PRINTED: 07/11/2025 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		N IDENTIFICATION NUMBER: (X2) MULTIF				MB NO. 0938-0	
		DENTIFICATION NUMBER:	A. BUILDING			TE SURVEY MPLETED	
		34G147	34G147 B. WING				
VAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	7/09/2025	
H YMMU	ILL II			279 SUNNY HILL DRIVE			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		LINCOLNTON, NC 28092			
PREFIX	(EACH DEFICIEN	ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OU II D DE	(X5) COMPLET DATE	
	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of the human rights committee (HRC). This affected 6 out of 6 sampled clients (#1, #2, #3, #4, #5 and #6). The findings are:		W 262	(W262) The QP will be in-ser program manager on ensurin are kept in date and complete appropriate frequency for mal continuity of care. QP will ensure consents are updated as need expiration date or any change require an updated consent.	g consents ed at the intained sure	07.25.2	
e k	when clients, staff and exited the home. Furth ocked padlock on the harp objects are kept evealed door alarms of edroom doors to soul pened.	on 7/8/25 and 7/9/25 und off on all exit doors d surveyors entered or her observations revealed a kitchen drawer where all c. Continued observations on clients #2 and #6 and when the doors are		EINED	17		
ex	vealed no written HR	client #1's clinical record C consent for alarms on on kitchen drawer for					
ex	vealed no written HR	client #2's clinical record C consent for alarms on kitchen drawer for sharp edroom door.					
rev	realed no written HR(it doors or padlocks o	client #3's clinical record C consent for alarms on In kitchen drawer for PLIER 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

STATEME	NT OF DEFICIENCIES	T			OMP NO SE
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	OMB NO. 093 (X3) DATE SURVI COMPLETED
	34G147		B. WING		
NAME O	F PROVIDER OR SUPPLIER		S. WING_		07/09/20
SUNNY	HILL II			STREET ADDRESS, CITY, STATE, ZIP CODE 279 SUNNY HILL DRIVE	1 07/03/20
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		LINCOLNTON, NC 28092	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	0.05
W 262	Continued From page sharp objects.	1	W 26	2	
	exit doors or padlocks sharp objects. E. Review on 7/9/25 of revealed no written HR exit doors or padlocks of sharp objects. F. Review on 7/9/25 of revealed no written HR exit doors or padlocks of sharp objects.	client #5's clinical record C consent for alarms on on kitchen drawer for client #6's clinical record C consent for alarms on kitchen drawer for sharp			
/ 263	Interview with the facility on 7/9/25 revealed that be located for review relibedroom chimes for clief locked kitchen cabinet. FPM confirmed that the fa obtained annual HRC co PROGRAM MONITORIN CFR(s): 483.440(f)(3)(ii)	Program Manager (PM) HRC consents could not ative to exit door alarms, ints #2 and #6 and a Further interview with the cility should have insents for all clients. IG & CHANGE Sure that these programs he written informed ents (if the client is a inet as evidenced by: record review and it to ensure restrictive for each of the client. In the written all guardian. This	a	W263) The QP will be in-serviced program manager on ensuring consider kept in date and completed at the ppropriate frequency for maintaine ontinuity of care. QP will ensure consents are updated as needed perpendicular to the properties of the pro	sents he ed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION		OMB NO. 0938-03	
				A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER		34G147	B. WING				
SUNNY H				STREET ADDRESS, CITY, STATE, ZIP COD 279 SUNNY HILL DRIVE	DE	07/09/2025	
(X4) ID	STRATADV			LINCOLNTON, NC 28092			
PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULDE	(X5) COMPLETIO DATE	
W 263	Continued From pag	ge 2	W 263	3			
E n	recertification survey revealed alarms to so clients, staff and survey home. Further observed padlock on the kitcher objects are kept. Con revealed door alarms bedroom doors to so opened. A. Review on 7/9/25 or revealed no written gue nexit doors or padlock and pobjects or chime. B. Review on 7/9/25 or evealed no written gue nexit doors or padlock and pobjects or padlock and pobjects.	on clients #2 and #6 und when the doors are of client #2's clinical record uardian consent for alarms cks on kitchen drawer for es on bedroom door. of client #5's clinical record uardian consent for alarms cks on kitchen drawer for					
O	evealed no written gua	f client #6's clinical record ardian consent for alarms eks on kitchen drawer for s on bedroom door.					
or no al an wi ha	n //9/25 revealed that of be located for review arms, bedroom chime and a locked kitchen ca th the PM confirmed to	ty Program Manager (PM) i guardian consents could w relative to exit door es for client's #2 and #6 abinet. Further interview that the facility should uardian consents for all					
V 382 DF	RUG STORAGE AND FR(s): 483.460(I)(2)	RECORDKEEPING	W 382				

