDED BY FULL TAGY (A7) ID PREPIX TAGY (A7) ID PREPIX TAGY (A7) ID PREPIX TAGY (A7) ID PROVIDERS PLAN OF CORRECTION BY COMMENTED THE PROPRIATE COMMENT TAGY (A7) ID PREPIX TAGY (A7) ID PROVIDERS PLAN OF CORRECTION OF CORRECTION OF COMMENT TAGY (A7) ID PREPIX TAGY (A7) ID PROVIDERS PLAN OF CORRECTION OF COMMENTED THE PROPRIATE (A7) ID PREPIX TAGY (A7) ID PROVIDERS PLAN OF CORRECTION OF COMMENT TAGY (A7) ID PREPIX TAGY (A7) ID PROVIDERS PLAN OF CORRECTION OF COMMENT TAGY (A7) ID PREPIX TAGY (A7) ID PROVIDERS PLAN OF CORRECTION OF COMMENT TAGY (A7) ID PREPIX TAGY (A7) ID PROVIDERS PLAN OF CORRECTION OF COMMENT TAGY (A7) ID PREPIX TAGY (A7) ID PROVIDERS PLAN OF CORRECTION OF COMMENT TAGY (A7) IN PROVIDER PLAN OF CORRECTION OF COMMENT TAGY (A7) IN PROVIDER PLAN OF CORRECTION OF COMMENT TAGY (A7) IN PROVIDER PLAN OF CORRECTION OF COMMENT TAGY (A7) IN PROVIDER PLAN OF COMMENT TAGY (A7) IN PROVIDER							
RAINBOW FARMS 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (A4) ID SUMMARY STATEMENT OF DEFICIENCIES BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CONTINUED From page 45 Review on 1/5/22 and 1/6/22 of client #1's record revealed: -31 year-old male -Admission date of 6/10/09 -Diagnoses of autism spectrum disorder and intellectual disability-severe -No documentation of any restrictive interventions being employed between the dates of 1/1/21 - 1/5/22 Review on 1/5/22 and 1/6/22 of client #1's Partial Interval Recording Sheet dated 9/13/21 - 1/2/22 revealed: -Observation periods were listed in 16 daily one-hour blocks from Sam - 11pm, and one single block which captured the hours of 11pm - 7amIndividual blocks were separated into two observable behaviors and recorded using tick marks. Behavior-1 was identified as "Self-Injurious Behavior (SIB)." -Staff initials were missing for 192 individual block hoursStaff initials were missing for 2 blocks which captured observation between the hours of 11pm - 7am (9/28/21 and 11/28/21). Interviews on 1/5/22 and 2/4/22 staff #1 stated: -She had been rehired with the agency or approximately 3 yearsThe aftermoon of 1/5/22 was the first afternoon she had used the "small bed" intervention with client #1 since her rehire.			MHL071-027	B. WING		03/	01/2022
(A4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) V 367 Continued From page 45 Review on 1/5/22 and 1/6/22 of client #1's record revealed: -31 year-old male -Admission date of 6/10/09 -Diagnoses of austism spectrum disorder and intellectual disability-severe -No documentation of any restrictive interventions being employed between the dates of 1/1/21 - 1/5/22 Review on 1/5/22 and 1/6/22 of client #1's Partial Interval Recording Sheet dated 9/13/21 - 1/2/22 revealed: -Observation periods were listed in 16 daily one-hour blocks from 8am - 11pm, and one single block which captured the hours of 11pm - 7amIndividual blocks were separated into two observable behaviors and recorded using tick marks. Behavior-1 was identified as "Aggression" and behavior-2 was identified as "Self-Injurious Behavior (SIB)." -Staff initials were missing for 192 individual block hoursStaff initials were missing for 2 blocks which captured observation between the hours of 11pm - 7am (9/28/21 and 11/26/21). Interviews on 1/5/22 and 2/4/22 staff #1 stated: -She had been rehired with the agency as of January 3, 2022She had previously worked with the agency for approximately 3 years -The afternoon of 1/5/22 was the first afternoon she had used the "small bed "intervention with client #1 since her rehire."	NAME OF P	ROVIDER OR SUPPLIER					
SUMMARY STATEMENT OF DEFICIENCIES REPLACE RECEIVED AND THE PROCEDED BY FULL REGULATORY OR LSC.IDENTIFYING INFORMATION) V 387 Continued From page 45 Review on 1/5/22 and 1/6/22 of client #1's record revealed: -31 year-old male -Admission date of 6/10/09 -Diagnoses of autism spectrum disorder and intellectual disability-severe -No documentation of any restrictive interventions being employed between the dates of 1/1/21 - 1/5/22 Review on 1/5/22 and 1/6/22 of client #1's Partial Interval Recording Sheet dated 9/13/21 - 1/2/22 revealed: -Observation periods were listed in 16 daily one-hour blocks from 8am - 11pm, and one single block which captured the hours of 11pm - 7amIndividual blocks were separated into two observable behaviors and recorded using tick marks. Behavior-1 was identified as "Self-Injurious Behavior (SIB)." -Staff initials were missing for 12 individual block hoursStaff initials were missing for 2 blocks which captured observation between the hours of 11pm - 7am (9/28/21 and 11/26/21). Interviews on 1/5/22 and 2/4/22 staff #1 stated: -She had been rehired with the agency as of January 3, 2022She had previously worked with the agency for approximately 3 yearsThe afternoon of 1/5/22 was the first afternoon she had used the "small bed" intervention with client #1 since her rehire.	RAINBOW	/FARMS					
Review on 1/5/22 and 1/6/22 of client #1's record revealed: -31 year-old male -Admission date of 6/10/09 -Diagnoses of autism spectrum disorder and intellectual disability-severe -No documentation of any restrictive interventions being employed between the dates of 1/1/21 - 1/5/22 Review on 1/5/22 and 1/6/22 of client #1's Partial Interval Recording Sheet dated 9/13/21 - 1/2/22 revealed: -Observation periods were listed in 16 daily one-hour blocks from 8am - 11pm, and one single block which captured the hours of 11pm - 7amIndividual blocks were separated into two observable behaviors and recorded using tick marks. Behavior-1 was identified as "Aggression" and behavior-2 was identified as "Self-Injurious Behavior (SIB)." -Staff initials were missing for 192 individual block hoursStaff initials were missing for 2 blocks which captured observation between the hours of 11pm - 7am (9/28/21 and 11/26/21). Interviews on 1/5/22 and 2/4/22 staff #1 stated: -She had been rehired with the agency as of January 3, 2022She had previously worked with the agency for approximately 3 yearsThe afternoon of 1/5/22 was the first afternoon she had used the "small bed "intervention with client #1 since her rehire.	PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE		BE	(X5) COMPLETE DATE		
the "small bed" straps with client #1 by ensuring the straps were secured properly and maintaining his safety throughout the process.		Review on 1/5/22 and revealed: -31 year-old male -Admission date of 6/1 -Diagnoses of autism intellectual disability-s -No documentation of being employed between 1/5/22 Review on 1/5/22 and Interval Recording Sherevealed: -Observation periods wone-hour blocks from 8 block which captured the Individual blocks were observable behaviors amarks. Behavior-1 was and behavior-2 was identified behavior (SIB)." -Staff initials were missionared observation between 1/5/22 are She had been rehired January 3, 2022She had previously we approximately 3 yearsThe afternoon of 1/5/2 she had used the "small client #1 since her rehired." -The Program Director the "small bed" straps were secure the straps were secure.	1/6/22 of client #1's record 10/09 spectrum disorder and evere any restrictive interventions een the dates of 1/1/21 - 1/6/22 of client #1's Partial eet dated 9/13/21 - 1/2/22 were listed in 16 daily Bam - 11pm, and one single he hours of 11pm - 7am. Experimental eat of a sidentified as "Aggression" entified as "Self-Injurious sing for 192 individual block sing for 2 blocks which between the hours of 11pm (26/21). and 2/4/22 staff #1 stated: with the agency as of orked with the agency for all bed " intervention with re. had shown her how to use with client #1 by ensuring d properly and maintaining	V 367	DEFICIENCY)		

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE S	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LIED
			B 141110			
		MHL071-027	B. WING		03/0	1/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STAT	TE, ZIP CODE		
DAINDOM	EADMS		D CREEK ROAI			
RAINBOW	FARMS	ROCKY PO	OINT, NC 28457	7		
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 367	Continued From page	e 46	V 367			
	Interviews on 1/6/22,	1/10/22, and 2/7/22 staff #2				
	stated:					
	-She had worked with					
	approximately 1 year -Client behaviors were	re supposed to be recorded				
	in a log book.					
		n the log book was not				
		ed to record data on a				
	regular basis.					
-Client #1 used the "small bed" intervention for						
as little as "30 minutes to all day." -She estimated that client #1 may have used the						
"small bed" intervention an average of "15-30"						
		er the "last few months."				
		and 1/11/22 staff #3 stated:				
		oyed with the agency for				
	approximately 1 year	re recorded in a black and				
	white notebook.	TO TOO TOO IT A SIGON GIVE				
		small bed" intervention for				
		es and as long as 1 hour.				
	The state of the second	t #1 had used the "small bed"				
	intervention up to 2-	3 times per week in				
	December of 2021.					
	Interviews on 1/5/22 stated:	, 1/12/22 and 2/4/22 staff #4				
		loyed with the agency since				
	November of 2021.					
		ed after a 1 year absence.				
		uirements for client #1's				
	The state of the s	orded in a black and white log				
	book.	'small bed" intervention for				
		tes" and as long as "1-2				
	hours."	2.12 20 10.19 20 1 2				
		nt #1 had used the "small bed"				
		es in December of 2021 and				

Division of Health Service Regulation

2-3 times in November of 2021.

PRINTED: 03/02/2022 FORM APPROVED

Division of Health Service Regulation

	of froutiff oct vice racgu	ilation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3)) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·		COMPLETED
					1	
		MIN 074 007	B. WING			
		MHL071-027				03/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		200 ISLA	ND CREEK RO	AD		
RAINBOV	V FARMS		POINT, NC 284			
	0.000000		01141, 140 204			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF C		(X5)
TAG		SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETE DATE
	21-550 21-50 H (State C. F. Date Control Contr		1	DEFICIENCY		
14007	o .:					
V 367	Continued From page	47	V 367			
	Interview on 2/7/22 st	aff #6 stated:				
		yed with the agency since				
	August of 2021.	yed with the agency since				
		#1 had used the "small bed"				
		erage of 1 time per week in				
	December of 2021.	erage of 1 time per week in				
		mall bed" intervention for	1			
	as little as "15-20 mini					ļ
	as illie as 13-20 illilli	utes at a minimum.				
	Interview on 2/4/22 sta	off #9 stated:	-			
		yed with the agency for				
	approximately 1 year.	in at 4di.a. Ha - Harra H				
		ient #1 using the "small				
		vo separate occasions				
	during the overnight sl			1		
	-The data recorded in					
	accurate, as staff faile	d to record data on a				
	regular basis.					
	1.4.	er un				
	Interview on 2/4/22 sta					
		ed with the agency since				
	September of 2020.					
	-Documentation requir					
		ed in a black and white log				
	book.					
		mall bed" intervention for				
		ites" and as long as "all				
	day."					
		f1 had used the "small bed"				
	intervention 2-3 times i	in December of 2021.				
		ormer staff (FS #5) stated:				
	-Her employment with	the agency ended in				
	December 2021.					
	-Behaviors were docur	nented in a logbook but not				
	documented consisten	tly by staff.				
		nall bed" intervention for				
	as little as "15-20 minu	tes" and as much as				
	"maybe 8 hours."					

