| Bit Haw OF CONSIDER OF LEG LINE (1) (PROVERSIDATE FILENCIAL<br>DENTIFICATION NUMBER     (20) MALTIFILE CONSTRUCTION<br>A BUILING     (20) MALTIFILE CONSTRUCTION<br>A BUILING     (20) MALTIFILE CONSTRUCTION<br>A BUILING       MARE OF PROVIDER OR SUPPLIER     346073     5. Wmo   |  | -  | ID HUMAN SERVICES<br>MEDICAID SERVICES |            |  |                              | RM APPROVED NO. 0938-0391 |
|---|--|--|--|------------|--|------------------------------|---------------------------|
| IMAGE OF PROVIDER OF SUPPLIER     STREET ADDRESS, CITY, STATE, ZP CODE       SUNNY HILL GROUP HOME #1     STREET ADDRESS, CITY, STATE, ZP CODE       IMAGE OF PROVIDER OF SUPPLIER     STREET ADDRESS, CITY, STATE, ZP CODE       IMAGE OF PROVIDER OF SUPPLIER     STREET ADDRESS, CITY, STATE, ZP CODE       IMAGE OF PROVIDER OF SUPPLIER     BEDIMARY STATEMENT OF DECIDINCES       IMAGE OF PROVIDER OF NUMBER OF DECIDINCES     PROVIDER OF AND CORRECTION OF CREATENES       IMAGE OF PROVIDER OF NUMBER OF DECIDINCES     PROVIDER OF AND CORRECTION OF CREATENES       IMAGE OF PROVIDER OF NUMBER OF DECIDINCES     PROVIDER OF AND CORRECTION OF CREATENES       IMAGE OF PROVIDER OF NUMBER OF DECIDINCES     PROVIDER OF AND CORRECTION OF CREATENES       IMAGE OF PROVIDER OF ADDRESS OF AND CORRECTION OF CREATENES     PROVIDER OF AND CORRECTION OF CREATENES       IMAGE OF PROVIDER OF ADDRESS OF ADDRESS     STREET ADDRESS OF ADDRESS OF ADDRESS       IMAGE OF PROVIDER OF ADDRESS OF ADDRESS     PROVIDER OF ADDRESS OF ADDRESS       IMAGE OF ADDRESS OF ADDRESS OF ADDRESS     State and Local emergency       IMAGE OF ADDRESS OF ADDRESS OF ADDRESS OF ADDRESS     PROVIDER OF ADDRESS OF ADDRESS       IMAGE OF ADDRESS OF ADDRESS OF ADDRESS     State and Local entregency Preparedness program that meets the requirements. The placeNess program that meets the requirements. The placeNess of CREATENES       IMAGE OF ADDRESS OF ADDRESS OF ADDRESS     State address of CREATENES       IMAGE OF ADDRESS OF ADDRESS OF ADDRESS     State addres   | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPF |  | (X1) PROVIDER/SUPPLIER/CLIA            | ` <i>`</i> |  | (X3) DA                      | ATE SURVEY                |
| MAKE OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STRET, 2P CODE           SUNNY HILL GROUP HOME #I         23 UNNY HILL DRIVE<br>LINCOLNTON, NC 28692         29 UNNY HILL DRIVE<br>LINCOLNTON, NC 28692           (M4) D<br>PREFIX<br>TAG         SUMMARY STATEMENT OF DEFICIENCES<br>(EXCHEDERICEDED & YILL)<br>RESULATION OF LISC DENTIFYING INFORMATION)         D<br>PREFIX<br>RESULATION OF CORRECTIVE ACT ON STREET<br>(EXCHEDENCES) TO THE AFFROMMENT<br>CONSTRUMT         D<br>PREFIX<br>RESULATION OF CORRECTIVE ACT ON STREET<br>(EXCHEDENCES) TO THE AFFROMMENT<br>(EXCHEDENCES) TO THE AFFROMMENT<br>D<br>SUMMARY STREET ADDRESS OF CORRECTIVE ACT ON STREET<br>(EXCHEDENCES) TO THE AFFROMMENT<br>(EXCHEDENCES) TO THE AFFROMMENT<br>(EXCHEDENCES)<br>(EXCHEDENCES) TO THE AFFROMMENT<br>(EXCHEDENCES)<br>(EXCHEDEN | 34G073                                       |  | B. WING                                |            |  | 07/11/2023                   |                           |
| CMI ID<br>PRETRY<br>TNO         SUMMARY STATEMENT OF DEPICIENCIES<br>(EAD CORRECTION BE INSCREDED BY FULL<br>MG         PROVIDERS FLAN OF CORRECTION<br>(EAD CORRECTION ON HOUSE DEMINIPANCIES DEMINIPANCIES)         Design<br>(EAD CORRECTION DETAILS THE INSCREDED BY FULL<br>MG         PROVIDERS FLAN OF CORRECTION<br>(EAD CORRECTION ON HOUSE DEMINIPANCIES)         Design<br>(EAD CORRECTION DETAILS TO THE HOUSE HOUSE DEMINIPANCIES)         Design<br>(EAD TABLES)         Design   |  |  |  |            | 261 SUNNY HILL DRIVE   |                              |                           |
