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SUNNYSIDE RETIREMENT HOME	1600 U.S. HIGHWAY 221 S. FOREST CITY, NC 28043

(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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up and complaint investigation on January 31, 2023 through February 2, 2023 with an exit conference via telephone on February 2, 2023.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure health care referral and follow up for 2 of 5 sampled residents (#1 and #2) related to a resident who was not feeling well, developed a congested cough for two days, and was admitted to the hospital the third day after experiencing worsening symptoms (#1), and physician order to notify the Primary Care Provider of a resident's finger stick blood sugar (FSBS) greater than 400 (#2). The findings are: 1. Review of Resident #1's current FL2 dated 12/27/22 revealed: -Diagnoses included Parkinson's Disease, mild mental disabilities, iron deficiency, vitamin B12 deficiency, allergic rhinitis and constipation. -An order for Tylenol 325mg, 2 tablets three times a day. -An order for children's allergy 12.5mg every 8 hours as needed for allergies.	D 273		

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Review of Resident #1's care notes for December 2023 revealed there were no care notes documented.

Review of the county emergency medical services (EMS) Report dated 12/31/22 revealed:
-On 12/31/22, a call was placed to 911 from the facility at 5:32pm.
-At 5:47pm EMS arrived at the facility to find Resident #1 lying in bed on her left side.
-Resident #1 was breathing rapidly and abnormal, very dazed, confused and hot to the touch.
-Staff reported Resident #1 received a scheduled dose of Tylenol 325mg, 2 tablets at 2:00pm.
-Resident #1's blood pressure (BP) was 149/95 (normal was 120/80), heartrate (HR) was 114 (normal 60-100 beats per min), respiratory rate (RR) 44 (normal was 12-20 per minute), temperature of 99.5, and an oxygen saturation of 52% on room air, (normal range is 95% or higher).
-At 6:01pm, Resident #1 was transported to the hospital for evaluation.

Review of Resident #1's Emergency Room (ER) record dated 12/31/22 revealed:
-Initially Resident #1 met the sepsis (a life threatening complication of an infection) criteria (a protocol used when HR was greater than 90, RR was greater than 20, and altered mental status which were signs of infection or sepsis) and was found to have a urinary tract infection.
-Resident #1 was noted to have a large vomitus and was pulseless.
-Cardiopulmonary resuscitation (CPR) was performed for 16 minutes, she was intubated and put on a mechanical ventilator.
-A tube was placed into the stomach through the nose and 200cc of "coffee-ground emesis" was obtained and was tested positive as blood.

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-A computerized tomography(CT scan) indicated the resident had, a massively large rectal stool burden.
-Resident #1 was admitted to the Intensive Care Unit (ICU).

Review of Resident #1's Admission note dated 01/01/23 revealed:
-Aspiration pneumonia due to vomit episode prior to arrival to the hospital and during the cardiac arrest episode.
-An upper gasterinal intestinal (GI) bleed was noted on admission.

Telephone interview with a medication aide (MA) on 01/31/23 at 2:45pm revealed:
-On 12/29/22, Resident #1 complained of not feeling well and a cough.
-It was not abnormal for Resident #1 to cough because she had a "smokers" cough.
-Resident #1 was a heavy smoker and smoking was her favorite thing to do every day.
-She did not think the cough was not abnormal because the resident also had allergies.
-On 12/30/22, Resident #1 complained of not feeling good, and her cough was a little worse and had a little congestion.
-She offered Resident #1 some of her as needed allergy medication and Resident #1 refused.
-She offered to call Resident #1's physician but Resident #1 refused.
-She did not call the physician because she did not "feel the need".
-On 12/31/22, Resident #1 complained of a cough and congestion that were a little worse, not feeling well, not wanting to eat breakfast and wanted to go lay down.
-She did not consider any of these issues to be a reason to call the physician because Resident #1 sometimes did not want to eat breakfast and