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) C	NO. 0938-03 DATE SURVEY OMPLETED
NAME OF	PROVIDER OR SUPPLIER	34G147	B. WING			
SUNNY I	HILL II			STREET ADDRESS, CITY, STATE, ZIP CODE 279 SUNNY HILL DRIVE LINCOLNTON, NC 28092		07/09/2025
PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	1000	(X5) COMPLETIO DATE
W 382	The facility must keep locked except when be administration. This STANDARD is no Based on observations failed to ensure all biole	all drugs and biologicals eing prepared for of met as evidenced by:	W 382	(W382) Staff will be in serviced QP on ensuring medications are properly in the designated area	a stored	07.25.20
V 463 FO	Interview with the facility confirmed client #1's prepowder. Further interview revealed that the client's should be kept secured in when not being administration CFR(s): 483.480(a)(4) The client's interdiscipling interview in the client's interdiscipling interdisciplin	ription labeled Nystatin m for client #1 sitting on a nor client #1 sitting	a o tt d m m	W463) The clinical team will be n-serviced by the QP to ensure a re followed as outlined per phys rders and training to be complet ne home manager to staff on ensiets are followed as outlined. The realtimes assessments will be contained to ensure this standaring followed.	all diets ician ed by suring ree empleted	07.25.2025

STATEMENT	T OF DEFICIENCIES	(X1) PROVIDED IN LINE IS A STATE OF THE STAT			OMB	NO. 0938-039	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) D	X3) DATE SURVEY COMPLETED	
		34G147	B. WING				
NAME OF PROVIDER OR SUPPLIER			S. WING			07/09/2025	
SUNNY H				STREET ADDRESS, CITY, STATE, ZIP CODE 279 SUNNY HILL DRIVE LINCOLNTON, NC 28092			
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIES	ID				
TAG	REGULATORY O	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OURDRE	(X5) COMPLETION DATE	
	sweet tea. Continue client #1 was served including a second second second with frosting. For client #1 to consume Record review on 7/9 evaluation for client #1 the client's diet order low cholesterol, chop Continued record revidinner menu for the 1 ground beef tacos (2 each), tomatoes, lettu	Des, sour cream, salsa and in rice, pinto beans, water and dobservation revealed that if all of the menu items above, serving of rice and a slice of surther observation revealed in the entire meal. 2/25 revealed a nutritional if 1 dated 11/22/24 indicating to be 1800 calories, low fat	W 46:				
B. fo	on 7/9/25 confirmed the confirmed the confirmed and, instead, should be confirmed and with lite doubt the PM confirmed arved their specially placed. The facility failed to be confirmed at the confirmed and the	morning meal on 7/9/25 consist of cheese grits, s, milk, water and regular revation revealed client #2 above items and to					
Re	cord review on 7/9/2	5 revealed a nutritional					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB	OMB NO. 0938-03	
NAME OF PROVIDER OR SUPPLIER		IDENTIFICATION NUMBER:	A. BUILDIN		(X3) DA	MPLETED	
		B. WING					
SUNNY H	ILL II			STREET ADDRESS, CITY, STATE, ZIP CODE 279 SUNNY HILL DRIVE LINCOLNTON, NC 28092		7/09/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OUI D DE	(X5) COMPLETION DATE	
W 463	grapefruit or caffeine.	2 dated 3/19/25 indicating to be Heart Healthy, no	W 463				
	regular coffee. Further	r interview with the PM					
	C. The facility failed to for client #3. For exam	ensure the prescribed diet ple:					
s c	evealed the meal to co sausage links, peaches coffee. Continued obse	s, milk, water and regular ervation revealed client #3 above items, but no crance					
tt p g E	valuation for client #3 ne client's diet order to ortions, ½" consistence rind food if client #3 pr nsure plus every morn	y with thin liquids (may efers) no grapefruit, ing. Continued record ular diet breakfast menu		?			
or the	at client #3 should hav ange juice with breakfa	PM on 7/9/25 confirmed be been served 8 oz of last. Further interview with li clients should be served be diets at every meal.					
D. for	The facility failed to er client #4. For example	nsure the prescribed diet					
Ob	servation during the e	vening meal on 7/8/25					