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR COMPLETE	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	
		MHL071-027	B. WING		03/01/2	2022
			DECC CITY CTAT	T. 710 CODE	,	
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STAT			
RAINBOW	FARMS		ID CREEK ROAI DINT, NC 28457			
	OLUMAN DV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	NO.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMIENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP	D BE	COMPLETE 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). During interviews on 1/5/22, 1/6/22, and 1/10/22 the Qualified Professional (QP)/ Executive					
					1	
	Director (ED) stated: -The facility had witnessed positive results with					
		of the "small bed" intervention				
		to use the method as a				
	1 0 0	apeutic intervention moving				
	forwardClient #1's use of the "small bed" intervention varied depending on his mood. There were times					
		ented daily and other times				
		ented once a week, or less.				
		evel II incident reporting was				
	The state of the s	he established behavior plan				
	with the intervention	e for completing all level II				
	incident reports.	e for completing an level in				
	morasin reports					
		oss referenced into 10A				
		ompetencies of Qualified				
		ssociate Professionals I rule violation and must be				
	corrected within 23 of					
	Corrected William 20 C	sayo.			1	
V 513	27E .0101 Client Rig	ahts - Least Restictive	V 513			
	Alternative					
	1 40.00 10 400.0000000000000000000000000			E s		
	10A NCAC 27E .010	1 LEAST RESTRICTIVE				
	ALTERNATIVE	all provide services/supports				
		and respectful environment.				
	These include:					
	(1) using the	east restrictive and most				
	appropriate settings	and methods;				
1	(2) promoting	coping and engagement				

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL071-027	B. WING		001	04/0000
		WITE071-027			03/	01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
RAINBOW	LEADME	200 ISLA	ND CREEK RO	AD		
KAINBON	PARMS	ROCKY P	OINT, NC 284	57		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 513	self or others; (3) providing ch meaningful to the clien (4) sharing of or the client/legally respond (b) The use of a restr procedure designed to always be accompanionate dignity and respondering the companion of the companion	ives to injurious behavior to noices of activities nts served/supported; and control over decisions with consible person and staff. ictive intervention or reduce a behavior shall ed by actions designed to pect during and after the	V 513			
	facility failed to provide used the least restricti to reduce a behavior for findings are: Review on 1/5/22 and revealed: -31 year-old male -Admission date of 6/1 -Diagnoses of autisms intellectual disability-se	ws and interviews, the e services/supports that ve intervention procedure or 1 of 3 clients (#1). The 1/6/22 of client #1's record 1/6/9 spectrum disorder and evere ailable to support the use of				
	Review on 1/5/22 and Individual Support Plar revealed: -"WHAT OTHERS NEI					

Division of Health Service Regulation

SUPPORT ME...Social Network: I need 1:1

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
RAINBOW	FARMS		D CREEK ROAD			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFIGIENCY)	BE	(X5) COMPLETE DATE
V 513	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 Inform restrictive nature of the well as his preferred specialized bed with 'small bed'), one of [of increase time out of eventually leading to ASAP (Autism Supportered to keep the (Human Rights Comthat are outside the support Plan)." -"Clinical Formulation use the restraint bed in SIB or physical agfrequently), as well a onset of precursor be [Program Director] diadditional strategies. Review on 2/4/22 of dates of 10/6/21 - 2/2-There were over 30 citing the use of the -There were 30 shift whether a restraint versmall bed" interventions."	EED TO KNOW TO BEST lical/Behavioral: my severe SIB) have lessened over crisis services with 2:1 my SIB continues." If 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. Out and Programs) staff have esmall bed as per their HRC mittee) recommendations acope of this BSP (Behavior In They are continuing to as well if [client #1] engages gression (SIB most as PRN (as needed) at the enaviors. At the current time, ones not feel like they need Is shifts with specific entries "small bed" intervention. In swithout any indication of was employed while using the	V 513			

Division of Health Service Regulation

bed" intervention.

Division (of Health Service Regu	lation					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03/	01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST.	ATE, ZIP CODE			
			ND CREEK RO				
RAINBOW	/ FARMS		OINT, NC 284				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 513	-There were 3 shifts vuse of the "small bed' restraints in the bedThere was 1 shift with the use and non-use of "small bed" interventionThere was no docum of less restrictive interviews on 1/6/22, stated: -She had been emplo approximately 1 yearShe had been trained intervention was to be when addressing clierShe had been inform	with specific entries citing while not using the has specific entry citing both of restraints while using the on. entation identifying the use ventions. 1/10/22 and 2/7/22 staff #2 yed with the agency for that the "small bed" autilized as a "last resort" at #1. ed by co-workers that they intervention when "they	V 513				
	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. -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 had witnessed staff use the "small bed" intervention as a way to "avoid" client #1. 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 bed" intervention as a means of avoiding more						

Division of Health Service Regulation								
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU			
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED			
		1						
		MHL071-027	B. WING		03/01/2022			
		INITLO7 1-027			1 03/0	112022		
NAME OF PE	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	TE, ZIP CODE				
		200 ISLA	ND CREEK ROA	D				
RAINBOW	FARMS	ROCKY F	OINT, NC 28457					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIAIE	DATE		
V 513	Continued From page	e 52	V 513					
	8 27.2							
	"aggressive behavior	S.						
	Interview on 2/4/22 s	taff #8 stated:						
		byed with the agency for						
	approximately 1 year							
		all bed" intervention was						
		ciplinary action by staff who				B		
	"did not want to deal with him."							
	did not want to dear with min.							
	Interview on 1/10/22 the Qualified Professional							
	(QP)/ Executive Dire	ctor (ED) stated:						
	-All data pertaining to	the details of the "small						
	bed" intervention wer	re recorded in client #1's						
	logbook.							
	-She was responsible	e for reviewing all client						
	documentation and e	ensuring it was implemented.						
		oss referenced into 10A						
	Company of the control of the contro	ompetencies of Qualified						
l	The state of the s	ssociate Professionals						
		rule violation and must be						
	corrected within 23 of	lays.						
		The second second second	12.77					
V 514	27E .0102 Client Rig	hts - Prohibited Procedures	V 514					
	10A NCAC 27E .010	2 PROHIBITED						
	PROCEDURES	Harrison from a section of the section of						
		llowing types of procedures						
	shall be prohibited:	ventions which have been						
	1.7	ventions which have been or rule which shall include:						
		ention which would be						
		punishment under G.S.						
	122C-59;	pariistiment ander 0.0.						
		gent use of painful body						
	contact;	,o 200 or paintal body						
	8	s administered to induce						
	1-7	ons, exclusive of Antabuse;				100		
		ock (excluding medically						
	1-7		1					

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		MHL071-027	B. WING		03/	01/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
DAINIDON	V 54 5440	200 ISLA	ND CREEK RO	AD			
RAINBOV	V FARMS		OINT, NC 284				
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES			000507:01	Т	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO		(X5) COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE		DATE	
				DEFICIENCY))		
V 514	Continued From page	53	V 514				
	Continued From page	. 55	V 314				
	administered electroc	onvulsive therapy);					
	(e) insulin shock						
	(f) unpleasant t	tasting foodstuffs;					
	(g) contingent a	pplication of any noxious					
	substances which incl	ude but are not limited to		1			
	noise, bad smells or s	plashing with water; and		1			
	 (h) any potentially physically painful procedure, excluding prescribed injections, or stimulus which is administered to the client for the purpose of reducing the frequency or intensity of a behavior. (2) those interventions determined by the 						
				1			
				-			
	governing body to be	unacceptable for or					
	prohibited from use in	the facility.					
					j		
	This Rule is not met a						
	Based on record revie						
		to prohibited procedures	1				
	administered to the cli						
		y or intensity of a behavior,					
	affecting 1 of 3 clients	(#1). The findings are:					
	<u> </u>					1	
		1/6/22 of client #1's record					
	revealed:					1	
	-31 year-old male	0.100					
	-Admission date of 6/1						
	-Diagnoses of autism s						
	intellectual disability-se	evere				- 1	
	Deview 4/5/00 : 1	4/0/00 - 6 - 15 4 - 441					
	Review on 1/5/22 and		1			1	
	Individual Support Plan	1 (ISP) dated 6/1/21					
1	revealed:	TO TO KNOW TO DECT					
-		ED TO KNOW TO BEST				1	
	SUPPORT MESocial						
	assistance and occasion	onal 2:1 supports if I				- 1	
	engage in behaviors.	TO 1010111 TO 2555				- 1	
		ED TO KNOW TO BEST				1	
		al/Behavioral: my severe				- 1	
	injurious behaviors (SII	B) have lessened over					

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE O3/01/2022		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 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) V 514 Continued From page 54 time, but I have used crisis services with 2:1 staffing last year and 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	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	IEU
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 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) V 514 Continued From page 54 time, but I have used crisis services with 2:1 staffing last year and 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			27 NOOSO 100 1 TOO CALEBRA	B WING		02/04/2022	
RAINBOW FARMS ROCKY POINT, NC 28457 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 514 Continued From page 54 time, but I have used crisis services with 2:1 staffing last year and 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			MHL071-027	B. WING		03/01	/2022
RAINBOW FARMS ROCKY POINT, NC 28457 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 514 Continued From page 54 time, but I have used crisis services with 2:1 staffing last year and 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	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 514 Continued From page 54 V 514 time, but I have used crisis services with 2:1 staffing last year and 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	BVINDON	/ FARMS					
WAY TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	KAINDUN	TARMO	ROCKY PO	DINT, NC 28457			
time, but I have used crisis services with 2:1 staffing last year and 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	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
'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" 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 had been employed with the agency for approximately 1 year. -She estimated that client #1 may have used the "small bed" intervention 15-30 times per month on average over the last "few months."		time, but I have used staffing last year and Review on 1/11/22 of Plan dated 12/2/21 re-"Background Inform restrictive nature of the well as his preferred specialized bed with 'small bed'), one of [cincrease time out of eventually leading to ASAP (Autism Supportered to keep the (Human Rights Comthat are outside the Support Plan)." -"Clinical Formulation use the restraint bed in SIB or physical agrequently), as well as onset of precursor be [Program Director] dadditional strategies Attempted interviews 1/6/22 proved unsuclimitations and client interview process. Interviews on 1/6/22 stated: -She had been emplapproximately 1 years -She estimated that "small bed" interviews	risis 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 examil bed as per their HRC mittee) recommendations acope of this BSP (Behavior In They are continuing to as well if [client #1] engages agression (SIB most as PRN (as needed) at the ehaviors. At the current time, oes not feel like they need in the element with the agency for a support of the element from the element #1 may have used the tion 15-30 times per month	V 514	DEFICIENCY)		

resort.

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03/	01/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE	1 00/	01/2022
RAINBOV	V FARMS	200 ISLAN	D CREEK RO	AD		
	T		DINT, NC 284	57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 514	Continued From page 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. 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 2021She 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 u					
	and displaying probler aggression.	matic behaviors and				
	Interview on 2/3/22 sta -She had worked with	aff #7 stated: the agency since October				
	The figure of the control of the con	orked with the agency prior				
	to her rehireClient #1 used the "sr approximately 4 times					
	-There had been some	e staff, who were no longer cy, that had used the "small				
		means of avoiding more				
	Interview on 2/4/22 sta	aff #8 stated: yed with the agency for				
	approximately 1 year.	e "small bed" intervention				
		ciplinary" action by staff as				
	Interview on 1/10/22 th (QP)/ Executive Direct	ne Qualified Professional or (ED) stated:				

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUR	
AND PLAN C	DF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		MHL071-027	B. WING		03/01/2022	
NAME OF ST	DOVIDED OF CHIRDLES		INDESS CITY STAT	F ZIP CODE	1 00/01/	
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT ND CREEK ROAI			
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 OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 514	-The "small bed" inte	rvention was used to prevent	V 514			
	dangerous self-injurious behaviors and to provide sensory stimulation. -The "small bed" intervention was sometimes requested by client #1 to help calm him.					
	requested by client #1 to help calm him. This deficiency is cross referenced into 10 A 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 518	27E .0104(e1-2) Clie	nt Rights - Sec. Rest. & ITO	V 518			
	10A NCAC 27E .010 PHYSICAL RESTRATIME-OUT AND PROFOR BEHAVIORAL (e) Within a facility way be used, the poin accordance with th (1) the require restrictive alternative attempted whenever more restrictive inter (2) consideration physical and psychoduring and after utilizintervention, includin (A) review of the client's comprehenconducted upon administration assessment shall incorre-existing medical	A SECLUSION, AINT AND ISOLATION DTECTIVE DEVICES USED CONTROL where restrictive interventions licy and procedures shall be ne following provisions: ment that positive and less is are considered and possible prior to the use of ventions; on is given to the client's logical well-being before, extion of a restrictive ig: ne client's health history or ensive health assessment hission to a facility. The inprehensive health clude the identification of conditions or any disabilities would place the client at				

(B)

continuous assessment and monitoring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL071-027	B. WING		03/01	1/2022
NAME OF P	PROVIDER OR SUPPLIER	200 ISLA	DDRESS, CITY, STATE ND CREEK ROAD POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 518	of the physical and ps the client and the safe the duration of the res who are physically pre of emergency safety in (C) continuous trained in the use of caresuscitation of the clie psychological well-bei restraint; and (D) continued me trained in the use of caresuscitation of the clie	ychological well- being of a use of restraint throughout trictive intervention by staff esent and trained in the use interventions; monitoring by an individual ardiopulmonary ent's physical and ing during the use of manual conitoring by an individual erdiopulmonary ent's physical and ing for a minimum of 30 to the termination of a	V 518			
	were present to monitor psychological well-beint the duration of the rest failed to ensure that possible for alternatives were consistent whenever possible for findings are: Review on 1/5/22 and revealed: -31 year-old male -Admission date of 6/1 -Diagnoses of autism sintellectual disability-sell-No documentation of a	ws, observation, and failed to ensure that staff or the physical and and of the client throughout trictive intervention, and estive and least restrictive idered and attempted 1 of 3 clients (#1). The 1/6/22 of client #1's record 1/6/22 of client #1				