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wanted to go back to bed and the cough, in her opinion was not bad enough yet.
-On 12/31/22, around lunch time Resident #1 still did not want to eat, complained of not feeling well.
-She continued with a cough and congestion, wanted to go back to bed and did not want to go smoke.
-Resident #1 declining to go smoke, which was one of her favorite activities, was not considered as a reason to notify the PCP of an acute change.
-She did not take a temperature because Resident #1 did not complain of a fever and Resident #1 did not feel hot.
-She did not take Resident #1's temperature because there was no order to do so.
-On 12/31/22, between 4:00pm and 5:00pm, the personal care aides (PCAs) called out from Resident #1's room.
-She entered the room and found Resident #1 sitting up in bed with vomit on her and on the pillow.
-Resident #1 was confused, lethargic, coughing really bad, and she called 911.
-While on the phone with 911, she checked Resident #1's oxygen saturation and it was 54% on room air.
-EMS arrived and Resident #1 was transported to the hospital.

Interview with the MA supervisor on 02/01/23 at 10:19am revealed:
-On 12/31/22, the MA on duty called to notify her Resident #1 was being transported to the hospital for vomiting and aspiration.
-After Resident #1 was sent out to the hospital, the MA called her back and reported that Resident #1 had been sleeping all day, and not feeling good.
-The MA was responsible for notifying the physician when the residents had medical

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complaints.
-The MA could also call her with the complaints from a resident and she would call the resident's physician for the MA.

Telephone interview with Resident #1's primary care provider (PCP) on 01/31/23 at 12:00pm revealed:
-Resident #1 was last seen in the facility on 12/27/22 and had no complaints or medication changes.
-Resident #1 was a heavy smoker, and a history of constipation and allergic rhinitis.
-On 12/31/22, staff notified the on call service Resident #1 was sent out to the hospital for cough, congestion, vomiting and diarrhea.
-She did not receive notification Resident #1 was coughing, not feeling well and congested for 3 days, not eating, and not smoking for 1 day.
-Resident #1 was a heavy smoker and coughed daily.
-She expected the facility to notify her if there was a change in a resident's condition.
-If the facility called with symptoms of cough and congestion, she would order the staff to watch the resident and report any changes in her condition including fever and vomiting.
-Resident #1 not smoking was abnormal.

Interview with the Resident Care Coordinator (RCC) on 02/01/23 at 1:28pm revealed:
-Resident #1 was a heavy smoker and it was normal for her to cough.
-About 2 months ago Resident #1 vomited with episodes of diarrhea and was diagnosed with a fecal impaction.
-Resident #1 would sleep a lot during the day about 3 days a week and just get up to smoke.
-She did not know Resident #1 was complaining of coughing with congestion, sleeping a lot, not

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eating or did not go to smoke.
-The MAs were responsible for notifying the facility physician for changes in Resident #1, and things that were not normal for Resident #1.
-The MAs could also notify the MA supervisor or her at anytime there was a question about a resident but she was not notified about Resident #1 not eating or smoking.
-There was no documenting of Resident #1's recent bowel movements, vital signs, or documentation of a physician's notification completed.

Refer to interview with the Administrator on 02/01/23 at 1:29pm.

2. Review of Resident #2's current FL2 dated 09/26/22 revealed:
-Diagnoses included kidney failure, diabetes mellitus type II, peripheral neuropathy, left below the knee amputation and history of depression.
-There was an order for finger stick blood sugars (FSBS) three times daily before meals.
-There was an order for Humalog (a rapid acting insulin to treat high blood sugars) sliding scale insulin: FSBS: 151-200= 5 units, 201-250= 9 units, 251-300= 13 units, 301-350= 17 units and greater than 351= 20 units.
-There was an order for the facility to notify the primary care provider (PCP) of FSBS greater than 400.

Review of Resident #2's subsequent physician's orders dated 12/13/22 revealed:
-There was an order for FSBS three times daily before meals.
-There was an order for Humalog sliding scale insulin: FSBS: 151-200= 5 units, 201-250= 9 units, 251-300= 13 units, 301-350= 17 units and

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greater than 351= 20 units.
-There was an order for the facility to notify the PCP of FSBS greater than 400.