| CFR(s): 483.475(a)<br>§403.748(a), §416.54(a), §418.113(a),<br>§441.184(a), §400.84(a), §482.15(a), §483.73(a),<br>§483.475(a), §484.102(a), §485.68(a),<br>§485.542(a), §485.625(a), §485.727(a),<br>§485.542(a), §485.625(a), §485.727(a),<br>§484.62(a).<br>The [facility] must comply with all applicable<br>Federal, State and local emergency<br>preparedness requirements. The [facility] must<br>develop establish and maintain a comprehensive<br>emergency preparedness program that meets the<br>requirements of this section. The emergency<br>preparedness program must include, but not be<br>limited to, the following elements:<br>(a) Emergency Plan. The [facility] must develop<br>and maintain an emergency preparedness plan<br>that must be [reviewed], and updated at least<br>every 2 years. The plan must do all of the<br>following:<br>* [For hospitals at §482.15 and CAHs at<br>§486.625(a):] Emergency Plan. The [hospital or<br>CAH] must comply with all applicable Federal,<br>State, and local emergency preparedness<br>requirements of this section, utilizing an<br>all-hazards approach.<br>* [For LC Facilities at §483.73(a):] Emergency<br>Plan. The LTC facility must develop and maintain<br>an emergency preparedness program that meets the<br>requirements of this section, utilizing an<br>all-hazards approach.   | PREFIX                                       | (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  |            | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH | N SHOULD BE<br>E APPROPRIATE | COMPLETION                |
|   | E 004  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)<br>Develop EP Plan, Review and Update Annually<br>CFR(s): 483.475(a)<br>\$403.748(a), \$416.54(a), \$418.113(a),<br>\$441.184(a), \$460.84(a), \$482.15(a), \$483.73(a),<br>\$483.475(a), \$484.102(a), \$485.68(a),<br>\$485.542(a), \$485.625(a), \$485.727(a),<br>\$485.920(a), \$486.360(a), \$491.12(a),<br>\$494.62(a).<br>The [facility] must comply with all applicable<br>Federal, State and local emergency<br>preparedness requirements. The [facility] must<br>develop establish and maintain a comprehensive<br>emergency preparedness program that meets the<br>requirements of this section. The emergency<br>preparedness program must include, but not be<br>limited to, the following elements:<br>(a) Emergency Plan. The [facility] must develop<br>and maintain an emergency preparedness plan<br>that must be [reviewed], and updated at least<br>every 2 years. The plan must do all of the<br>following:<br>* [For hospitals at \$482.15 and CAHs at<br>\$485.625(a).] Emergency Plan. The [hospital or<br>CAH] must comply with all applicable Federal,<br>State, and local emergency preparedness<br>requirements. The [hospital or CAH] must<br>develop and maintain a comprehensive<br>emergency preparedness program that meets the<br>requirements. The [hospital or CAH] must<br>develop and maintain a comprehensive<br>emergency preparedness program that meets the<br>requirements of this section, utilizing an<br>all-hazards approach.<br>* [For LTC Facilities at \$483.73(a):] Emergency<br>Plan. The LTC facility must develop and maintain<br>an emergency preparedness plan that must be |  | EO         | 04   |                              |                           |

