

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL081042</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>12/03/2014</b> |
|--|--|---|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNNYSIDE RETIREMENT HOME</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1600 U.S. HIGHWAY 221 S.<br/>FOREST CITY, NC 28043</b> |
|--|--|

| (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 |
|--------------------|---|---------------|---|--------------------|
| C 000              | Initial Comments<br><br>Report of Biennial Construction Survey by Dennis Harrell on 12-3-2014.<br><br>Records indicate this facility was first licensed or submitted on 7-1-1972, for 34 residents. Based on this information, we are requiring the facility to meet the 1967 North Carolina State Building Code, the 1971 Minimum and Desired Standards and Regulations for Homes for the Aged and Infirm and the applicable portions of the 2005 Rules for the Licensing of Adult Care Homes of Seven or More Beds.   | C 000         |   |                    |
| C 111              | Must Have Current San. & Fire Safety Reports<br><br>SECTION .0300 - PHYSICAL PLANT<br>10A NCAC 13F .0302 DESIGN AND CONSTRUCTION(<br>f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review.<br><br>This Rule is not met as evidenced by:<br>Based on review of documents, the following reports were not available in the home for review:<br>1. Current sanitation report for the building,<br>2. Current sanitation report for the kitchen,<br>3. Current fire and building safety inspection report,<br>4. Current report of inspection of the fire alarm system. | C 111         |   |                    |
| C 189              | Building Equipment Maintained Safe, Operating<br><br>SECTION .0300 - PHYSICAL PLANT<br>10A NCAC 13F .0311 OTHER REQUIREMENTS  | C 189         |   |                    |

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL081042</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>12/03/2014</b> |
|--|--|---|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNNYSIDE RETIREMENT HOME</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1600 U.S. HIGHWAY 221 S.<br/>FOREST CITY, NC 28043</b> |
|--|--|

| (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 |
|--------------------|---|---------------|---|--------------------|
| C 189              | <p>Continued From page 1</p> <p>(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.</p> <p>(k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.</p> <p>This Rule is not met as evidenced by:</p> <p>1. Based on observation, the facility was not maintained in a safe manner by blocking a fire door open and preventing the door from closing rapidly in order to contain smoke and fire. This could affect all residents and staff by not containing smoke and fire in the room of origin.<br/>Findings include:<br/>The 1½ hour fire door between the kitchen and the sunroom was propped open.</p> <p>2. Based on observation the required one-hour fire rated walls and/or ceilings were compromised in several locations.<br/>Findings include:<br/>a. Hole in wall at TV wire in front stairwell,<br/>b. Hole beside conduit in corridor outside room 16,<br/>c. Crack at corner of ceiling in furnace closet off room 12.<br/>Holes and cracks that are not sealed with materials approved for use in one-hour fire rated construction present the possibility that a fire that begins in one space can quickly spread to other areas of the facility.</p> <p>3. Based on observation, the facility failed to maintain the corridors in a smoke and fire resisting condition because of corridor doors not fitting the openings properly. Corridor doors that do not fit the opening present the possibility that a fire that begins in one space can quickly spread</p> | C 189         |   |                    |

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL081042</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>12/03/2014</b> |
|--|--|---|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNNYSIDE RETIREMENT HOME</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1600 U.S. HIGHWAY 221 S.<br/>FOREST CITY, NC 28043</b> |
|--|--|

| (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 |
|--------------------|---|---------------|---|--------------------|
| C 189              | <p>Continued From page 2</p> <p>to the corridor and the remainder of the facility. Findings include;</p> <p>a. The door stop was missing at the top of the door to room 11,</p> <p>b. The door stop was missing at the side of the door to room 15.</p> <p>4. Based on observation, the exterior light at the exit near room 1 was not working. Inadequate exterior lighting can cause a delay in an emergency evacuation.</p> <p>5. Based on observation, the building was not maintained in a safe manner by not properly handling portable medical oxygen cylinders. This could affect all residents, staff and visitors if cylinders fall, breaking their valves, propelling the cylinder and turning it into a dangerous projectile. Findings include:<br/>Several portable medical oxygen cylinders were not stored in an approved rack in the room under the front stairs.</p> <p>6. Based on observation, there were hasps and padlocks on 2 of the bedroom closets on the second floor. Latching hardware that can only be operated from one side of the door, such as hasps and padlocks, present the possibility that someone could be locked in the closet.</p> | C 189         |   |                    |
| C 191              | <p>Unvented &amp; Portable Elec. Heaters Prohibited</p> <p>SECTION .0300 - PHYSICAL PLANT<br/>10A NCAC 13F .0311 OTHER REQUIREMENTS<br/>(b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking</p>  | C 191         |   |                    |

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL081042</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>12/03/2014</b> |
|--|--|---|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNNYSIDE RETIREMENT HOME</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1600 U.S. HIGHWAY 221 S.<br/>FOREST CITY, NC 28043</b> |
|--|--|

| (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 |
|--------------------|---|---------------|---|--------------------|
| C 191              | <p>Continued From page 3</p> <p>appliances.</p> <p>(2) Unvented fuel burning room heaters and portable electric heaters are prohibited.</p> <p>(k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation, the facility was not maintained in a safe condition because of the use of a portable electric heater.</p> <p>Findings include:<br/>A portable electric heater was found in the office.</p> | C 191         |   |                    |