Review of Resident #2's December 2022 electronic Medication Administration Records (eMAR) revealed:
-There was an order for FSBS three times daily before meals.
-There was an order for Humalog sliding scale insulin: FSBS: 151-200= 5 units, 201-250= 9 units, 251-300= 13 units, 301-350= 17 units and greater than 351= 20 units.
-There was an order for the facility to notify the PCP of FSBS greater than 400.
-Resident #2's FSBS from 12/02/22 at 8:00am to 12/30/22 at 8:00pm was documented as greater than 400 on 20 opportunities ranging from 402 to 498.
-There was no documentation the facility notified the PCP of FSBS greater than 400 for the month of December.

Review of Resident #2's January 2023 electronic Medication Administration Records (eMAR) revealed:
-There was an order to check FSBS three times daily before meals.
-There was an order for Humalog sliding scale insulin: FSBS: 151-200= 5 units, 201-250= 9 units, 251-300= 13 units, 301-350= 17 units and greater than 351= 20 units.
-There was an order for the facility to notify the PCP of FSBS greater than 400.
-Resident #2's FSBS from 01/02/23 at 12:00pm to 01/30/23 at 4:00pm was documented as greater than 400 on 13 opportunities ranging from 401 to 564.
-There was documentation that the facility notified the PCP on 01/30/23 at 12:00pm and 4:00pm.

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D 273	Continued From page 7 -There was no documentation the facility notified the PCP of blood sugars greater than 400 on 01/04/23 at 4:00pm, 01/05/23 at 8:00am and 12:00pm, 01/11/23 at 8:00am, 01/24/23 at 8:00am and 4:00pm and 12/29/23 at 4:00pm Interview with a medication aide (MA) on 02/01/23 at 11:15am revealed: -The MAs were responsible for checking resident's FSBS three times daily before meals. -If the resident's FSBS was greater than 400, she notified the RCC who was responsible for sending the PCP a message via the facilities paging system. -She did not have access to the facility's paging system. -She sometimes called the PCP's office and would leave a message. -She stated that the PCP office did not always return calls. -She did not always follow up with the PCP office when calls were not returned. -The PCP office would sometimes fax orders for MA to follow after being notified of a FSBS greater than 400. Interview with the RCC on 02/01/23 at 2:00pm revealed: -The MAs were responsible for checking resident's FSBS three times daily before meals. -If the Resident's blood sugar was greater than 400, she was notified by the MA and would send a message to the PCP using the facility's paging system. -She would sometimes call the PCP office and leave a message. -The PCP office did not always return calls. -She was unable to view and/or print any messages that had been sent to the PCP via the facility's paging system.	D 273		

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-The facility sometimes received faxed orders after being messaged via the facility paging system.
-The PCP did not always respond after messages had been sent via the facility paging system.
-She did not receive responses from the PCP office via the paging system.

Telephone interview with Resident #2's PCP on 02/01/22 at 8:15am and 10:59am revealed:
-She did not always receive notification from the facility when Resident #2's FSBS were greater than 400.
-She expected the facility to notify her or her office when Resident #2's FSBS were greater than 400 to adjust residents insulin.
-She was able to view any messages sent via the facility's paging system.
-She did not receive notification of Resident #2's being greater than 400 on 12/03/22 - 12/05/22 at 8:00am, 12:00pm and 4:00pm, 12/11/22 at 8:00am, 12/12/22 at 12:00pm, 12/17/22- 12/19/22 at 12pm, 12/24/22 at 4:00pm, 12/25/22 at 12:00pm and 4:00pm, 12/26/22 at 4:00pm, 12/29/22 at 8:00am, 12/30/22 at 8:00am, 01/02/23 at 12:00pm and 4:00pm, 01/04/23 at 4:00pm, 01/05/23 at 8:00am and 12:00pm, 01/11/23 at 8:00am, 01/24/23 at 8:00am and 4:00pm, 12/29/23 at 4:00pm and 01/30/23 at 12:00pm and 4:00pm.
-High blood sugars could lead to vision impairment, hinder wound healing and cause kidney damage.

Refer to interview with the Administrator on 02/01/23 at 1:29pm.