Division of Health Service Regulation

Division of Health Service Regulation				1		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	: IEU
					1	
		MHI 071 027	B. WING		03/0	1/2022
		MHL071-027			1 03/0	1/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
		200 ISLA	ND CREEK ROAL	o e		
RAINBOW	FARMS	ROCKY F	POINT, NC 28457			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIAIE	DATE
V 518	Continued From page	e 58	V 518			
	A DOMESTIC OF THE PROPERTY OF	ogical well-being throughout				
	the duration of the re-					
		ne dates of 1/1/21 - 1/5/22				
		nat the least restrictive				
	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					
	An example as a second	sional 2:1 supports if I				
	engage in behaviors.					
1		EED TO KNOW TO BEST				
	1	lical/Behavioral: my severe				
		SIB) have lessened over				
6		I crisis services with 2:1				
	staffing last year and	my SIB continues."				
	D	f aliant #41a Bahaviar Cuana				
	The state of the s	f client #1's Behavior Support				
	Plan dated 12/2/21 r					
		ation Due to the very				
		he wrist band procedure (as				
	The second secon	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				
	THE RESERVE AND LOSS OF THE PROPERTY OF THE PR	scope of this BSP (Behavior				
	Support Plan)."					
		n They are continuing to				
		as well if [client #1] engages				
	in SIB or physical ag					
		as PRN (as needed) at the				
	onset of precursor b	ehaviors. At the current time,				

Division of Health Service Regulation

additional strategies..."

[Program Director] does not feel like they need

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ COMPLETED MHL071-027 B. WING 03/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD **RAINBOW FARMS ROCKY POINT, NC 28457**

	KOOKIT	01141, 140 204	TVI	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 518	Continued From page 59	V 518		
	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 documentation of alternatives to restrictive interventions being employed between the dates of 1/1/21 - 1/5/22 -There was no documentation of staff monitoring the physical and psychological well-being throughout the duration of the restrictive intervention. -There was no documentation that the least restrictive intervention alternatives were considered.			
	Observation on 1/5/22 at approximately 11:45am revealed: -Staff #1 was providing 1:1 services with client #1Client #1 was observed alone in his bedroom with the bedroom light outClient #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 anklesThe "small bed" was positioned adjacent to a second bed which was identified by staff as the "big bed" which client used for sleepingClient #1 did not appear in distress and was unresponsive to dialogue.			
	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			

Division of Health Service Regulation

Division o	if Health Service Regu	lation			Total Control	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					1	1
		MIN 074 067	B. WING		03/01/2022	
		MHL071-027	1		03/0	1/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		200 ISLAN	ND CREEK ROA	D		
RAINBOW	FARMS		OINT, NC 2845			1
				PROVIDER'S PLAN OF CORRECTION	N	/۷5
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	No. of the Control of	(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
IAG		•		DEFICIENCY)		
			11.510			
V 518	Continued From page	e 60	V 518			
	on average over the	last "few months."				
		ific observation times for				
	monitoring client #1 while using the "small bed" intervention.					
	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 the "small bed" intervention, to ensure that client #1 did not wriggle free from					
	The first of the second field of the first of the second field of	#1 did not wriggle free from				
	the restraints.	ack on client #1 "when he				
		eck on client #1 "when he				
	was ready."	Variation and the				
	-There were no addit					
	1 .	client #1 used the "small bed"				
	intervention.					
		1/10/00				
		, 1/12/22 and 2/4/22 staff #4				
	stated:					
		client #1 had used the "small				
		5 times in December of				
		in November of 2021.				
		cific observation requirements				
	10	#1 while using the "small				
	bed" intervention.					
		ed to remain in the room with				
	client #1 while he wa	as utilizing the "small bed"				
	intervention.					
				1		
	Interview on 2/7/22	staff #6 stated:				
		red use of the restrictive				
	straps with his "sma	Il bed" approximately once				
	per week during Dec					
		quirements for client #1 were				
	to check on him eve					
		quirements for client #1 when				
		ed" intervention were to				
		e more often" than normal				
1	SHOOK SHITING IIII			La company of the com		

	er rioditir oorvioo rtoga	I				***************************************	
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	COMPLETED	
		MHL071-027	B. WING		02	/01/2022	
V 200 WWW. 20 DOX 1						01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
RAINBOW	/ FARMS	200 ISLAN	ND CREEK RO	AD			
TOAITEON	TARMO	ROCKY P	OINT, NC 284	57			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 518	Continued From page	61	V 518				
		, 6 ,					
	observation periods.						
	Interview on 0/0/00 at	-ff #7 -t-t- d					
	Interview on 2/3/22 st -Client #1 used the "s						
	approximately 4 times						
		ed to be in the room to					
		e using the "small bed"					
	intervention.						
	Interview on 2/4/22 sta						
		vernight shifts where client					
	#1 had used the "sma						
	II	ic observation requirements					
	bed" intervention.	1 while using the "small					
	bed intervention.						
	Interview on 1/11/22 for stated:	ormer staff #5 (FS #5)					
		mall bed" intervention for					
	as little as 15-20 minu hours.						
		#1 had used the "small bed"					
		ately 10 times for the last					
	full month she worked						
	-There were no specifi	ic observation requirements					
		1 while using the "small					
	bed" intervention.						
	Interview at 0/4/00	-# 40 -1-1-					
	Interview on 2/4/22 sta						
		e "small bed" intervention es in December of 2021.					
		nall bed" intervention, staff					
	would return to check						
		utes to assess his progress.					
	1,	p. 09. 000.					
	Interview on 1/10/22 th	ne Qualified Professional					
	(QP)/ Executive Direct	or (ED) stated:					
	-All data pertaining to t	the details of the "small					

Division of Health Service Regulation

logbook.

bed" intervention were recorded in client #1's

Division o	f Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
		MHL071-027	B. WING		03/0	1/2022
		I WILLOT 1-027		(-20)	1 00/0	
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
DAINDO	LADMO	200 ISLA	ND CREEK ROA	D		
RAINBOW	FARMS	ROCKY	POINT, NC 28457	7		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	The same of the sa	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORTORT	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		
V 518	Continued From page	e 62	V 518			
	She was responsible	e for reviewing all client				
		nsuring it was implemented.				
	accumontation and o					
	This deficiency is cro	ss referenced into 10A				
		mpetencies of Qualified				
		sociate Professionals				
		rule violation and must be				
	corrected within 23 d	ays.				
V 521	27E .0104(e9) Client	Rights - Sec. Rest. & ITO	V 521			N
		ture C petition - by automorphy (2 727 Art				
	10A NCAC 27E .010					
		AINT AND ISOLATION				
		DTECTIVE DEVICES USED				
	FOR BEHAVIORAL					
		where restrictive interventions				
		licy and procedures shall be				
		ne following provisions:				
		ictive intervention is utilized,				
		be made in the client record				
	to include, at a minin					
	(A) notation of the cli psychological well-be					
		equency, intensity and				
	duration of the behav					
		precipitating circumstance				
	contributing to the or					
		the use of the intervention,				
	1	estrictive interventions				
		and the inadequacy of less				
		on techniques that were used;				
		he intervention and the date,				
	time and duration of					
		accompanying positive				
	methods of intervent					
		he debriefing and planning				
	with the client and the	ne legally responsible person,				

if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate

1	OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY MPLETED
		MHL071-027	B. WING		0:	3/01/2022
NAME OF P	ROVIDER OR SUPPLIER	200 ISLA	DDRESS, CITY, STA	AD		
	T		POINT, NC 2845			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 521	or reduce the probabilinestrictive intervention	lity of the future use of s;	V 521			
	with the client and the if applicable, for the plant physical restraint or is					
	determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.					
	facility failed to ensure	ws and interviews, the the necessary the client record when a was utilized for 1 of 3				
	revealed: -31 year-old male -Admission date of 6/1 -Diagnoses of autism sintellectual disability-seNo documentation of	spectrum disorder and evere				
	restrictive intervention -No documentation of and duration of the be intervention -No documentation of the restrictive interven interventions consider	the frequency, intensity, havior which led to the the rationale for the use of tion, and the alternative ed a description, date, time, ervention				
	Review on 1/5/22 and	1/6/22 of client #1's				

Division of Health Service Regulation

MHL071-027 B. WING	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	100000000000000000000000000000000000000
MANUS OF PROVIDER OR SUPPLIER STREETADRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD ROCKY POINT, NO. 28457 (A) ID PREFEIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL TAG V 521 Continued From page 64 Individual Support Plan (ISP) dated 6/1/21 revealed: "WHAT OTHERS NEED TO KNOW TO BEST SUPPORT ME Medical/Behaviors. "WHAT OTHERS NEED TO KNOW TO BEST SUPPORT ME Medical/Behaviors. "WHAT OTHERS NEED TO KNOW TO BEST SUPPORT ME Medical/Behaviors!" Review on 1/11/22 of client #1's Behavior Support Plan dated 1/2/21 revealed: "Background Information Due to the very restrictive nature of the wrist band procedure (as well as his preferred activity of slaying in a specialized bed with leg and wrist restraints (aka 'small bed'), one of [client #1's] goals has been to increase time out of wrist band/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 logbook for the dates of 10/6/21 - 2/2/22 revealed: -There were over 30 shifts with specific entries				A. BOILDING.			
RAINBOW FARMS 200 ISLAND CREEK ROAD ROCKY POINT, No. 28457 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES DESCRIPTION ROCKY POINT, No. 28457 TAG PREFIX TAG CROSS-REFERENCE TO THE APPROPRIATION DESCRIPTION STORMATION) V 521 Continued From page 64 Individual Support Plan (ISP) dated 6/1/21 revealed: "WHAT OTHERS NEED TO KNOW TO BEST SUPPORT HE Social Network: I need 1:1 assistance and occasional 2:1 supports if I engage in behaviors. "WHAT OTHERS NEED TO KNOW TO BEST SUPPORT ME Medical/Behavioral: my severe injurious behaviors (ISIB) have lessened over time, but I have used crisis services with 2:1 staffing last year and my SIB continues." Review on 1/11/22 of client #1's Behavior Support Plan dated 12/22'r 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 'small bed'), one of [client #1's] gash has been to increase time out of wrist band/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 logbook for the dates of 10/6/21 - 2/27/22 revealed: "There were over 30 shifts with specific entries			MHL071-027	B. WING		03/0	1/2022
CAU DI CAU DI CAU CAU	NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	E, ZIP CODE		
QMAINT STATEBUT OF DEFICIENCES PREFIX TROS SUMMARY STATEBUT OF DEFICIENCES DY PULL REGULATORY ON LSC DESTRIPTING NEORMATION) V 521 Continued From page 64 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 engage in behaviors. "WHAT OTHERS NEED TO KNOW TO BEST SUPPORT MEMedical/Behavioral: my severe injurious behaviors (SIB) have lessened over time, but I have used crisis services with 2:1 staffing last year and 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 '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 SSP (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 logbook for the dates of 10/6/21 - 2/2/22 revealed: -There were over 30 shifts with specific entries	RAINBOW	FARMS					
PREFIX TAG V 521 Continued From page 64 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 engage in behaviors. "WHAT OTHERS NEED TO KNOW TO BEST SUPPORT MEMedical/Behavioral: my severe injurious behaviors (SIB) have lessened over time, but I have used crisis services with 2:1 staffing last year and 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 '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 Plany). "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 logbook for the dates of 10/6/21 - 2/2/22 revealed: "There were over 30 shifts with specific entries		OLIMAN DV OT				CTION	/Y5)
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 engage in behaviors"WHAT OTHERS NEED TO KNOW TO BEST SUPPORT MEMedical/Behavioral: my severe injurious behaviors (SIB) have lessened over time, but I have used crisis services with 2:1 staffing last year and 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 '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 logbook for the dates of 10/6/21 - 2/2/22 revealed: - There were over 30 shifts with specific entries	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETE DATE
[Program Director] does not feel like they need additional strategies" 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	V 521	Individual Support Plarevealed: -"WHAT OTHERS NE SUPPORT MESociassistance and occase engage in behaviors"WHAT OTHERS NE SUPPORT MEMedinjurious behaviors (Stime, but I have used staffing last year and Review on 1/11/22 of Plan dated 12/2/21 re-"Background Inform restrictive nature of the well as his preferred specialized bed with 'small bed'), one of [cincrease time out of eventually leading to ASAP (Autism Support Plan)." -"Clinical Formulation use the restraint bed in SIB or physical aggrequently), as well as grequently), as well as grequently, as well as greater and occasion as the restraint bed in SIB or physical aggrequently), as well as greater and occasion as the restraint bed in SIB or physical aggrequently), as well as greater and occasion as the restraint bed in SIB or physical aggrequently), as well as greater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion as the restraint bed in SIB or physical aggreater and occasion and occasion and occasion as the restraint bed in SIB or physical aggreater and occasion and occasion as the restraint bed in SIB occasion and occasion and occasion and occasion as the restraint bed in SIB occasion and	an (ISP) dated 6/1/21 EED TO KNOW TO BEST fal Network: I need 1:1 sional 2:1 supports if I EED TO KNOW TO BEST lical/Behavioral: my severe SIB) have lessened over I crisis services with 2:1 my SIB continues." If 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 agression (SIB most as PRN (as needed) at the	V 521	DEFICIENCY)		
-There was no additional documentation detailing		additional strategies Review on 2/4/22 of dates of 10/6/21 - 2/ -There were over 30 citing the use of the	client #1's logbook for the 2/22 revealed: shifts with specific entries "small bed" intervention.				