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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: 07/13/2023

|                          | -   | ID HUMAN SERVICES  |  |  |  | FORM   | 07/13/2023                 |
|--------------------------|---|--|--|--|--|--|----------------------------|
|                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | -  | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED |                            |
| 34G073                   |   |  | B. WING                                | B. WING                                    |  |  | 11/2023                    |
| NAME OF PI               | ROVIDER OR SUPPLIER   |  | Ş                                      | STREET ADDRESS, CITY, S                    | TATE, ZIP CODE   |  |                            |
| SUNNY HI                 | LL GROUP HOME #1  |  |  | 261 SUNNY HILL DRIVE<br>LINCOLNTON, NC 280 | 92   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | (EACH CORRE<br>CROSS-REFERE                | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BI<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| E 004                    | Plan. The ESRD facili<br>maintain an emergent<br>must be [evaluated], a<br>years.<br>This STANDARD is r<br>Based on record revit<br>failed to ensure that th<br>plan (EPP) was review<br>every two years. The<br>Review of the facility<br>revealed a facility EP | s at §494.62(a):] Emergency<br>ity must develop and<br>cy preparedness plan that<br>and updated at least every 2<br>not met as evidenced by:<br>iew and interview, the facility<br>he emergency preparedness<br>wed and updated at least   | E 004                                  |  |  |  |                            |
|                          | of 6 clients (#1, #2, #3<br>EPP manual also reve<br>plans ranging from 1/<br>Subsequent review of<br>not reveal evidence of<br>mock drills or tabletop  | f the facility EPP manual did<br>f updated in-service training,<br>o exercises. Continued<br>anual revealed a facility   |  |  |  |  |                            |
|                          | professional (QIDP) of<br>were provided in-serv<br>meetings however ev-<br>training was not availa<br>Continued interview w<br>that evidence of current<br>tabletop exercises co-<br>survey. Further interv-<br>that client specific info                         | alified intellectual disabilities<br>on 7/11/23 revealed that staff<br>vice training during staff<br>idence of the in-service<br>able during the survey.<br>with the QIDP also revealed<br>ent facility mock drills and<br>uld not be located during the<br>iew with the QIDP revealed<br>ormation in the EPP manual<br>very two years or as needed. |  |  |  |  |                            |

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_\_ 34G073 B. WING 07/11/2023 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 (X5) COMPLETION (X4) ID 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 104 Continued From page 2 W 104 W 104 GOVERNING BODY W 104 CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure the exterior of the facility was sanitary and orderly. The finding is: Observations during the 7/10/23-7/11/23 survey revealed a small table, chairs and patio umbrella to sit in the walkway on the grounds of the facility leading up to the front door steps. Observations also revealed mold and mildew on all patio furniture cushions to include several tears within the cushions. Continued observations revealed an oversized recliner to lay on the front door steps of the grounds of the facility. Interview with staff A on 7/10/23 revealed that the recliner had been removed from the facility because it was broken and had been outside for about two weeks awaiting city trash pick up. Interview with the home manager (HM) on 7/11/23 revealed he was not aware of the recliner laying on the front steps of the facility. Interview with the residential team lead (RTL) on 7/11/23 revealed that staff were instructed to remove the recliner from the facility and place it to the street for city trash pick up. Interview with the qualified intellectual disabilities professional (QIDP) on 7/11/23 revealed that the recliner was removed from a client's bedroom due to a case of bed bugs. Continued interview

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/13/2023

| CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |  |   |                               | (X2) MULTIPLE CONSTRUCTION   |               |  |  |
|--|--|---|-------------------------------|--|---------------|--|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  | A. BUILDING   | (X3) DATE SURVEY<br>COMPLETED |  |               |  |  |
|  |  | 34G073  | B. WING                       |  | 07/11/2023    |  |  |
| NAME OF PROVIDER OR SUPPLIER   |  |   |                               | STREET ADDRESS, CITY, STATE, ZIP CODE  |               |  |  |
| SUNNY HILL GROUP HOME #1   |  |   |                               | 261 SUNNY HILL DRIVE<br>LINCOLNTON, NC 28092   |               |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE COMPLE |  |  |
| W 104  | Continued From page  | 23  | W 10                          | 4  |               |  |  |
|  | had planned to discar  | ed that maintenance staff<br>rd the recliner and was not<br>er was still on the facility<br>rview with the QIDP   |                               |  |               |  |  |
| W 247  | revealed that mainter<br>items to the street for<br>INDIVIDUAL PROGR<br>CFR(s): 483.440(c)(6   | AM PLAN   | W 24                          | 7  |               |  |  |
|  | Based on observatio<br>interviews, the facility<br>opportunities for clien<br>self-management for  | t choice and<br>not met as evidenced by:<br>n, record reviews and<br>failed to include<br>t choice and<br>4 of 6 clients (#2, #3, #4,<br>ming out of their rooms and      |                               |  |               |  |  |
|  | AM - 7:00 AM revealed<br>Further observations<br>the kitchen and staff (<br>room stating "you will<br>until first shift comes<br>revealed staff C to en<br>remind him to remain<br>shift staff comes in. F<br>revealed staff C to co |   |                               |  |               |  |  |
|  | AM but was told he is<br>at 7:00 AM. Additiona<br>confirmation during a<br>revealed all clients ar<br>until first shift arrives.   | a scheduled to report to work<br>al observations and<br>n interview with staff C<br>e to remain in the bedrooms<br>Staff C also stated "one<br>uled to come in at 6:30 AM |                               |  |               |  |  |

