

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-619</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>05/30/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

**SUNNY ACRES GROUP HOME**

**611 COUNTRY CLUB DRIVE  
FAYETTEVILLE, NC 28301**

(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

INITIAL COMMENTS

A complaint and follow up survey was completed on May 30, 2019. The complaint was substantiated (intake #NC00151607). Deficiencies were cited.

This facility is licensed for the following category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.

V 000

*DHSR - Mental Health  
JUN 07 2019  
Lic. & Cert. Section*

V 118

27G .0209 (C) Medication Requirements

10A NCAC 27G .0209 MEDICATION REQUIREMENTS

(c) Medication administration:

- (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.
- (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.
- (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.
- (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:
  - (A) client's name;
  - (B) name, strength, and quantity of the drug;
  - (C) instructions for administering the drug;
  - (D) date and time the drug is administered; and
  - (E) name or initials of person administering the drug.
- (5) Client requests for medication changes or checks shall be recorded and kept with the MAR

V 118

V118 - By June 29, 2019 the QP/Home Manager will monitor the medications weekly to ensure all medications are current and that we have current orders in the individual charts. QP will coordinate with the pharmacy monthly to ensure the MAR's are current. QP will coordinate with the physicians to clarify all orders and the frequency of BP and BG checks. All Sunny Acres staff will have a medication review on or before June 29, 2019.

Division of Health Service Regulation

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

TITLE

(X6) DATE

*Tiffany Bennett BSOP* 6-4-19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-619</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/30/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>SUNNY ACRES GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>611 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301</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
V 118	<p>Continued From page 1</p> <p>file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting two of three audited clients (#1 and #6). The findings are:</p> <p>Review on 05/29/19 of client #1's record revealed: - 43 year old male. - Admission date of 03/01/95. - Diagnoses of Mild Mental retardation, Autism, Hypertension, Diabetes and Hyperlipidemia.</p> <p>A. Review on 05/29/19 of client #1's medication orders revealed: 01/25/19 - Stop Lopressor (treats high blood pressure). - Start Coreg (treats heart failure and high blood pressure) 6.25 milligrams (mg) - take twice daily. - No documentation to discontinue Coreg.</p> <p>Review on 05/29/19 of client #1's January 2019 thru May 2019 revealed no transcribed entry for Coreg.</p> <p>B. Review on 05/29/19 of a physician visit summary dated 04/30/19 revealed: - Staff should check blood sugar check daily. - Staff should check blood sugars twice daily. - No clarification of the frequency of blood sugar checks.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-619</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/30/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>SUNNY ACRES GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>611 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301</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
V 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on May 30, 2019. The complaint was substantiated (intake #NC00151607). Deficiencies were cited.</p> <p>This facility is licensed for the following category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 118	<p><b>27G .0209 (C) Medication Requirements</b></p> <p><b>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</b></p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR</p>	V 118		

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:  <b>MHL026-619</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/30/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>SUNNY ACRES GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>611 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301</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
V 118	<p>Continued From page 2</p> <p>Review on 05/29/19 of client #1's blood sugar chart from March 2019 thru May 2019 revealed the following blanks:</p> <ul style="list-style-type: none"> <li>- 03/02/19</li> <li>- 03/17/19</li> <li>- 04/14/19</li> <li>- 04/16/19</li> <li>- 04/17/19</li> </ul> <p>C. Review on 05/29/19 of client #1's medication order dated 01/1/19 revealed:</p> <ul style="list-style-type: none"> <li>- Ativan (Lorazepam - anti-anxiety) 1mg - once daily for agitation.</li> </ul> <p>Review on 05/29/19 of client #1's May 2019 MAR revealed the following handwritten transcribed entry:</p> <ul style="list-style-type: none"> <li>- Lorazepam - "take 1 tab (tablet) as needed for agitation."</li> <li>- No directions for the dosage strength or frequency of the Lorazepam.</li> </ul> <p>Interview on 05/29/19 client #1 stated he received his medications as ordered.</p> <p>Finding #2: Review on 05/29/19 of client #6's record revealed:</p> <ul style="list-style-type: none"> <li>- 67 year old female.</li> <li>- Admission dated 03/31/17.</li> <li>- Diagnoses of Moderate Intellectual Developmental Disability, Depressive Disorder and Diabetes.</li> <li>- No order to discontinue Metformin.</li> </ul> <p>Review on 05/29/19 of client #6's Physician visit summary dated 02/18/19 revealed:</p> <ul style="list-style-type: none"> <li>- Metformin (treats Diabetes) 500mg - take twice daily.</li> </ul>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-619</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/30/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>SUNNY ACRES GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>611 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301</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
V 118	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- Fexofenadine (treats allergies) 180mg - take once daily as needed.</li> <li>- Check blood sugar labs and if stable likely take client #6 off Metformin.</li> </ul> <p>Review on 05/29/19 of client #6's May 2019 MAR revealed:</p> <ul style="list-style-type: none"> <li>- Metformin - "D/C (discontinue)" handwritten.</li> <li>- Fexofenadine - no strength or frequency documented.</li> </ul> <p>Interview on 05/29/19 the Qualified Professional stated:</p> <ul style="list-style-type: none"> <li>- Client #1 was scheduled to see his Cardiologist on 05/31/19 and they would review the Coreg order.</li> <li>- She would follow up on the need clarify orders.</li> </ul> <p>[This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]</p>	V 118		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:</p> <p>Observation on 05/30/19 at approximately</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-619</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/30/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>SUNNY ACRES GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>611 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301</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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

