

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL083-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2023
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NAME OF PROVIDER OR SUPPLIER RAINBOW 66 STOREHOUSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 22521 BUNCH ROAD LAUREL HILL, NC 28351
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual survey was attempted on May 5, 2023. According to the Director of Operations there were no clients being served at the facility. The last time clients were served at the facility was April 9, 2023.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services for individuals of all Disability Groups (Residential).</p> <p>Interview on 5/5/23 the Director of Operations stated she would notify the appropriate parties when clients were being served.</p>	V 000		

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