| Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE | CONSTRUCTION | | (X3) DATE SURVEY | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------|------------------|-----------------|
| ND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: 01 | | COMPLETED | |
| | | HAL081042 | B. WING | | 02/ | 13/2019 |
| IAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S ⁻ | TATE, ZIP CODE | | |
| SUNNYS | IDE RETIREMENT HO | OME | . HIGHWAY 22 | | | |
| (X4) ID | SUMMARY STA | | CITY, NC 280 | PROVIDER'S PLAN OF C | ORRECTION | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | IE APPROPRIATE | COMPLET DATE |
| C 000 | Initial Comments | | C 000 | | | |
| | Report of Construc by Dennis Harrell o | tion Section Biennial Survey n 2-13-2019. | | | | |
| | 7-1-1972, for 34 res information, we are the 1967 North Car 1971 Minimum and Regulations for Hou and the applicable | is facility was first licensed on sidents. Based on this requiring the facility to meet rolina State Building Code, the Desired Standards and mes for the Aged and Infirm portions of the 2005 Rules for ult Care Homes of Seven or | | | | |
| C 153 | Exit Door Locks-Sir | ngle Hand Motion | C 153 | | | |
| | exits are: (3) All exit door loc | | , | | | |
| | | et as evidenced by: ion, the door to the front exit econd floor required 2 hand | | | | |
| C 166 | Housekeeping-Mai | ntained Free of Hazards | C 166 | | | |
| | SECTION .0300 - F 10A NCAC 13F .03 FURNISHINGS (a) Adult care home (5) be maintained i | 06 HOUSEKEEPING AND | | | | |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------|-------------------------|--|
| | | HAL081042 | B. WING | 3. WING | | 02/13/2019 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | ADDRESS, CITY, S | TATE, ZIP CODE | | | |
| UNNYS | IDE RETIREMENT H | | S. HIGHWAY 22 | | | | |
| | | FORES | T CITY, NC 280 | | | | |
| (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 ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE | |
| C 166 | Continued From pa | age 1 | C 166 | | | | |
| | hazards; | e of all obstructions and apply to new and existing | | | | | |
| | Based on obser maintained in a saf handling portable n could affect all resid cylinders fall, break cylinder and turning Findings on 2-13-20 a. Several (30) sm cylinders were store b. Several (8 large oxygen cylinders w beverage crates. C. One portable me stored free standing | all portable medical oxygen ed in cardboard boxes. and 7 small) portable medica ere stored in unapproved edical oxygen cylinder was g in no container at all. | e I | | | | |
| | on the door knob to | vation there were sharp edges the bathroom across from edges presented a laceration | | | | | |
| C 185 | Fire Safety-Rehear | sals on Each Shift | C 185 | | | | |
| | quarterly on each s requirement of the Enforcement Officia (c) Records of reh- and copies furnishe | 09 PLAN FOR rehearsals of the fire plan hift in accordance with the local Fire Prevention Code | f | | | | |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------|-------------------------|
| | | HAL081042 | B. WING | | 02/ | 13/2019 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | E, ZIP CODE | • | |
| SUNNYS | DIDE RETIREMENT HO | OME | S. HIGHWAY 221 S 「CITY, NC 28043 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| C 185 | Continued From pa | ige 2 | C 185 | | | |
| | shift, staff members description of what (f) This Rule shall a facilities. This Rule is not me Based on a review | of documents, the records | | | | |
| C 189 | what the rehearsal | luded little to no description of involved. t Maintained Safe, Operating | C 189 | | | |
| | SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an mechanical, and plu care home shall be operating condition (k) This Rule shall facilities with the ex | PHYSICAL PLANT 11 OTHER and all fire safety, electrical, umbing equipment in an adult maintained in a safe and | | | | |
| | are prevented from resist the passage doors that do not cl present the possibil one space can quic the remainder of th Findings on 2-13-20 a. The door to roor closed. b. The door knob room 20. | vation, many corridor doors closing quickly and latching to of fire and smoke. Corridor ose completely and latch lity that a fire that begins in ckly spread to the corridor and e facility. | | | | |

STATE FORM

6899

If continuation sheet 3 of 5

| Division of Health Service Regu STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------|-------------|--------------------------|
| | | A. BUILDING: 0 | (X3) DATE SURVEY COMPLETED | | |
| | | | | | 1 |
| | HAL081042 | B. WING | | 02/13 | 3/2019 |
| NAME OF PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | |
| SUNNYSIDE RETIREMENT HOM | | HIGHWAY 22 | | | |
| | | CITY, NC 280 | PROVIDER'S PLAN OF CORRECT | | |
| PREFIX (EACH DEFICIENCY M | MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| C 189 Continued From page | e 3 | C 189 | | | |
| d. The door jamb is b the strike is missing. e. The door to bedroe closed. f. The latchset is dam 18. g. The strike is missin h. The door to room 1 j. Part of the door sto bedroom 14. k. The door to room 2 closed. l. The door to room 6 properly to be resistan 2. Based on observatifire rated walls and/or in locations. Holes an sealed with materials one-hour fire rated co possibility that a fire the quickly spread to othe Findings on 2-13-2019 a. Hole, about 3 inche of the furnace closet of b. Heat detector not fit the kitchen. 3. Based on observatithe range hood fire su properly positioned an condition. With syste | 44 will not latch when closed. op is missing on the door to 13 will not latch when 6 does not fit the opening nt to the passage of smoke. Ation, the required one-hour r ceilings were compromised and penetrations that are not approved for use in onstruction present the hat begins in one space can er areas of the facility. 9: les in diameter in the ceiling off room 3, fitted tight to the ceiling in tion, one of the nozzles on uppression system was not nd maintained in a safe em nozzles miss-positioned, uppression system may not ssing a range fire as | | | | |

STATE FORM

MRL721

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE A. BUILDING: 0 | | (X3) DATE SURVEY COMPLETED | | |
|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------|-----------------------------------|-------------------------|--|
| | | HAL081042 | B. WING | | 02/ | 02/13/2019 | |
| IAME OF I | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | | | | |
| SUNNYS | IDE RETIREMENT HO | | . HIGHWAY 22 CITY, NC 280 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| C 189 | Continued From pa | ge 4 | C 189 | | | | |
| | | over the griddle. Note; This ected during the survey. | | | | | |
| C 199 | Exhaust Ventilation | | C 199 | | | | |
| | provided with exhau two cubic feet per in requirement does in before April 1, 1984 these specified spa (1) soiled linen stor (2) soil utility room; (3) bathrooms and (4) housekeeping of (5) laundry area. (k) This Rule shall facilities with the ex- which shall not app This Rule is not me Based on observati maintain required e Finding on 2-13-20 | 11 OTHER ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This not apply to facilities licensed with natural ventilation in ices: rage; toilet rooms; closets; and apply to new and existing iception of Paragraph (e) ly to existing facilities. et as evidenced by: ion the facility failed to exhaust in a working condition. 19; ed was not working in the | | | | | |

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