Division of Health Service Regulation

client's physical and psychological well-being

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY
		MHL071-027	B. WING		03	/01/2022
	PROVIDER OR SUPPLIER		DRESS, CITY, STA			
RAINBOV	V FARMS	ROCKY P	OINT, NC 2845	7		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 521	which led to the intervof the restrictive intervof the restrictive intervinterventions consider and duration of the intervention of the intervention of the intervention of the interventions, time of it that led to the interventions, time of it that led to the intervention. There were no debrie use of "small bed." Interview on 1/11/22 a -She documented why "small bed" intervention for the intervention, an intervention in client #" Interviews on 1/4/22, 1 stated: -Staff were required to used the "small bed" ir -There were no specific requirements with regal #1 when he finished the interventionDocumentation was religional. Interview on 2/4/22 star-Staff were supposed to causal factors leading if #1's logbook. The logb staff often failed to comrequirements appropria	estrictive intervention, and duration of the behavior ention, rationale for the use ention, alternative ed, description, date, time, ervention, and debriefing ion. 1/10/22 and 2/7/22 staff #2 dates of behaviors and factors tion in client #1's logbook. fing requirements following and 2/4/22 staff #3 stated: client #1 needed the n, what caused the need d how he felt after the l's logbook. 1/12/22 and 2/4/22 staff #4 document when client #1 tervention. and documentation and to follow-up with client e use of the "small bed" ecorded in client #1's ff #8 stated: a record behaviors and to the behaviors in client book was not accurate, as applete documentation	V 521			

Division of Health Service Regulation

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: ___

> B. WING _ 03/01/2022 MHL071-027

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RAINBOW FARMS

200 ISLAND CREEK ROAD

	ROCKIT	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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 521	Continued From page 66	V 521		
	use of "small bed."			
	Interview on 2/4/22 staff #9 stated: -She documented all actions leading to the use of the"small bed" intervention in client #1's logbookStaff were not consistently recording data in client #1's logbook.			
	Interview on 1/10/22 the Qualified Professional (QP)/ Executive Director (ED) stated: -All data pertaining to the details of the "small bed" intervention were recorded in client #1's logbookShe was responsible for reviewing all client documentation and ensuring it was implemented.			
	This deficiency is cross referenced into 10A 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 523	3 27E .0104(e11) Client Rights - Sec. Rest. & ITO	V 523		
	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 may be used, the policy and procedures shall be in accordance with the following provisions: (11) The following precautions and actions shall be employed whenever a client is in: (A) seclusion or physical restraint, including a protective device when used for the purpose or with the intent of controlling unacceptable behavior: periodic observation of the client shall occur at least every 15 minutes, or more often as necessary, to assure the safety of the client,			

Division of Health Service Regulation

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	IPLETED
		MHL071-027	B. WING		03	3/01/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
DAINDO	N EADMC	200 ISLA	ND CREEK ROAD			
RAINBOV	V FARIVIS	ROCKY	POINT, NC 28457			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 523	attention shall be paid meals, bathing and the observation and attent the client record; (B) isolation time-out: employee in attendan responsibility than to replaced in isolation time continuous observation with the client when an observation shall be direcord; and (C) physical restraint a injury: a facility employ with the client continuous the client continuous. This Rule is not met as Based on record review interviews, the facility observation of the clieminutes during a physical safety of the client, afford the client, afford the client interview on 1/5/22 and revealed: -31 year-old male -Admission date of 6/1-Diagnoses of autisms intellectual disability-sellectual	to the provision of regular e use of the toilet; and such tion shall be documented in there shall be a facility ce with no other immediate monitor the client who is e-out; there shall be an and verbal interaction ppropriate; and such locumented in the client and may be subject to yee shall remain present ously. The sevidenced by: The sevidenc	V 523			

Division of Health Service Regulation

PRINTED: 03/02/2022 FORM APPROVED

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 03/01/2022 MHL071-027 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD **RAINBOW FARMS ROCKY POINT, NC 28457** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 523 V 523 Continued From page 68 assistance and occasional 2:1 supports if ! engage in behaviors. -"WHAT OTHERS NEED TO KNOW TO BEST SUPPORT ME...Medical/Behavioral: my severe injurious behaviors (SIB) have lessened over time, but I have used crisis services with 2:1 staffing last year and 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 '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..." 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

Division of Health Service Regulation

s wrists and ankles.

from the bed and connected to both of client #1 '

-The "small bed" was positioned adjacent to a

1	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3	3) DATE SURVEY COMPLETED
		MHL071-027	B. WING			03/01/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	FATE, ZIP CODE		03/01/2022
RAINBOV	V FARMS		ID CREEK RO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 523	second bed which wa "big bed " which client -The client did not appunresponsive to dialog Attempted interviews 1/6/22 proved unsuccilimitations and client interview process. Interviews on 1/6/22, stated: -She estimated that client stated: -She estimated that client realization average over the large stated average stated average stated average stated average stat	s identified by staff as the tused for sleeping. Dear in distress and was gue. with client #1 on 1/5/22 and essful due to verbal #1's detachment from the 1/10/22 and 2/7/22 staff #2 ient #1 may have used the on "15-30 times" per month ast "few months." ient #1 used the "small bed" ininutes" at a minimum to ic observation times for inile using the "small bed" and 1/11/22 staff #3 stated: #1 had used the "small mes per week in December watch client #1 for "5 - 10 ine "small bed" intervention, I did not wriggle free from ik on client #1 "when he 1/12/22 and 2/4/22 staff #4 ent #1 had used the "small times in December of November of 2021.	V 523			

Division of Health Service Regulation

Division of	f Health Service Regu	lation			
O 11 11	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL071-027	B. WING		03/01/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
		200 ISLA	ND CREEK ROAL		
RAINBOW	TAKINO	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 OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 523	Continued From page	e 70	V 523		
		toff #6 stated:			
	Interview on 2/7/22 staff #6 stated: -Client #1 only required use of the restrictive straps with his "small bed" approximately once per week during December of 2021.				
	-The observation req	uirements for client #1 were			
	to check on him ever	y 30 minutes. uirements for client #1 when			
	utilizing the "small be	ed" intervention were to			
	check on him a "little observation periods.	more often" than normal			
	Interview on 2/3/22 s				
	-Client #1 used the "approximately 4 time	small bed" intervention es per month.			
	-Staff were not requi	red to be in the room to			
	observe client #1 wh intervention.	ile using the "small bed"			
	Interview on 2/4/22 s				
		cific observation times for while using the "small bed"			
	intervention.				
	Interview on 1/11/22 stated:	former staff #5 (FS #5)			
	-Client #1 used the "	small bed" intervention for			
	as little as 15-20 mir hours.	nutes and as much as 8			
	-She estimated clien	at #1 had used the "small bed"			
		mately 10 times for the last ed (October of 2021).			
	-There were no spec	cific observation times for			
	intervention.	while using the "small bed"			
	Interview on 2/4/22	staff #9 stated:		II .	

-Client #1 had used the "small bed" intervention approximately 2 -3 times in December of 2021.

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			LETED
		MHL071-027	B. WING		03/	01/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
PAINPON	VEADMC	200 ISLA	ND CREEK RO	AD		
RAINBOV	V FARIVIS	ROCKY F	POINT, NC 284	57		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	E CORRECTION	T (VE)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC	TION SHOULD BE	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENT		DATE
				DEITOIEN		
V 523	Continued From page	71	V 523			
	-When utilizing the "sr	mall bed" intervention, staff				
	would return to check					
		utes to assess his progress.				
		he behavior analyst stated:-				
		nave been checking and		1		
		nt #1 every 15 minutes				
	when he was in a rest	raint. that staff remained within				
		ent #1 was using the "small				
	bed" intervention.	one #1 was asing the small				
		ne Qualified Professional			l)	
	(QP)/ Executive Direct					
		supervision and should be				
	within line of sight whe					
		ously employed 15-minute				
		was using his small bed. per completed 15-minute				
	checks.	jer completed 13-minute				
		#1 in 15-minute increments				1
	had not been documer					- 1
	-Staff were required to	check on client #1 to				- 1
	ensure he was not wet	when he was using the				
	"small bed."					1
	-She was responsible	-				
	documentation and en	suring it was implemented.				
	This deficiency is cross	s referenced into 10 A				
	NCAC 27G .0203 Com					1
	Professionals and Asso					
		ule violation and must be				
	corrected within 23 day					
V 524		ent Rights - Sec. Rest. &	V 524			1
	ITO					
	104 NOAC 07E 0404	SECULISION.				
	10A NCAC 27E .0104 PHYSICAL RESTRAIN	SECLUSION, NT AND ISOLATION				

Division of Health Service Regulation

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X2) MULTIPLE CONSTRUCTION		JRVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	:TED
		MHL071-027	B. WING		03/0	1/2022
NAME OF D	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STAT	E. ZIP CODE		
NAME OF P	NOVIDER OR SUFFLIER		ND CREEK ROAI			
RAINBOW	FARMS		OINT, NC 28457			
	CLIMMADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N I	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	The same of the sa	COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
V 524	Continued From page	e 72	V 524			
	TIME_OLIT AND DRO	TECTIVE DEVICES USED				
	FOR BEHAVIORAL O					
		here restrictive interventions				
		icy and procedures shall be				
		e 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				
	frame specified in the					
	intervention, a new a obtained.	utionzation must be				
		oval of the designee of the				
		be required when the				
		estrictive intervention is				
	renewed for up to a t					
	accordance with the	limits specified in Item (E) of				
	Subparagraph (e)(10					
	1.124 27	or PRN orders shall not be				
		e use of seclusion, physical				
	restraint or isolation					
		strictive intervention shall be				
	specified in G.S. 122	ion of the client's rights as				
		rements in this Rule shall				
		ents specified in G.S.				
	122C-62(e) for rights					
		ctive intervention is utilized				
		on of others shall occur as				
	follows:					
	(A) those to be notifi-	ed as soon as possible but				
	within 24 hours of the	e next working day, to				
	include:					1
	(i) the treatment or h	abilitation team, or its				

designee, after each use of the intervention; and (ii) a designee of the governing body; and (B) the legally responsible person of a minor client or an incompetent adult client shall be

1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/01/2022	
		MHL071-027	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		v
RAINBOV	FARMS		D CREEK RO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 524	notified immediately unot to be notified. This Rule is not met a Based on record revier facility failed to docume treatment team and le following each restrict affecting 1 of 3 clients Review on 1/5/22 and revealed: -31 year-old male -Admission date of 6/1-Diagnoses of autism intellectual disability-sind documentation of notifications following-No documentation of legally responsible for restrictive intervention Review on 1/5/22 and Individual Support Plan revealed: -"WHAT OTHERS NEI SUPPORT MESocial assistance and occasion engage in behaviors"WHAT OTHERS NEI SUPPORT MEMedicinjurious behaviors (SI time, but I have used of staffing last year and in Review on 2/4/22 of clients.	as evidenced by: as evidenced by: as and interviews, the beent notification of the gally responsible person ive intervention as required, (#1). The findings are: 1/6/22 of client #1's record 1/6/22 of client #1's record 1/6/22 of client #1's record 1/6/22 of client #1's client #1 following each 1/6/22 of client #1's n (ISP) dated 6/1/21 ED TO KNOW TO BEST I Network: I need 1:1 conal 2:1 supports if I ED TO KNOW TO BEST cal/Behavioral: my severe B) have lessened over crisis services with 2:1 ny SIB continues."	V 524			
	dates of 10/6/21 - 2/2/2 -There were over 30 sl	22 revealed: hifts with specific entries				

Division of Health Service Regulation

citing the use of the "small bed" intervention.