OLIVIERS FOR MED	ICARE &	MEDICAID SERVICES				NO SOOS SO	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	3	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) D	(X3) DATE SURVEY COMPLETED	
		34G147	B. WING				
NAME OF PROVIDER OR SUF	PPLIER		J. WILL	ornore		07/09/2025	
SUNNY HILL II				STREET ADDRESS, CITY, STATE, ZIP COU 279 SUNNY HILL DRIVE LINCOLNTON, NC 28092	DE		
PREFIX (EACH	DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE	
ground beef, flour tortilla, it sweet tea. Co client #4 was including a se cake with fros client #4 to co Record review evaluation for the client's die no caffeine, no review revealed diabetic diet to and 6" tortilla ocup green sale beans, 16 oz with that client #4 so cake during the have been send dressing. Furth that all clients so prescribed diet. E. The facility for client #5. For Observation durevealed the me sausage links, pooffee. Continue	meal to be tomatoes Mexican in continued of served a second served as econd with life water. The facility should not be dinner in eved a great er interview and every sailed to element of the eleme	se 2 tacos consisting of se, sour cream, salsa and ice, pinto beans, water and observation revealed that all of the menu items above, ving of rice and a slice of the observation revealed ne entire meal. 25 revealed a nutritional dated 3/12/25 indicating to be Diabetic, no grapefruit, for 8pm. Continued record 1/25 dinner menu for the nund beef tacos (2 oz meat matoes, lettuce, salsa, 1/2 and dressing, 1/2 cup black of the period of the number of	W 46	3			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2025 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** (X3) DATE SURVEY A. BUILDING COMPLETED 34G147 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2025 STREET ADDRESS, CITY, STATE, ZIP CODE SUNNY HILL II 279 SUNNY HILL DRIVE LINCOLNTON, NC 28092 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 7 W 463 the client's diet order to be Regular diet, double portions, regular snacks. 1" consistency, thin liquids. Continued record review revealed the regular diet breakfast menu to include 8 oz of orange juice. Interview with the facility PM on 7/9/25 confirmed that client #5 should have been served 8 oz of orange juice with breakfast. Further interview with the PM confirmed that all clients should be served their specially prescribed diets at every meal. F. The facility failed to ensure the prescribed diet for client #6. For example: Observation during the evening meal on 7/8/25 revealed the meal to be 2 tacos consisting of ground beef, tomatoes, sour cream, salsa and flour tortilla, Mexican rice, pinto beans, water and sweet tea. Continued observation revealed that client #6 was served all of the menu items above, including a second serving of rice and a slice of cake with frosting. Further observation revealed client #6 to consume the entire meal. Record review on 7/9/25 revealed a nutritional evaluation for client #6 dated 7/11/24 indicating the client's diet order to be Diabetic, no concentrated sweets, low sodium, seconds of non-starchy veggies only, no caffeine. Continued record review revealed the 7/8/25 dinner menu for the diabetic diet to be 2 ground beef tacos (2 oz meat and 6" tortilla each), tomatoes, lettuce,

black beans, 16 oz water.

salsa, ½ cup green salad with lite dressing, ½ cup

Interview with the facility PM on 7/9/25 confirmed that client #6 should not have been served rice or cake during the dinner meal and, instead, should