Facility ID: 952674

If continuation sheet Page 4 of 6

|   | -   | D HUMAN SERVICES   |  |                             |  | FORM  | 07/13/2023<br>APPROVED     |
|---|---|--|--|-----------------------------|--|---|----------------------------|
| CENTERS FOR MEDICARE & N<br>STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                      | (X2) MULTIPLE CONSTRUCTION A. BUILDING |                             |  | OMB NO. 0938-039<br>(X3) DATE SURVEY<br>COMPLETED |                            |
|   |   | 34G073   | B. WING                                |                             | _  | 07/11/2023  |                            |
| NAME OF P   | ROVIDER OR SUPPLIER   |  | S                                      | STREET ADDRESS, CITY, ST    | TATE, ZIP CODE   | -   |                            |
|   | LL GROUP HOME #1  |  | 2                                      | 61 SUNNY HILL DRIVE         |  |   |                            |
|   |   |  | L                                      | INCOLNTON, NC 2809          | 92   |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)       | ID<br>PREFIX<br>TAG                    | (EACH CORRE<br>CROSS-REFERE | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BE<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE |
| W 247   | Continued From page   | 4  | W 247                                  |                             |  |   |                            |
|   | Continued From page 4<br>Subsequent observations in the group home from<br>7:00 AM-8:15 AM revealed all clients to<br>participate in a staggered breakfast schedule<br>while their plates were being prepared and placed<br>on the table by staff. Continued observations<br>revealed staff to prompt client #2 to throw away<br>two other clients plastic and paper products in the<br>trash can. Further observations revealed client #3<br>offer to help pack and carry lunch bags to the<br>van. Staff D responded " I don't need help client<br>#2 will do it" and redirected him out of the kitchen.<br>Subsequent observations revealed the home<br>manager (HM) to inform client #3 that staff didn't<br>need anymore help and would let him know if the<br>client's help was needed. Additional observations<br>revealed the HM to remind client #3 that he could<br>not stand in the kitchen area and to prompt him to<br>follow the kitchen rules. Continued observations<br>revealed client #5 to enter the kitchen area as<br>staff C prompt the client to stay out of the kitchen.<br>Interview with staff C and HM on 7/11/23 revealed<br>that clients are restricted from the kitchen area<br>unless permission is granted to assist. Continued<br>interview with the HM revealed this process has<br>been in place since his employment about a<br>month ago. Further interview with the HM and<br>staff C revealed there are clients in the home who<br>have a tendency to go into the pantry and<br>refrigerator and take food items to eat.<br>Subsequent interview with the HM revealed since<br>there are no locks on the pantry or refrigerator,<br>the current process is what they have to work with<br>until locks are implemented.<br>Review of record on 7/11/23 for clients #2, #3, #4 |  |  |                             |  |   |                            |
|   | and #5 on 7/11/23 did   | 7/11/23 for clients #2, #3, #4<br>not reveal restrictions to<br>gerator or pantry. Further |  |                             |  |   |                            |

Facility ID: 952674

If continuation sheet Page 5 of 6

|   |  | ID HUMAN SERVICES<br>MEDICAID SERVICES  |  |     |  | FOR                           | D: 07/13/2023<br>M APPROVED<br>D. 0938-0391 |
|---|--|---|--|-----|--|-------------------------------|---|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |   |
| 34G073  |  | B. WING   |  |     | 07/11/2023   |                               |   |
| NAME OF PI  | ROVIDER OR SUPPLIER  |   | •                                      |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |   |
| SUNNY HI  | LL GROUP HOME #1   |   |  |     | 261 SUNNY HILL DRIVE<br>LINCOLNTON, NC 28092   |                               |   |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG                      | IX  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE                  |
| W 247   | professional (QIDP) of<br>clients BSP's are curr<br>verified all clients sho<br>any areas of their hor<br>BSP's. Further intervi<br>clients should be prov | ehavior support plans<br>ss restrictions to the<br>r pantry area.<br>ed intellectual disabilities<br>on 7/11/23 revealed all<br>rent. Continued interview<br>ould not be restricted from<br>mes unless identified in their<br>ew with the QIDP revealed | W                                      | 247 |  |                               |   |

Facility ID: 952674

If continuation sheet Page 6 of 6