PRINTED: 03/02/2022

Division of Health Service Regulation FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		MHL071-027	B. WING	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	200 ISLA	DDRESS, CITY, STATE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
V 524	There was no docume notifications following intervention. There was no docume of parties legally respected following each restrict. Attempted interviews 1/6/22 proved unsuch limitations and client interview process. Interviews on 1/6/22, stated: She estimated that of "small bed" intervent on average over the limitation of limitation of the limitation of limi	nentation of treatment team y each restrictive nentation of the notification ponsible for client #1 tive 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 he the bed was used. 1/12/22 and 2/4/22 staff #4 client #1 had used the "small of times in December of 2021 rember of 2021. staff #6 stated: red use of the restrictive Il bed" approximately 1 time tember of 2021. staff #7 stated:	V 524				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL071-027	B. WING		03/	01/2022
NAME OF F	PROVIDER OR SUPPLIER	200 ISLA	DDRESS, CITY, STAT AND CREEK ROAL POINT, NC 28457	o .		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 524	Interview on 2/4/22 sta-She had worked 2 ov #1 had used the "sma Interview on 1/11/22 for stated: -She estimated client intervention approximated full month she worked Interview on 2/4/22 sta-Client #1 had used the approximately 2 -3 time. Interview on 2/7/22 client-Agency staff notified is significant concerns. He did not feel it was to notify him following interventionHe had no concerns were ceiving. Interview on 1/10/22 the (QP)/ Executive Direct -Client #1 had been us intervention approximated Team reviews were concerned but were completed "we COVID 19 emergence -She was responsible to documentation and entitle This deficiency is cross NCAC 27G .0203 Comprofessionals and Asset	aff #8 stated: vernight shifts where client II bed" intervention. primer staff #5 (FS #5) #1 had used the "small bed" ately 10 times for the last (October of 2021). aff #9 stated: e "small bed" intervention es in December of 2021. ent #1's guardian stated: nim when there were any necessary for agency staff every restrictive with the care client #1 was are Qualified Professional or (ED) stated: sing the "small bed" ately once per week of late. completed prior to COVID 19 when we can" since the for reviewing all client suring it was implemented. as referenced into 10 A apetencies of Qualified pociate Professionals ule violation and must be	V 524			

Division	of Health Service Regu	lation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
		MHL071-027	B. WING	B. WING		1/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STAT	E, ZIP CODE		
		200 ISLAN	D CREEK ROAL	0		
RAINBOV	V FARMS	ROCKY PO	DINT, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 525	Continued From page	e 76	V 525			
V 52	27E .0104(e17) Clier	nt Rights - Sec. Rest. & ITO	V 525			
	10A NCAC 27E .010 PHYSICAL RESTRATIME-OUT AND PROFOR BEHAVIORAL (e) Within a facility way be used, the polin accordance with the (17) The facility shall on any and all use of including: (A) a regular review governing body, and Committee, in complarules as specified in (B) an investigation unwarranted patterns (C) documentation of maintained on a log: (i) name of the clie (ii) name of the res (iii) date of each inte (v) type of intervent (vi) duration of each (vii) reason for use (viii) positive and that were used or the used and why those (ix) debriefing and policient, legally responsand staff, as specified of this Rule, to elimin of the future use of the control of	A SECLUSION, AINT AND ISOLATION DIECTIVE DEVICES USED CONTROL where restrictive interventions licy and procedures shall be ne following provisions: conduct reviews and reports frestrictive interventions, by a designee of the review by the Client Rights iance with confidentiality 10 A NCAC 28A; of any unusual or possibly s of utilization; and of the following shall be nt; ponsible professional; ervention; frestrictive alternatives at were considered but not alternatives were not used; clanning conducted with the usible person, if applicable, ed in Parts (e)(9)(F) and (G) mate or reduce the probability restrictive intervention; al and psychological				

PRINTED: 03/02/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING MHL071-027 03/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD **RAINBOW FARMS ROCKY POINT, NC 28457** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 525 Continued From page 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 -Admission date of 6/10/09 -Diagnoses of autism spectrum disorder and intellectual disability-severe -No documentation of restrictive intervention log to reflect the restrictive interventions between the dates of 1/1/21 - 1/5/22 -No documentation to accurately reflect the restrictive interventions performed at the facility between the dates of 1/1/21 - 1/5/22 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 ME...Social Network: I need 1:1 assistance and occasional 2:1 supports if I engage in behaviors.

-"WHAT OTHERS NEED TO KNOW TO BEST SUPPORT ME...Medical/Behavioral: my severe injurious behaviors (SIB) have lessened over time, but I have used crisis services with 2:1 staffing last year and my SIB continues."

Review on 1/11/22 of client #1's Behavior Support

-"Background Information. - Due to the very restrictive nature of the wrist band procedure (as well as his preferred activity of staying in a

Plan dated 12/2/21 revealed:

MALOT PROVIDER ON SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 SLAND CREEK ROAD ROCKY POINT, NC 25457 PROVIDER ON SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 SLAND CREEK ROAD ROCKY POINT, NC 25457 PROVIDERS PLAN OF CORRECTOR (RACH DEPOSITION WASTE REPOSED BY PRILL (REGULATORY OR LSC IDENTIFY NO INFORMATION) V 525 Continued From page 78 specialized bed with leg and wrist restraints (aka 'small bed'), one of [client #1*] goals has been to increase time out of wrist band/shrall be 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).* "Colinical Formulation They are continuing to use the restraint bed as well if (client #1) engages in SIS or physical aggression (SIB most frequently), as well as PRN (as needed) at the onast 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 cliting 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 eleachment 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, what caused the need		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
RAINBOW FARMS 200 ISLAND CREEK ROAD ROCKY POINT, NC 28457 (A4) ID PREFEX ISLAND CREEK ROAD ROCKY POINT, NC 28457 (A4) ID RECEIVED HISTORY MUST BE PRECEDED BY FULL PREPARED TO PREVENTING INFORMATION) V 525 Continued From page 78 specialized bed with leg and wrist restraints (aka '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 (Aultism 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 1.5-30 times per month on a verage over the last "few months." -She documented why client #1 needed the "small bed" intervention, what caused the need			MHL071-027	B. WING		03/01	/2022
CAU D SUMMARY STATEMENT OF DEFICIENCIES PREFIX REQUATORY OR 15C IDENTIFYING INFORMATION) PREFIX PREFIX REQUATORY OR 15C IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION AMOUNT BE PRECEDED BY PULL REQUATORY OR 15C IDENTIFYING INFORMATION) PREFIX TAG PREFIX PREFIX REQUATORY OR 15C IDENTIFYING INFORMATION) PREFIX TAG V 525 Continued From page 78 V 525 Continued From page 78 Specialized bed with leg and wrist restraints (abs 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 - 22/2/22 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, sharped to the need. **The Appendix of the	NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
Whether Tag and the commendation of the commen	RAINBOW	FARMS					
specialized bed with leg and wrist restraints (aka specialized bed with leg and wrist restraints (aka 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, what caused the need	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
for the intervention, and how he felt after the intervention in client #1's logbook.	V 525	specialized bed with 'small bed'), one of [cincrease time out of veventually leading to ASAP (Autism Supportered to keep the (Human Rights Committed the support Plan)." -"Clinical Formulation use the restraint bed in SIB or physical agfrequently), as well a onset of precursor be [Program Director] diadditional strategies. Review on 2/4/22 of notes) for the dates of the committed interview and documentations and client interview process. Interviews on 1/6/22 stated: -She estimated that "small bed" intervention average over the -She documented w "small bed" intervention, for the intervention,	leg and wrist restraints (aka dient #1's] goals has been to wrist bands/small bed discarding the wrist band. Out and Programs) staff have small bed as per their HRC mittee) recommendations acope of this BSP (Behavior In They are continuing to as well if [client #1] engages gression (SIB most is PRN (as needed) at the enaviors. At the current time, been not feel like they need in the enaviors of the second in the enaviors of the e	V 525			

Interviews on 1/6/22, 1/11/22, and 2/4/22 staff #3

1		T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
1	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	IPLETED	
			MHL071-027	B. WING		0:	3/01/2022	
-	NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	RAINBOW	/ FARMS		ND CREEK RO				
ŀ			ROCKY P	OINT, NC 284	57			
-	(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
	V 525	Continued From page	79	V 525				
		stated:.	d client #1 had used the					
			n 2-3 times per week in					
		December of 2021.	in 2 o times per week in					
		-Client #1 would only u	utilize the straps in his bed					
		about 50% of the time						
		-She documented why						
		"small bed" intervention, what caused the need for the intervention, and how he felt after the intervention in client #1's logbook.						
			1/12/22 and 2/4/22 staff #4					
		stated:	17 12/22 and 2/4/22 stail #4					
			ent #1 had used the "small					
		bed" intervention 3 - 5						
			2 -3 times in the month of					
		November, 2021,	document when client #1					
		used the "small bed" in						
		-There were no specific						
		requirements with rega	ards to follow-up with client					
			e use of the "small bed"					
	1	intervention.						
	1	 -Documentation was relogbook. 	ecorded in client #1's					
	- 1	Interview on 2/7/22 sta						
		-The use of the "small I						
		recorded in client #1's	0					
		-Client #1 only required straps with his "small h	ed" approximately 1 time					
		per week during Decen						
		Interview on 2/3/22 sta	ff #7 stated:					
		-The use of the "small t	bed" intervention was					
		recorded in client #1's I						
		-Interventions were not						
			"generally" logged in the					
		book. -Client #1 used the "sm	all had" intervention					
		One in the state of the state	ומוו ספט ווונפו עפוונוטוו	I	ſ		1	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		TED
		MHL071-027	B. WING		03/01	/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
		200 ISLANI	CREEK ROA	D		
RAINBOW	FARMS	ROCKY PO	INT, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 525	Continued From page	e 80	V 525			
	approximately 4 time	s per month.				
	Interview on 2/4/22 s -All actions related to recorded in the logborShe had worked 2 o #1 had used the "smStaff 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 dood documented consister -Client #1 used the " as little as "15-20 mit hours." -She estimated clien	taff #8 stated: a use of the "small bed" were book. evernight shifts where client all bed" intervention. d to record behaviors and g to the behaviors in client gbook was not accurate, as emplete documentation existely. former staff #5 (FS #5) numented 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				
	Interview on 2/4/22 s -She documented al the "small bed" inter -Staff were not consi client #1's logbookClient #1 had used approximately 2 -3 ti Interview on 1/10/22 (QP)/ Executive Dire -All data pertaining t bed" intervention we logbookShe was responsib	staff #9 stated: I actions leading to the use of vention in client #1's logbook. istently recording data in the "small bed" intervention imes in December.				

