	MENT OF HEALTH AN		FORM APPROVED OMB NO. 0938-0391							
CENTERS FOR MEDICARE & MEDICAID SERVICES										
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		34G073	B. WING _			03/27/2018				
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	E				
SUNNY HI	LL GROUP HOME #1			2	261 SUNNY HILL DRIVE					
	SUNNY HILL GROUP HOME #1				LINCOLNTON, NC 28092					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTIO		(X5)			
PREFIX TAG			PREFI		(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP					
1/10					DEFICIENCY)					
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on record review and interview, the person centered plan (PCP) for 1 of 3 sampled clients (#4), failed to include objective training to address identified needs relative to oral hygiene. The finding is: Review of client #4's record on 3/27/18 revealed a dental consult dated 10/3/17. Review of the dental consult revealed client #4 "to need an			242	DEFICIENCY)					
	review of dental cons client #4 "should use fluoride 2x's daily." C	continued review of the								
		ing client #4 "needs staff gement, and follow up to								
	professional (QIDP), client #4's PCP dated did not have a curren hygiene. Further inte	alified intellectual disabilities substantiated by review of 7/14/17, revealed client #4 t program to address oral rview with the QIDP eeds a formal objective to								
	address the identified	-								
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE			

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

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 03/29/2018 

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G073 B. WING 03/27/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 SUNNY HILL DRIVE SUNNY HILL GROUP HOME #1** LINCOLNTON, NC 28092 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 242 Continued From page 1 W 242 recommendations from the dentist. W 263 **PROGRAM MONITORING & CHANGE** W 263 CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the specially constituted committee, designated as the human rights committee (HRC), failed to assure written informed consent was obtained for the use of a sound monitor for 1 sampled client (#1). The finding is: Observations conducted in the facility during the recertification survey on 3/26/18 and 3/27/18 revealed a audio monitor was present on a counter of a hall area of the group home near the living room and staff office. The monitor was noted to be on throughout the survey as client #1 was in and out of his room. Interview with facility staff on 3/26/18 revealed the monitor was used for client #1 to monitor for seizures. Review of the record for client #1. conducted on 3/27/18, revealed a person centered plan (PCP) dated 11/14/17. Further review of the 11/14/17 PCP revealed no informed consent from client #1's guardian for the use of a sound monitor. Interview with the gualified intellectual disabilities professional (QIDP) on 3/27/18 verified a sound monitor is used for client #1 to monitor for seizures. Further interview with the QIDP

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CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G073	B. WING			03/27/2018	
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SUNNY H	ILL GROUP HOME #1				61 SUNNY HILL DRIVE INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 263	revealed a consent fr	e 2 om the guardian for the use as needed and had not been		263			

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Event ID: WF1711

Facility ID: 952674

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