TATELICAL	OF DEFICIENCIES	MEDICAID SERVICES				NO. 0938-03	
ND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	(X2) MULTIPLE CONSTRUCTION			
		A. BUIL			(X3) D	(X3) DATE SURVEY COMPLETED	
JAME OF F	PROVIDER OR SUPPLIER	34G147	B. WING		1.	7/00/000	
				STREET ADDRESS, CITY, STATE, ZIP CODE		7/09/2025	
BUNNY H	ILL II			279 SUNNY HILL DRIVE			
(X4) ID	CURRENT			LINCOLNTON, NC 28092			
PREFIX	(MACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT	TION		
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	M D DE	COMPLETIO DATE	
W 463	Continued From page	8	14/ 400				
	have been served a g		W 463				
	dressing. Further inter	view with the PM confirmed					
	triat all clients should l	De served their specially					
	prescribed diets at eve	ery meal.					
	MEAL SERVICES		14/ 47/	(M/474) Staff			
	CFR(s): 483.480(b)(2)	(iii)	VV 4/4	(W474) Staff will be in-serviced	by the	07.14.202	
				home manager to ensure appro	priate		
	Food must be served in	n a form consistent with the		diet consistencies are followed	per		
	developmental level of	the client		physician orders to maintain the			
	This STANDARD is no	ot met as evidenced by:		continued health and safety of a individuals in the home. Three	11		
	Based on observations	s, record review and		mealtimes assessments will be			
	interviews, the facility fa	ailed to serve food in a		mealtimes assessments will be monthly for the next three month	completed		
	orm consistent with the	e developmental levels and		clinical team to ensure this stand	is by the		
	rescribed diets of 3 of \$5). The findings are:	6 sampled clients (#1, #3,		being followed.	dard is		
1	A. The facility failed to e or client #1. For examp	ensure the prescribed diet le:					
C	bservation during the	evening meal on 7/8/25					
r	evealed the meal to con	nsist of 2 ground beef					
ta	acos consisting of group	nd beef, tomatoes, sour					
C	ream, salsa and flour to	ortilla, Mexican rice pinto					
D	eans, water and sweet	tea. Continued					
- OI	oservation revealed sta	iff to serve client #1 a					
110	our tortilla which was co	ut into pieces					
4	oproximately 1-2" in len	igtn.					
Re	ecord review on 7/9/25	revealed a putritional					
	aluation for client #1 d	ated 11/22/24 indicating					
the	e client's diet order to b	be 1800 calories, low fat,					
lo	w cholesterol, chopped	1/4" consistency. 1/4					
po	rtions of dessert.	, , , ,					
Int	erview with the program	m manager (PM) on					
7/9	3/25 confirmed that clie	nt #1's diet order is					
cui	rrent and that staff shou	uld have assisted them					
to	modify their food to 1/4"	consistency					

CTATES OF THE CO.		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI		TPLE CONSTRUCTION		OMB NO. 0938-03	
IDENTIFICATION NUMB		IDENTIFICATION NUMBER:		A. BUILDING		ATE SURVEY	
NAME OF	34G147		B. WING_				
SUNNY				STREET ADDRESS, CITY, STATE, ZIP C 279 SUNNY HILL DRIVE LINCOLNTON, NC 28092	CODE	07/09/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
W 474	Continued From page	9	W 47	74			
	B. The facility failed to for client #3. For exam	ensure the prescribed diet nple:					
	revealed the meal to of tacos consisting of grocream, salsa and flour beans, water and swe observation revealed s flour tortilla which was approximately 1-2" in let in the client's diet order to portions, ½" consistency grind food if client #3 persure plus every more	staff to serve client #1 a cut into pieces ength. 25 revealed a nutritional dated 4/24/24 indicating be Regular, double by with thin liquids (may refers) no grapefruit.					
S	nterview with the PM on 7/9/25 confirmed that lient #3's diet order is current and that staff should have assisted them to modify their food to 2" consistency.						
fo	C. The facility failed to e or client #5. For examp	ensure the prescribed diet le:					
ta cr be ot	evealed the meal to con acos consisting of group	nd beef, tomatoes, sour ortilla, Mexican rice pinto tea. Continued Iff to serve client #5 a ut into pieces					
Re	ecord review on 7/9/25 aluation for client #5 da	revealed a nutritional ated 11/26/24 indicating					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY EMPLETED
		34G147	B. WING			
NAME OF	PROVIDER OR SUPPLIER		279	EET ADDRESS, CITY, STATE, ZIP CODE SUNNY HILL DRIVE COLNTON, NC 28092		7/09/2025
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D BE	(X5) COMPLETION DATE
W 474	the client's diet orde portions, regular sna liquids. Interview with the PM client #5's diet order	ge 10 If to be Regular diet, double licks. 1" consistency, thin If on 7/9/25 confirmed that is current and that staff if them to modify their food to	W 474			