	T OF DEFICIENCIES OF CORRECTION	(XZ) MOZINI ZZ CONONICO		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/01/2022	
		MHL071-027	MHL071-027 B. WING			
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
RAINBOW	/ FARMS		IND CREEK ROAD POINT, NC 28457	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 525	This deficiency is cros NCAC 27G .0203 Cor Professionals and Ass	es referenced into 10A inpetencies of Qualified sociate Professionals rule violation and must be	V 525			
	10A NCAC 27E .0104 PHYSICAL RESTRAI TIME-OUT AND PROTEOR BEHAVIORAL Co. (e) Within a facility who may be used, the policin accordance with the (18) The facility shall of the use of seclusion and data collected and analysication incident: (A) the type of procedutime employed; (B) alternatives consid (C) the effectiveness of alternative employed. The facility shall analysication and the facility shall analysication a	NT AND ISOLATION FECTIVE DEVICES USED ONTROL here restrictive interventions by and procedures shall be infollowing provisions: hollect and analyze data on hid physical restraint. The halyzed shall reflect for each here used and the length of hered or employed; and if the procedure or here the data on at least a here the data on at least a here the data on at least a here corrective action here facility shall make the here exerting the procedure of here the data on the length of here the data on at least a here the data on at least a here the data on the length of here the data on th	V 526			
	This Rule is not met as					

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED

> B. WING _ 03/01/2022 MHL071-027

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

A. BUILDING: __

RAINBOW FARMS

200 ISLAND CREEK ROAD ROCKY POINT, NC 28457

KAINBOW	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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 82 facility failed to document the type of procedure used, effectiveness of procedures, length of time employed, and alternatives considered 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 -Admission date of 6/10/09 -Diagnoses of autism spectrum disorder and intellectual disability-severe -No documentation of the effectiveness of procedures, length of time employed, and alternatives to the restrictive intervention (small bed) being employed. 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 engage in behaviors"WHAT OTHERS NEED TO KNOW TO BEST SUPPORT MEMedical/Behavioral: my severe injurious behaviors (SIB) have lessened over time, but I have used crisis services with 2:1 staffing last year and 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 'small bed'), one of [client #1's] goals has been to increase time out of wrist bands/small bed		CROSS-REFERENCED TO THE APPROPRIATE	
	eventually leading to discarding the wrist band. ASAP (Autism Support and Programs) staff have preferred to keep the small bed as per their HRC			

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL071-027	B. WING		03/01/2022
NAME OF F	PROVIDER OR SUPPLIER	200 ISLA	ADDRESS, CITY, STATE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETE
V 526	(Human Rights Commithat are outside the significant support Plan)." -"Clinical Formulation use the restraint bed in SIB or physical aggrequently), as well as onset of precursor be [Program Director] do additional strategies Review on 2/4/22 of oddates of 10/6/21 - 2/2. -There were over 30 significant support of the premployed, and alternation and client support of the premployed of	nittee) recommendations cope of this BSP (Behavior They are continuing to as well if [client #1] engages pression (SIB most as PRN (as needed) at the haviors. At the current time, es not feel like they need dient #1's Logbook for the 1/22 revealed: shifts with specific entries small bed" intervention. entation of the rocedures, length of time atives considered for over es where the "small bed" rided. with client #1 on 1/5/22 and essful due to verbal entry and 2/7/22 staff #2 dates of behaviors and interventions, and factors ation in client #1's logbook. Iten #1 may have used the in "15-30 times" per month list "few months." and 2/4/22 staff #3 stated: #1 had used the "small mes per week in December	V 526		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING: MHL071-027 B. WING 03/01/	FED
MHL071-027 B. WING 03/01/	
WITEOT 1-021	/2022
WITEOT 1-021	/2022
WITEOT 1-021	IZUZZ
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
200 ISLAND CREEK ROAD	
RAINBOW FARMS ROCKY POINT, NC 28457	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
DEFICIENCY	
V 526 Continued From page 84 V 526	
"small bed" intervention, what caused the need	
for the intervention, and how he felt after the	
intervention in client #1's logbook.	
Intensions on 1/4/22, 1/12/22 and 2/4/22 staff #4	
Interviews on 1/4/22, 1/12/22 and 2/4/22 staff #4 stated:	
-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.	
-Documentation was recorded in client #1's	
logbook.	
Interview on 2/7/22 staff #6 stated:	
-Client #1 only required use of the restrictive	
straps with his "small bed" approximately 1 time	
per week during December of 2021.	
-Precursors to the use of the "small bed" and the	
amount of time the "small bed" was employed	
were documented in the logbook.	
Interview on 2/3/22 staff #7 stated:	
-Client #1 used the "small bed" intervention	
approximately 4 times per month.	
-The use of the "small bed" intervention was	
recorded in client #1's logbook.	
-Interventions were "generally" recorded in client	
#1's logbook.	
Interview on 2/4/22 staff #8 stated:	
Interview on 2/4/22 staff #8 stated: -Staff were supposed to record behaviors and	
causal factors leading to the behaviors in client	
#1's logbook.	
-The logbook was not accurate, as staff often	

Division of Health Service Regulation

failed to complete documentation requirements

1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDFLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMP	LETED	
		MHL071-027	B. WING		03/	01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE			
RAINBOV	/ FADMS	200 ISLAN	D CREEK RO	AD			
KAMBOV	TARMS	ROCKY PO	DINT, NC 284	57			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 526	Continued From page	85	V 526				
	appropriately.						
	intervention approxim full month she worked -Staff documented all "small bed" intervention -Documentation was rall staff. Interview on 2/4/22 star-Client #1 had used the approximately 2 -3 time-She documented all a "small bed" intervention.	#1 had used the "small bed" ately 10 times for the last I (October). actions related to use of the on in client #1's logbook. not recorded accurately by aff #9 stated: ie "small bed" intervention					
	(QP)/ Executive Direct -All data pertaining to bed" intervention were logbookShe was responsible documentation and en This deficiency is cros NCAC 27G .0203 Con Professionals and Ass	the details of the "small a recorded in client #1's for reviewing all client asuring it was implemented. s referenced into 10 A appetencies of Qualified ociate Professionals ule violation and must be					
V 528	10A NCAC 27E .0104 PHYSICAL RESTRAI		V 528				

Division of Health Service Regulation

PRINTED: 03/02/2022

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING MHL071-027 03/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 ISLAND CREEK ROAD **RAINBOW FARMS ROCKY POINT, NC 28457** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 528 V 528 Continued From page 86 FOR BEHAVIORAL CONTROL (g) When a restrictive intervention is used as a planned intervention, facility policy shall specify: (1) the requirement that a consent or approval shall be considered valid for no more than six months and that the decision to continue the specific intervention shall be based on clear and recent behavioral evidence that the intervention is having a positive impact and continues to be needed; (2) prior to the initiation or continued use of any planned intervention, the following written notifications, consents and approvals shall be obtained and documented in the client record: (A) approval of the plan by the responsible professional and the treatment and habilitation team, if applicable, shall be based on an assessment of the client and a review of the documentation required by Subparagraph (e)(9) and (e)(14) of this Rule if applicable; (B) consent of the client or legally responsible person, after participation in treatment planning and after the specific intervention and the reason for it have been explained in accordance with 10A NCAC 27D .0201; (C) notification of an advocate/client rights representative that the specific intervention has been planned for the client and the rationale for utilization of the intervention; and (D) physician approval, after an initial medical examination, when the plan includes a specific intervention with reasonably foreseeable physical consequences. In such cases, periodic planned monitoring by a physician shall be incorporated into the plan.

Division of Health Service Regulation

This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that consent or approval

	MENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PL	AN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED	
		MHL071-027	B. WING		03	/01/2022	
NAME	F PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
PAINE	OW FARMS	200 ISLA	ND CREEK RO	AD			
KAINE	OWTARMS	ROCKY	POINT, NC 284	57			
(X4) II PREF TAG	X (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 5	28 Continued From page	87	V 528				
	for planned restrictive considered valid for n and that the decision intervention shall be behavioral evidence thaving a positive impa	interventions shall be o more than six months, to continue a specific based on clear and recent					
	Review on 1/5/22 and 1/6/22 of client #1's record revealed: -31 year-old male -Admission date of 6/10/09 -Diagnoses of autism spectrum disorder and intellectual disability-severe -No documentation of semi-annual reviews for planned restrictive interventions since May of 2017						
	-"WHAT OTHERS NE SUPPORT MELife/s need a break, I will wa small bed and for the I gesture) that legs be s sensory needs I have -" WHAT OTHERS NE SUPPORT MEMedi	n dated 6/1/21 revealed: ED TO KNOW TO BEST Situation: When asked if I Ilk in my room toward my most part I only request (by strapped. This is due to had for many years." EED TO KNOW TO BEST cal/Behavioral: I have as in place related to these					
	Plan dated 12/2/21 rev -"Background Informat restrictive nature of the well as his preferred a specialized bed with le	cion Due to the very e wrist band procedure (as ctivity of staying in a g and wrist restraints (aka ent #1's] goals has been to					

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	120	
		MHL071-027	B. WING		03/0	1/2022	
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE			
DAINDO	EADMC.	200 ISLAN	D CREEK ROA	D			
RAINBOW	FAKWS	ROCKY PO	INT, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 528	ASAP (Autism Supporpreferred to keep the (Human Rights Commithat are outside the support Plan)." -"Clinical Formulation use the restraint bed in SIB or physical agrequently), as well a onset of precursor be [Program Director] do additional strategies. Review on 1/5/22 an Rights Committee (Hodated 5/24/17 - 5/26/HRC members apprefersoribed hospital only used upon [clien 'yes'/'no' cards." -HRC members appreciated only at the required only at the required Review on 1/14/22 of notes/emails dated 1/1-There was no docur client #1. -There was no docur client #1's restrictive Interview on 1/10/22 (QP)/ Executive Directlient #1's behavior by HRC and were in support plan and incomposite the support plan and incomposite th	discarding the wrist band. ort and Programs) staff have small bed as per their HRC mittee) recommendations scope 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, oes not feel like they need" d 1/6/22 of ASAP Human IRC) document signed and /17 revealed: roved the use of a bed with safe straps that are nt #1's] request using roved the use of "arm bands uest of [client #1]." of 5 HRC meeting 10/28/19 - 8/10/21 revealed: mentation present identifying mentation present identifying interventions. the Qualified Professional ector (ED) stated: r interventions were approved cluded in his behavior lividual support plan. n when HRC last gathered	V 528				
1	-one was responsible	le for reviewing all client					

Division of Health Service Regulation

documentation and ensuring it was implemented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL071-027	B. WING		03/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	
RAINBOW	V FARMS		AND CREEK ROAD	K.	
		ROCKY	POINT, NC 28457		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 528	Continued From page	89	V 528		
	NCAC 27G .0203 Cor Professionals and Ass	rule violation and must be			
V 529	27E .0104(g3-6) Clien	t Rights - Sec. Rest. & ITO	V 529		
	FOR BEHAVIORAL Co. (g) When a restrictive planned intervention, f. (3) within 30 days of ir planned intervention, t. Committee established .0106 of this Section, t. recommend approval or may abstain from m. (4) within any time dur intervention, if request Advisory Committee sl opportunity to review the plan; (5) if any of the person in Subparagraphs (h)(2) not approve the initial or planned intervention, the initiated or continued. resolution of any disagent the planned intervention accordance with gover (6) documentation in the the use of a planned in	NT AND ISOLATION TECTIVE DEVICES USED ONTROL Intervention is used as a facility policy shall specify: nitiation of the use of a the Intervention Advisory d in accordance with Rule by majority vote, may or disapproval of the plan laking a recommendation; ing the use of a planned ed, the Intervention hall be given the the treatment/habilitation as or committees specified (2) or (h)(3) of this Rule do use or continued use of a the intervention shall not be Appeals regarding the reement over the use of on shall be handled in ning body policy; and the client record regarding thervention shall indicate: quency of debriefing with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			ADMINISTRAÇÃO PORTES DE CONTRAÇÃO DE CONTRARADA DE			
		MHL071-027	B. WING		03/01/2022	
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STAT			
RAINBOW	FARMS		D CREEK ROAL DINT, NC 28457			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 529	Continued From page	e 90	V 529			
	necessary. Debriefin	g shall be conducted as to				
	the level of cognitive	functioning of the client;				
		ation of the planned by the onal who approved the				
	planned intervention;					
	(C) review, at least m	nonthly, by the				
		team that approved the				
	planned intervention.					
	This Rule is not met					
		ews and interviews, the documentation in the client				
		d frequency of debriefing,				
	bi-monthly evaluation	ns of the planned				
		nthly review of the planned				
		eatment/habilitation team s (client #1). the findings				
	are:					
	Daviou on 1/5/22 on	d 1/6/22 of client #1's record				
	revealed:	u 170722 OF CHEFTE# ES TECOTO				
	-31 year-old male					
	-Admission date of 6					
		n spectrum disorder and				
	intellectual disability-	-severe of description and frequency				
1	of debriefing					
	-No documentation of	of bi-monthly evaluations of				
	the planned interven					
		of monthly reviews of the by the treatment/habilitation				
	team					
	Review on 1/5/22 on	nd 1/6/22 of client #1's				
	- [2]	lan dated 6/1/21 revealed:				
	-"WHAT OTHERS N	EED TO KNOW TO BEST				
		e/Situation: When asked if I				
		walk in my room toward my				
	small bed and for the	e most part I only request (by				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL071-027	B. WING		03/	01/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
RAINBOW FARMS		D CREEK ROA			
	ROCKY PO	DINT, NC 2845	7		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE	(X5) COMPLETE DATE
sensory needs I have -"WHAT OTHERS NE SUPPORT ME Sch beside supports with bands and supports uld like the small bed needed for me to eng specific item or maint cannot physically put myself in the small be must physically assist those coping strategie -" WHAT OTHERS NI SUPPORT ME Med staff keep data sheets following activities: me behaviors, sleep, wrist in small bed, leisure tiprivate time, choices of injuries, and behavior restrictions in place realist and behavior plan. Review on 1/11/22 of Plan dated 12/2/21 re -"Background Informates restrictive nature of the well as his preferred as specialized bed with lees she in the second preferred to keep the second preferred to keep the support Plan)." -"Clinical Formulation."	strapped. This is due to had for many years." EED TO KNOW TO BEST ool/Vocational: I will stand my arm out to request arm use yes/no cards to ask me if so supports are always age and say I want the ain that routine. I also on the arm band or put and independently, someone are with implementing as." EED TO KNOW TO BEST dical/Behavioral: Support as to track/document the eals, bowels, urination, at cuff removals, time spent and activities, personal of activities, body scan for chartsI have documented elated to these risks in my n." client #1's Behavior Support vealed: tion Due to the very e wrist band procedure (as activity of staying in a leg and wrist restraints (aka lient #1's] goals has been to	V 529			