The facility failed to contact the PCP when Resident #1 developed episodes of coughing with

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D 273	Continued From page 9 congestion, complaining of not feeling good, declining to eat meals or participate in one of her favorite activities, resulting in a delay of care and hospitalization of aspiration pneumonia(#1), and not following the physician order to notify the primary care provider of FSBS greater than 400 for 29 of 33 occasions (#2). This failure was detrimental to the health, and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 121D-34 on 02/01/23. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 19, 2023.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to administer medications as ordered for 1 of 5 residents (Resident #5) related to an antibacterial skin wash. The findings are:	D 358		

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Review of Resident #5's current FL2 dated 09/26/22 revealed:
-Diagnoses included diabetes and depression.
-An order for Hibiclens (used as an antibacterial skin wash) 4% topical apply liberally to skin once a week while bathing.
-Personal care assistance was needed with bathing.

Review of Resident #5's physician's orders dated 09/20/22 revealed:
-An order to stop Hibiclens twice weekly.
-An order to start Hibiclens 4% topical liquid and apply one liberally to skin once a week.
-"Patient to bathe with this solution once weekly."

Review of Resident #5's September 2022 electronic medication administration record (eMAR) revealed:
-An entry for Hibiclens 4% topical apply liberally to skin once a week while bathing was written on the eMAR.
-There was a line drawn through the dates of 09/01/22 - 09/22/22.
-A backslash was written in from 09/23/22 - 09/26/22.
-A backslash was written in from 09/28/22 - 09/30/22.
-Hibiclens was documented as administered on 09/27/22.

Review of Resident #5's October 2022 eMAR revealed there was no entry for Hibiclens.

Review of Resident #5's November 2022 eMAR revealed there was no entry for Hibiclens.

Interview with Resident #5 on 02/01/23 at 10:50am revealed:
-She received assistance from staff with

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showering once a week.
-Staff did not use any medicated liquid when assisting her in the shower.
-She had multiple skin issues in the past few months.
-She had to take antibiotics to help heal her skin.

Observation of Resident #5's medications on hand on 02/01/23 at 11:21am revealed there was no Hibiclens available for application.

Interview with a medication aide (MA) on 02/01/23 at 11:21am revealed:
-Resident #5 was not using Hibiclens.
-She was unaware of an order for Resident #5 to have Hibiclens applied once a week with her shower.

Telephone interview with the facility's consultant Pharmacist on 02/01/23 at 11:39am revealed:
-There was an order dated 09/20/22 for Hibiclens for Resident #5.
-It was to be used once a week while bathing.
-Only one bottle was delivered to the facility for Resident #5 on 08/12/22.
-One bottle was equal to a 30-day supply.
-Hibiclens has not been discontinued for Resident #5.
-They printed the monthly eMAR's for the facility.

Telephone interview with the facility's Nurse Practitioner (NP) on 02/01/23 at 2:04pm revealed:
-Resident #5 had recurrent skin issues including MRSA (a bacterial infection that is highly resistant to treatment with antibiotics).
-She ordered bathing with Hibiclens twice a week in August of 2022 for Resident #5.
-She changed the order in September of 2022 to bathing once a week with Hibiclens for Resident #5.

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SUNNYSIDE RETIREMENT HOME	1600 U.S. HIGHWAY 221 S. FOREST CITY, NC 28043

(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
D 358	Continued From page 12 -Resident #5 should still be given Hibiclens during her weekly shower. -She had not discontinued the order. -She expected staff to follow medication orders until they are discontinued. Interview with the Resident Care Coordinator (RCC) on 02/01/23 at 2:17pm revealed: -She was responsible to check the eMARs from month to month to make sure all medications were carried over to the new eMAR. -Resident #5 had several skin infections. -They had been writing the physician's orders on the eMAR. -The pharmacy was responsible to enter all medications on the eMAR. -There were no nurse's notes with any information about Resident #5's skin issues. -She was not sure why the Hibiclens order was not entered on the eMAR for Resident #5. Interview with the Administrator on 02/01/23 at 3:05pm revealed: -He expected staff to administer all medications to residents per physician's orders. -He thinks the Hibiclens order for Resident #5 got looked over by the RCC when the eMAR was being checked. -It should have been caught during the pharmacy review. -He did not like having orders written on the eMAR from one month to another. -The pharmacy should be putting in any new orders received so they would print out on the next month's eMAR.	D 358		