STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G073	A. BUILDING ______ 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** **LINCOLNTON, NC 28092**

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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the emergency preparedness plan (EPP) was reviewed and updated at least every two years. The finding is: Review of the facility EPP manual on 7/10/23 revealed a facility EPP manual dated 3/24/20. Continued review of the facility EPP manual revealed outdated client specific information for 6 of 6 clients (#1, #2, #3, #4, #5, #6). Review of the EPP manual also revealed expired client specific plans ranging from 1/7/19 to 11/1/19. Subsequent review of the facility EPP manual did not reveal evidence of updated in-service training, mock drills or tabletop exercises. Continued review of the EPP manual revealed a facility mock drill dated 10/1/20. Interview with the qualified intellectual disabilities professional (QIDP) on 7/11/23 revealed that staff were provided in-service training during staff meetings however evidence of the in-service training was not available during the survey. Continued interview with the QIDP also revealed that evidence of current facility mock drills and tabletop exercises could not be located during the survey. Further interview with the QIDP revealed that client specific information in the EPP manual should be updated every two years or as needed.	E 004		

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W 104	Continued From page 2	W 104		
W 104	GOVERNING BODY 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	W 104		

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W 104	Continued From page 3 with the QIDP revealed that maintenance staff had planned to discard the recliner and was not aware that the recliner was still on the facility grounds. Further interview with the QIDP revealed that maintenance should place all trash items to the street for city trash pickup.	W 104		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to include opportunities for client choice and self-management for 4 of 6 clients (#2, #3, #4, and #5) relative to coming out of their rooms and access to the kitchen area. The finding is: Observation in the group home on 7/11/23 at 6:40 AM - 7:00 AM revealed all clients in their rooms. Further observations revealed client #5 to enter the kitchen and staff C to redirect him back to his room stating "you will have to stay in your room until first shift comes in". Continued observations revealed staff C to enter client #2's bedroom and remind him to remain in his bedroom until first shift staff comes in. Further observations revealed staff C to contact another staff to confirm whether he is scheduled to work at 6:30 AM but was told he is scheduled to report to work at 7:00 AM. Additional observations and confirmation during an interview with staff C revealed all clients are to remain in the bedrooms until first shift arrives. Staff C also stated "one staff is always scheduled to come in at 6:30 AM and another at 7:00 AM".	W 247		

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W 247	Continued From page 4	W 247		

Subsequent observations in the group home from 7:00 AM-8:15 AM revealed all clients to participate in a staggered breakfast schedule while their plates were being prepared and placed on the table by staff. Continued observations revealed staff to prompt client #2 to throw away two other clients plastic and paper products in the trash can. Further observations revealed client #3 offer to help pack and carry lunch bags to the van. Staff D responded " I don't need help... client #2 will do it" and redirected him out of the kitchen. Subsequent observations revealed the home manager (HM) to inform client #3 that staff didn't need anymore help and would let him know if the client's help was needed. Additional observations revealed the HM to remind client #3 that he could not stand in the kitchen area and to prompt him to follow the kitchen rules. Continued observations revealed client #5 to enter the kitchen area as staff C prompt the client to stay out of the kitchen.

Interview with staff C and HM on 7/11/23 revealed that clients are restricted from the kitchen area unless permission is granted to assist. Continued interview with the HM revealed this process has been in place since his employment about a month ago. Further interview with the HM and staff C revealed there are clients in the home who have a tendency to go into the pantry and refrigerator and take food items to eat. Subsequent interview with the HM revealed since there are no locks on the pantry or refrigerator, the current process is what they have to work with until locks are implemented.

Review of record on 7/11/23 for clients #2, #3, #4 and #5 on 7/11/23 did not reveal restrictions to the kitchen area, refrigerator or pantry. Further

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W 247	Continued From page 5 review of all clients behavior support plans (BSP's) did not address restrictions to the kitchen, refrigerator or pantry area. Interview with qualified intellectual disabilities professional (QIDP) on 7/11/23 revealed all clients BSP's are current. Continued interview verified all clients should not be restricted from any areas of their homes unless identified in their BSP's. Further interview with the QIDP revealed clients should be provided the choice or opportunity to exit their bedrooms or enter any areas of their home.	W 247		