Division of Health Service Regulation

CTATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING			
		MHL071-027	B. WING		03/01	/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
RAINBOW	FARMS		D CREEK ROAL			
			OINT, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 529	onset of precursor be [Program Director] do additional strategies. Review on 2/4/22 of dates of 10/6/21 - 2/2 - There were over 30 citing the use of the "-There was no described debriefing for over 30 the "small bed" interview on 1/5/22 an Rights Committee do 5/24/17 - 5/26/17 review on 1/5/24 and Rights Committee do 5/24/17 - 5/26/17 review on 1/5/24 and The serview on 1/14/22 on the serview on 1/14/22	gression (SIB most s PRN (as needed) at the chaviors. At the current time, bes not feel like they need" client #1's Logbook for the 2/22 revealed: shifts with specific entries 'small bed" intervention. iption and frequency of precorded shift entries where vention was recorded. d 1/6/22 of ASAP Human becument signed and dated vealed: proved the use of a bed with safe straps that are not #1's] request using proved the use of "arm bands uset of [client #1]." of 5 board meeting 10/28/19 - 8/10/21 revealed: mentation present identifying interventions. s with client #1 on 1/5/22 and deessful due to verbal at #1's detachment from the	V 529	DETICION		
	use of "small bed."	riefing requirements following				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL071-027	B. WING		03/	03/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE			
RAINBOV	VFARMS		D CREEK RO				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 529	client #1's logbook at were not completed by not accurate. Interviews on 1/4/22, stated: -There were no specific requirements with regular when he finished the intervention. Interview on 2/4/22 stated: -All actions related to recorded in client #1's -There were no debried use of "small bed." Interview on 1/10/22 at Professional (QP)/ Exestated: -Client #1's behavior in by a board and were in support plan and indiving a board and were in support plan and indiving the was not certain with due to COVID 19Team reviews were consulted the COVID 19 emergence. This deficiency is cross NCAC 27G .0203 Comprofessionals and Asset	at #1 were to be recorded in the end of each shift but y all staff regularly and were 1/12/22 and 2/4/22 staff #4 The documentation and to follow-up with client the use of the "small bed" aff #8 stated: use of the "small bed" were logbook. If the graph of the	V 529				
V 537	27E .0108 Client Right	s - Training in Sec Rest &	V 537				

Division of Health Service Regulation

STATE FORM

Divisio	n of Health Service Regu	lation				
STATEM	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SU COMPLE	
		MHL071-027	B. WING		03/01	1/2022
NAME O	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		200 ISLA	ND CREEK ROAD			
RAINB	OW FARMS	ROCKY	POINT, NC 28457			
(X4) IE PREFI TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 5	27 Continued From page 10A NCAC 27E .010 SECLUSION, PHYSI ISOLATION TIME-OI (a) Seclusion, physic time-out may be empleen trained and have competence in the pitto these procedures. Staff authorized to emprocedures are retracompetence at least (b) Prior to providing disabilities whose traincludes restrictive in service providers, envolunteers shall competence at least (b) Prior to providing disabilities whose traincludes restrictive in service providers, envolunteers shall competence at least (c) A pre-requisite for demonstrated. (c) A pre-requisite for demonstrating competraining in preventing the need for restrictive (d) The training shall include measurable measurable testing (behavior) on those comethods to determine course. (e) Formal refreshe by each service providers.	Re 94 8 TRAINING IN ICAL RESTRAINT AND UT cal restraint and isolation bloyed only by staff who have we demonstrated roper use of and alternatives Facilities shall ensure that imploy and terminate these ined and have demonstrated annually. direct care to people with eatment/habilitation plan interventions, staff including imployees, students or plete training in the use of estraint and isolation time-out ese interventions until the I and competence is or taking this training is etence by completion of g, reducing and eliminating we interventions. I be competency-based,	V 537		SATE	
	provider plans to em the Division of MH/D Paragraph (g) of this	s Rule. ing programs shall include,				

DIVISION	of Health Service Regu	lation			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL071-027	B. WING		03/01/2022
NAME OF P	ROVIDER OR SUPPLIER	CTDEET AF	DRESS, CITY, ST	ATE ZIR CODE	1 00/0 //2022
			ND CREEK RO		
RAINBOW	/ FARMS		OINT, NC 284		
/VA) ID	SLIMMADVSTA				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	BE COMPLETE
V 537	Continued From page	95	V 537		
	(1) refresher infithe use of restrictive in (2) guidelines of (2) emphasis or rights and dignity of all concepts of least restrincremental steps in a (4) strategies for of restrictive interventions which increases sment and monity psychological well-being use of restraint through restrictive interventions (6) prohibited profession (7) debriefing string documentation of initial at least three years. (1) Documentation (A) who participate outcomes (pass/fail); (B) when and who (C) instructor's in (2) The Division review/request this documents: (1) Trainers shall by scoring 100% on testing the strictive intervention (3) instructor Qualificate (4) requirements: (1) Trainers shall by scoring 100% on testing the strictive intervention (5) instructor Qualificate (6) instructor Qualificate (7) requirements:	ormation on alternatives to nterventions; in when to intervene ent danger to self and in safety and respect for the Il persons involved (using ictive interventions and in intervention); in the safe implementation ons; intergency safety clude continuous toring of the physical and ing of the client and the safe thout the duration of the se; and on methods/procedures, including their se; and on methods/procedures. Shall maintain in and refresher training for on shall include: ited in the training and the mere they attended; and itame. of MH/DD/SAS may cumentation at any time.	V 557		
		I demonstrate competence sting in a training program			

Division of	of Health Service Regu	lation		The state of the s			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL071-027	B. WING		03/01/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE			
		200 ISLA	ND CREEK ROA	D			
RAINBOW	FARMS	ROCKY P	OINT, NC 28457	7	, , , , , , , , , , , , , , , , , , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE		
V 537	Continued From page		V 537				
	The state of the s	eclusion, physical restraint					
	and isolation time-ou	t. all demonstrate competence					
		grade on testing in an					
	instructor training pro						
	(4) The training	The control of the co					
		nclude measurable learning					
		ole testing (written and by rior) on those objectives and					
		s to determine passing or					
	failing the course.	to actorning passing or					
	(5) The conten	t of the instructor training the					
	service provider plan	1					
		sion of MH/DD/SAS pursuant					
	to Subparagraph (j)(6) (6) Acceptable	instructor training programs					
		be limited to, presentation					
	100000	ing the adult learner;					
		or teaching content of the					
	course;						
	1	of trainee performance; and					
	1 '	tion procedures. nall be retrained at least					
		strate competence in the use					
		al restraint and isolation					
		d in Paragraph (a) of this					
	Rule.						
	CPR.	nall be currently trained in					
		hall have coached experience					
		of restrictive interventions at					
	least two times with coach.	a positive review by the					
		nall teach a program on the					
		erventions at least once					
	annually.						
	1	nall complete a refresher					
	instructor training at	least every two years.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL071-027	B. WING		03/	01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
RAINBOW	/ FARMS	200 ISLA!	ND CREEK RO	AD		
TOMINDOT	T AKMO	ROCKY P	OINT, NC 284	57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 537	training for at least thr (1) Documental (A) who participal outcome (pass/fail); (B) when and who instructor's (2) The Division review/request this documents as a train (1) Qualifications of Coccess should be competed by complete and the course which is competence by complete and the competence by complete and the course which is considered and the course which is consider	shall maintain al and refresher instructor ree years. tion shall include: ated in the training and the where they attended; and name. n of MH/DD/SAS may becomentation at any time. oaches: all meet all preparation iner. all teach at least three ch is being coached. all demonstrate detion of coaching or ction. hall be the same ners. as evidenced by: ews, observation, and failed to ensure 2 of 8 #3) received annual training hysical restraint and a findings are: taff #1's personnel record	V 537			
	training dated 9/3/20,	Ţ.				

Division of Health Service Regulation								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
MHL071-027		MHL071-027	B. WING		03/01/2022			
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	FE, ZIP CODE				
RAINBOW FARMS 200 ISLAN		ID CREEK ROA DINT, NC 2845						
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE		
V 537	Review on 1/5/22 of srevealed: -Date of Hire: 10/8/20 -Job Title: Paraprofes -EBPI dated 11/6/20, -No documentation or Observation on 1/5/2 revealed: -Staff #1 was providir -Client #1 was observed with the bedroom lighten of the small bed) with 4 from the bed and cores wrists and anklesThe "small bed" was second bed which was bed " which clientThe client did not apunresponsive to dialocate the second of 1/5/20 -She had been rehired January 3, 2022She had previously approximately 3 yearsThe afternoon of 1/5/20 -She had used the " sclient #1 since her resultThe Program Direct the "small bed" strap	staff #3 's personnel record sisional expired 11/6/21 f updated EBPI training 2 at approximately 11:45am ag 1:1 services with client #1. wed alone in his bedroom at out. a bed (identified by staff as leather straps extending anected to both of client #1 ' a positioned adjacent to a as identified by staff as the at used for sleeping. appear in distress and was ap	V 537	DEFICIENCY)				
	stated:	1/11/22, and 2/4/22 staff #3 oyed with the agency for over						

-She initially estimated client #1 had used the

PRINTED: 03/02/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ((X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BUILDING:			
		MHL071-027	B. WING		03	3/01/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE		
4.0000000000000000000000000000000000000			ND CREEK ROAD			
RAINBOV	V FARMS		POINT, NC 28457			
(X4) ID	SUMMARYST	FATEMENT OF DEFICIENCIES			CORRECTION	
PREFIX TAG	(EACH DEFICIENC	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	COMPLETE DATE
V 537	Continued From page 99		V 537			
	"small bed"intervention 2-3 times per week in the month of December, 2021Client #1 would only utilize the straps in his bed about 50% of the time the bed was used.					
	Interviews on 1/14/22	2, and 2/8/22 the Qualified				
	no additional question	recutive Director (ED) had ns related to EBPI trainings.				
	ris additional quotion	to rotated to EDI Titalinings.				



March 21, 2022

Plan of Correction: DHSR – MHL Annual & Complaint Survey 3/1/2022 MHL # 071-027 (Rainbow Farms) Intake #NC00184029 & #NC00185589

1. 27G .0203 Privileging/Training Professionals

- Qualified Professional will provide closer supervision of all team members.
- Qualified Professional will immediately develop a written individualized plan for Associate Professional to monitor competency in each core skill.
- Moving forward, Executive Director will ensure all professionals receive a written individualized plan upon hire and monitor monthly.

2. 27G .0205 Assessment and Treatment/Habilitation or Service Plan

- Qualified Professional will review all assessments and strategies for each participant in the program.
- Qualified Professional will be responsible for overseeing staff implementation of all strategies outlined in each plan.
- Qualified Professional will perform monthly supervisions with all staff and document implementation of all strategies, concerns, and feedback on progress of all goals with participants.

3. 27G .5602 Supervised Living for Adults with Mental Illness-Staff

- Effective immediately all shifts will have 2 staff members present to remain in compliance with staff-client ratios. All staff will be able to effectively remove all residents from the facility in the event of an emergency.
- Programs Director will be responsible for ensuring two staff members are scheduled across all three shifts.

4. 27G .0603 Incident Response Requirements for Category A and B Providers (V366)

- All staff members will receive training and will be required to document in writing any occurrences of behavioral episodes or injuries utilizing forms for incident reporting. Agency will maintain the incident reports on-site in a separate notebooks.
- Qualified Professional/Programs Director will ensure all staff attend training classes to review procedure for completing incident reports. Qualified Professional/Associate Professional will ensure all Level I and Level II incident reports are maintained in notebook identified by location.

