DEPART		FORM APPROVED							
		& MEDICAID SERVICES			0		0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G147	B. WING _	WING		10/22/2019			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
SUNNY H	401.1.10			279 SUNNY HILL DRIVE					
301111				LINCOLNTON, NC 28092					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD HE APPROPF	D BE COMPLETION			
W 436	CFR(s): 483.470(g)(2)		W 43	36					
	The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.								
	Based on observat interview, the facility and make informed	s not met as evidenced by: tion, record review and y failed to teach a client to use I choices relative to a hearing oled clients (#4). The finding							
	from 3:15 PM to 4:4 not wearing a heari prompted by staff to Further observation standing close to cl prompting into the of her room. Continue 7:40 AM revealed of medication room fo administration, and to her room to watco observed wearing a noted, client #4 was day programming of observations at 7:5 aide was located in Interview with staff #4 will sometimes of aide in the medication	e group home on 10/21/19 45 PM revealed client #4 was ng aide, and was not o apply a hearing aide. Is at 4:15 PM revealed staff C ient #4 and repeatedly verbally client's ear, to take an item to ed observations on 10/22/19 at client #4 to enter the r morning medication after was observed to return th television. Client #4 was not a hearing aide. It should be s sick and was not attending on 10/22/19. Further 0 AM revealed the hearing the medication room. C at that time revealed client choose to keep the hearing ion room. Further interview d she did not know why the							

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

TITLE

(X6) DATE

PRINTED: 10/27/2019

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICAID SERVICES OMB NO. 093										
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
34G147		B. WING		10/22/2019						
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
SUNNY H	4ILL II		279 SUNNY HILL DRIVE LINCOLNTON, NC 28092							
(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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE					
W 436	Continued From page 1 client sometimes made the choice to store the hearing aide in the medication room. Review of the record for client #4 on 10/22/19 revealed a person centered plan (PCP) dated 5/14/19. The PCP indicated client #4 had diagnoses which included profound hearing loss and had a prescribed hearing aide for her right ear. The PCP also indicated the hearing aide was being stored in the med closet when not in use. Further review of the record revealed current quarterly physician orders which indicated the hearing aide was kept in the bedroom overnight. Continued review of the PCP did not reveal any training programs related to the use or storage of the hearing aide. The PCP did contain past programing related to hearing aides, but the programs were prescribed, and discontinued at least eight years prior to the survey date because criteria had been met.		W 436							
	professional (QIDP #4 will sometimes r aide. Continued int she was not sure w the hearing aide in interview with the C not contain any trai use of the hearing a	pualified intellectual disabilities on 10/22/19 revealed client refuse to wear the hearing terview with the QIDP revealed why the client sometimes stores the medication room. Further QIDP confirmed the PCP did ning programs related to the aide, or for the care and ing aide, for client #4.								

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 922673

If continuation sheet Page 2 of 2