V 118	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- Fexofenadine (treats allergies) 180mg - take once daily as needed.</li> <li>- Check blood sugar labs and if stable likely take client #6 off Metformin.</li> </ul> <p>Review on 05/29/19 of client #6's May 2019 MAR revealed:</p> <ul style="list-style-type: none"> <li>- Metformin - "D/C (discontinue)" handwritten.</li> <li>- Fexofenadine - no strength or frequency documented.</li> </ul> <p>Interview on 05/29/19 the Qualified Professional stated:</p> <ul style="list-style-type: none"> <li>- Client #1 was scheduled to see his Cardiologist on 05/31/19 and they would review the Coreg order.</li> <li>- She would follow up on the need clarify orders.</li> </ul> <p>[This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]</p>	V 118		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:</p> <p>Observation on 05/30/19 at approximately</p>	V 736	<p>V736 - All of the repairs cited on May 30, 2019 will be completed by June 29, 2019. Sophia B. Pierce &amp; Associates, Inc. will maintain an attractive and safe facility. The facility manager will conduct a walk through every month and notate any repairs needed.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-619</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/30/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>SUNNY ACRES GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>611 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301</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
V 736	<p>Continued From page 4</p> <p>2:00pm revealed:</p> <ul style="list-style-type: none"> <li>- A steep dirt incline was required to be climbed in order to enter the front door</li> <li>- A smoke detector in the hallway emitted a chirping sound approximately every 35 seconds indicating a battery was needed.</li> <li>- The smoke detector in client #6's emitted a chirping sound approximately every 35 seconds.</li> <li>- The living room revealed a basketball sized area of the ceiling was peeling off.</li> <li>- The bathroom revealed a rusty floor vent.</li> <li>- The rail on the front porch was bowed in the middle.</li> <li>- The medication door revealed a basketball sized crack in the door.</li> </ul> <p>Interview 05/30/19 the House Manager stated:</p> <ul style="list-style-type: none"> <li>- The medication door was broken when someone fell against it.</li> <li>- The maintenance staff were at the facility to fix the front porch rails.</li> <li>- He had recently put batteries in the smoke detectors.</li> <li>- He would follow up on identified items for repair.</li> </ul> <p>[This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]</p>	V 736		

**Sophia B. Pierce & Associates, Inc.**  
**1422 Murchison Road**  
**PO Box 2813**  
**Fayetteville, NC 28302**  
**Phone (910) 488-8477 Fax (910) 822-1951**

June 4, 2019

DHSR - Mental Health

JUN 07 2019

Lic. & Cert. Section

Dear Gloria Locklear & Keith Hughes,

Thank you for your recent visit to our facility on May 30, 2019. We have received the list of deficiencies and have already started making adjustments to comply with state regulations and guidelines. Enclosed you will find our plan of correction for those deficiencies. If you have any questions or concerns please contact our office at (910) 488-8477.

Sincerely,

Handwritten signature of Tiffany Harrington in cursive script, including the initials "BS&P" at the end.

Tiffany Harrington  
Qualified Professional