5. 27G .0604 Incident Response Requirements for Category A and B Providers (V367)

- Agency will inform local LME of all Level II or higher incident via the Incident Response Improvement System (IRIS) within 72 hours.
- Qualified Professional/Programs Director will be responsible for ensuring all staff members complete written reports to provide detailed information referencing the occurrence.

6. 27E .0101 Least Restrictive Alternative (V513)

- All staff members will receive a refresher training to understand the process of using least restrictive interventions to assist in de-escalation of maladaptive behaviors.
- Programs Director, who is also the EBPI (Evidenced Based Protective Interventions) Instructor, will be responsible for ensuring all new staff receive this training upon hire and current staff will immediately receive a refresher training.

7. 27E .0102 Prohibited Procedures (V514)

- Agency will immediately discontinue use of "small bed" as a means to assist with
 de-escalation of maladaptive behaviors. All staff were informed via email that
 this practice has been discontinued and least restrictive EBPI interventions will be
 used moving forward. Approved EBPI restrictive interventions will be used as a
 last resort to ensure the safety of each resident.
- Qualified Professional/Programs Director will ensure each staff remains current on his/her EBPI certification and will be informed anytime restrictive EBPI interventions are utilized.

8. 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V518)

- All staff will be retrained on monitoring requirements during use of restrictive interventions. Moving forward all staff members will discontinue use of "small bed" and will utilize least restrictive and/or restrictive (when necessary) EBPI interventions to de-escalate maladaptive behaviors.
- Qualified Professional/Associate Professional/Programs Director will be responsible for ensuring all staff are providing required monitoring of all residents.

9. 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V521)

- All staff members will receive training and will be required to document in
 writing any occurrences of behavioral episodes on formal incident reports. All
 incident reports will be kept in a binder which will be maintained and reviewed by
 the Qualified Professional.
- Qualified Professional/Programs Director will be responsible for ensuring all staff members are writing these detailed reports and submitting them in the required time frame.

10. 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V523)

- All staff will be retrained on monitoring requirements during use of restrictive interventions. Moving forward all staff members will discontinue use of "small bed" and will utilize least restrictive and/or restrictive (when necessary) EBPI techniques to de-escalate maladaptive behaviors. All staff members will utilize 15-minute checklist for monitoring the safety and well-being during use of restrictive interventions for all residents.
- Qualified Professional/Associate Professional/Programs Director will be responsible for ensuring all staff are providing required monitoring of residents during the use of any approved EBPI interventions.

11. 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V524)

- Effective immediately all parents, legal guardians, and treatment team will be notified each time an approved EBPI restrictive intervention is utilized.
- Qualified Professional/Associate Professional/Programs Director will be responsible for this notification and documenting the method of contact, which will be kept in the client's record.

12. 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V525)

- Agency will maintain an accurate log of all EBPI approved restrictive interventions.
- Qualified Professional and Human Rights Committee will meet quarterly and review all rights restrictions every 6 months for any trends or other interventions that may be effective in reducing maladaptive behaviors.

13. 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V526)

- All staff members will receive training and will be required to document in writing any occurrences of behavioral episodes or injuries utilizing forms for incident reporting.
- All incident reports will include details of the least restrictive and/or restrictive interventions, effectiveness of the interventions, and how long the intervention(s) lasted.
- Qualified Professional/Associate Professional/Programs Director will be responsible for ensuring all staff are completing detailed incident reports with required information for all residents.

14. 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V528)

- Agency will immediately discontinue use of "small bed" (planned intervention) to
 assist with de-escalation of maladaptive behavior(s). All staff were informed via
 email that this practice has been discontinued and least restrictive EBPI
 techniques will be used moving forward. Approved EBPI restrictive techniques
 will be used as a last resort to ensure the safety of each resident.
- Qualified Professional, Human Rights Committee, and Treatment Team will review any "planned" restrictive interventions bi-monthly for any trends or other interventions that may be effective in reducing maladaptive behaviors.

15. 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V529)

- Agency will develop operating procedure with clear bi-monthly timelines to review all planned interventions with the Treatment Team and Human Rights Committee.
- Qualified Professional will be responsible for facilitating these meetings and document the outcome in the client's record.

16. 27E .0108 Training in Seclusion, Physical Restraint, and Isolation Time-Out (V537)

- All staff members will receive a refresher training to understand the process of using least restrictive interventions to assist in de-escalation of maladaptive behaviors.
- Programs Director, who is also the EBPI (Evidenced Based Protective Interventions) Instructor, will be responsible for ensuring all new staff receive this training upon hire and current staff will immediately receive a refresher training.

17. 27G. 0205 Assessment and Treatment/Habilitation or Service Plan

- Agency will review ISP for client #1 and immediately implement 15-minute tracking of client's maladaptive behaviors (SIB, physical aggression, or property destruction).
- Agency will review "Partial Interval Recording Sheet" with all staff to accurately record specified maladaptive behaviors.
- Qualified Professional/Associate Professional will be responsible for ensuring 15minute checklist and "Partial Interval Recording Sheet" are completed daily for all specified hour intervals.

18. 27G .0207 Emergency Plans and Supplies

- Agency will perform monthly Fire/Disaster drills. One of each drill will be unannounced and one of each drill will be performed across all 3 shifts.
- Fire evacuation routes will be posted from each room and practiced during drills.
- Programs Director will be responsible for ensuring these drills are performed and documented properly and kept in an on-site binder.

19. 27G .0209 (C) Medication Requirements

- All med-certified staff will receive a refresher training on proper procedures to administer medications to all residents. Training will also include accurately documenting on the MAR when a medication has been administered to a client.
- Any errors or missed doses will immediately be reported to the Programs Director and an incident report with supporting details will be written.
- Programs Director/Associate Professional will be responsible for ensuring the MARs are completed accurately and any errors are immediately documented.

20. 27G .5602 Supervised Living - Staff

- Agency will review the requirements of all residents' ISPs and retrain all staff members.
- Client #1 will receive close 1:1 staffing and supervision; all residents will have 24-hour awake staff at night for the safety of all residents; All residents will receive 15-minute monitoring for their safety and all needs pertaining to their care.
- Qualified Professional/Associate Professional/Programs Director will be responsible for ensuring all staffing requirements are being met and accurate monitoring is being completed.

21. 27G .5603 Supervised Living – Operations

- Agency will ensure all residents are scheduled and taken to appointments with professionals for all their routine needs and care.
- Physician notes will be included in the resident's files, detailing the outcome of each visit.
- Programs Director will be responsible for coordination of all physician appointments and any follow-up appointments as needed.

22. 27G .0603 Incident Response Requirements

- Agency will input all Level II and Level III incident reports with details into the IRIS system within 72 hours of the incident.
- Agency will keep detailed incident reports for all residents on-site in a binder for review.
- Qualified Professional will be responsible for inputting incident reports into the IRIS system and maintaining the binder.

23. 27G .0604 Incident Response Requirements

- Agency will input all Level II and Level III incident reports with details into the IRIS system within 72 hours of the incident.
- Agency will keep detailed incident reports for all residents on-site in a binder for review.
- Qualified Professional will be responsible for inputting incident reports into the IRIS system and maintaining the binder.

24. 27E .0101 Least Restrictive Alternative

- Agency immediately discontinued the use of the "small bed" as an intervention to de-escalate any occurrences of aggression or maladaptive behaviors.
- All staff will be retrained to utilize least restrictive EBPI techniques to assist with calming and anxiety displayed by the residents.
- Programs Director will ensure all staff are retrained and are competent in utilizing least restrictive interventions; EBPI approved restrictive interventions will only be used as a last resort to maintain the safety of each resident.

25. 27E .0102 Client Rights – Prohibited Procedures

- Agency immediately discontinued the use of the "small bed" as an intervention to de-escalate any occurrences of aggression or maladaptive behaviors.
- All staff will be retrained to utilize least restrictive EBPI techniques to assist with calming and anxiety displayed by the residents.
- Programs Director will ensure all staff are retrained and are competent in utilizing least restrictive interventions; EBPI approved restrictive interventions will only be used as a last resort to maintain the safety of each resident.

26. 27E .0104 (e1-2) Seclusion, Physical Restraint, and Isolation Time-Out and Protective Devices Used For Behavioral Control

- Agency immediately discontinued the use of the "small bed" as an intervention to de-escalate any occurrences of aggression or maladaptive behaviors.
- All staff will be retrained to utilize least restrictive EBPI techniques to assist with calming and anxiety displayed by any of the residents. Staff will be retrained to visually monitor all residents every 15 minutes and while implementing any EBPI (least and/or restrictive) approved interventions.
- Programs Director will ensure all staff are retrained and are competent in utilizing least restrictive interventions; EBPI approved restrictive interventions will only be used as a last resort to maintain the safety of each resident.

27. 27E .0104 (e9) Seclusion, Physical Restraint, and Isolation Time-Out and Protective Devices Used For Behavioral Control

- All staff members will receive training and will be required to document in writing any occurrences of behavioral episodes or injuries utilizing forms for incident reporting.
- All incident reports will include details of the least restrictive and/or restrictive interventions, effectiveness of the interventions, and how long the intervention(s) lasted.
- Qualified Professional/Associate Professional/Programs Director will be responsible for ensuring all staff are completing detailed incident reports with required information of client #1 and all other clients.

28. 27E .0104 (e11) Seclusion, Physical Restraint, and Isolation Time-Out and Protective Devices Used For Behavioral Control

- Agency immediately discontinued the use of the "small bed" as an intervention to de-escalate any occurrences of aggression or maladaptive behaviors.
- All staff will be retrained to utilize least restrictive EBPI techniques to assist with calming and anxiety displayed by any of the residents. Staff will be retrained to visually monitor all residents every 15 minutes and while implementing any EBPI (least and/or restrictive) approved interventions.
- Programs Director will ensure all staff are retrained and are competent in utilizing least restrictive interventions; EBPI approved restrictive interventions will only be used as a last resort to maintain the safety of each resident.

29. 27E .0104 (e12-16) Seclusion, Physical Restraint, and Isolation Time-Out and Protective Devices Used For Behavioral Control

- Effective immediately all parents, legal guardians, and treatment team will be notified each time an approved EBPI restrictive intervention is utilized.
- Qualified Professional/Associate Professional/Programs Director will be responsible for this notification and documenting the method of contact, which will be kept in the client's record.

30. 27E .0104 (e17) Seclusion, Physical Restraint, and Isolation Time-Out and Protective Devices Used For Behavioral Control

- Agency will maintain an accurate log of all EBPI approved restrictive interventions.
- Qualified Professional and Human Rights Committee will review all rights restrictions bi-monthly for any trends or other interventions that may be effective in reducing maladaptive behaviors.

31. 27E .0104 (e18-19) Seclusion, Physical Restraint, and Isolation Time-Out and Protective Devices Used For Behavioral Control

- All staff members will receive training and will be required to document in writing any occurrences of behavioral episodes or injuries utilizing forms for incident reporting. Agency will maintain the incident reports on-site in a separate notebook for each location.
- Qualified Professional/Programs Director will ensure all staff attend training to review procedure for completing incident reports. Qualified Professional will ensure all Level I and Level II incident reports are maintained in these notebooks.

32. 27E .0104 (g1-2) Seclusion, Physical Restraint, and Isolation Time-Out and Protective Devices Used For Behavioral Control

- Agency will immediately discontinue use of "small bed" (planned intervention) to
 assist with de-escalation of maladaptive behavior(s). All staff were informed via
 email that this practice has been discontinued and least restrictive EBPI
 techniques will be used moving forward. Approved EBPI restrictive techniques
 will be used as a last resort to ensure the safety of each resident.
- Qualified Professional, Human Rights Committee, and Treatment Team will review any "planned" restrictive interventions bi-monthly for any trends or other interventions that may be effective in reducing maladaptive behaviors.

33. 27E .0104 (g3-6) Seclusion, Physical Restraint, and Isolation Time-Out and Protective Devices Used For Behavioral Control

- Agency will develop operating procedure with clear bi-monthly timelines to review all "planned interventions" with the Treatment Team and Human Rights Committee.
- Qualified Professional will be responsible for facilitating these meetings and document the outcome in the client's record.

34. 27E .0108 Training In Seclusion, Physical Restraint, and Isolation Time-Out

- All staff members will receive a refresher training to understand the process of using least restrictive interventions to assist in de-escalation of maladaptive behaviors.
- Programs Director, who is also the EBPI (Evidenced Based Protective Interventions) Instructor, will be responsible for ensuring all new staff receive this training upon hire and current staff will immediately receive a refresher training. Certificates identifying completion of this training will be kept in staff's file and updated at least annually.

