STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081042	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE RETIREMENT HOME	1600 U.S. HIGHWAY 221 S. FOREST CITY, NC 28043

(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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/21/25 and 10/22/25.	D 000		
D 108	10A NCAC 13F .0311 (b)(2) Other Requirements 10A NCAC 13F .0311 Other Requirements (b) The following shall apply to heaters and cooking appliances: (2) unvented fuel burning room heaters and portable electric heaters are prohibited; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to prohibit the use of a portable electric heater used one staff office. The findings are: Observation of the Manager's office on 10/21/25 at 8:37am revealed: -There was a portable electric heater plugged into an electrical outlet in the wall. -The heater was on and a digital thermometer on the heater read 76 degrees F°. Interview with a personal care aide (PCA) on 10/22/25 at 7:17am revealed: -She did not know how long the portable heater was in the office. -She did not know that portable heaters were prohibited in the facility. Interview with the medication aide (MA) on 10/22/25 at 7:30am revealed: -She brought the portable heater to the facility on 10/21/25. -She did not know that portable heaters were prohibited.	D 108		

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D 108	Continued From page 1 Interview with the Manager on 10/21/25 at 8:44am revealed she thought that portable electric heaters were allowed to be used in the facility as long as they were not plugged into an extension cord.	D 108		
D 119	10A NCAC 13F .0311(j) Other Requirements 10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that a hand bell or other signaling device was in place for 2 of 2 sampled residents (Resident #7 and #2), who were non-ambulatory and required assistance with incontinent care. The findings are: 1. Review of Resident #7's current FL2 dated 09/22/25 revealed: -Diagnoses included paroxysmal atrial fibrillation and hypertension. -Resident #7 was non-ambulatory and required assistance with incontinent care.	D 119		

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D 119	Continued From page 2 Review of Resident #7's Resident Register revealed an admission date of 01/20/12. Review of Resident #7's care plan dated 10/06/25 revealed: -Resident #7 required total care with toileting, ambulation, bathing, dressing, grooming, and transfers. -Resident #7 had limited range of motion and strength in her upper extremities. Interview with Resident #7 on 10/22/25 at 1:00pm revealed: -She did not have a hand bell or signaling device in her room until yesterday. -She had to "holler" for staff when she needed something. -Her voice was not very strong, so it was difficult for her to "holler." -She felt "terrible having to holler." -Staff would usually come by her room every 15-30 minutes and a lot of times she would wait until the next time they came by when she would need help with incontinent care because they would not hear her right away. -She waited 15 to 20 minutes sometimes when she was soaked in urine. Interview with the Manager on 10/21/25 at 9:56am revealed Resident #7 was non-ambulatory and had never had a hand bell or signaling device in her room. Refer to the interview with the personal care aide (PCA) on 10/21/25 at 11:35am. Refer to the interview with the medication aide (MA) on 10/21/25 at 8:55am.	D 119		

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D 119	Continued From page 3 Refer to the interview with the Manager on 10/21/25 at 9:56am. Refer to the interview with the Administrator on 10/21/25 at 2:55pm. 2. Review of Resident #2's current FL2 dated 09/05/25 revealed diagnoses included hypertension, heart and chronic kidney disease with heart failure, anemia, and diabetes. Review of Resident #2's Resident Register revealed an admission date of 09/12/25. Review of Resident #2's care plan dated 10/21/25 revealed: -Resident #2 had limited range of motion and limited strength in her upper extremities. -Resident #2 was incontinent of bowel and bladder. -Resident #2 required total care with toileting, ambulation, bathing, dressing, grooming, and transferring. Interview with Resident #2 on 10/21/25 at 8:46am and on 10/22/25 at 10:02am revealed: -She complained that she did not have a way to get help when needed. -She never had a hand bell or signaling device or any way to call for help. -If she needed help, she would have to "yell." -She had to "yell" for help when she was in pain, getting comfortable in bed, or getting up out of bed. -She felt "awful" having to yell for help. -Sometimes it took over 15 minutes to get help. Observation on 10/21/25 at 8:50am revealed Resident #2 was lying in bed hollering out "help, help, help" for staff to come into her room.	D 119		

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D 119	Continued From page 4 Interview with a resident on 10/21/25 at 9:00am revealed: -He heard Resident #2 yelling out for help frequently. -Staff needed to "do something" to help her because she always yelled out. Interview with the Hospice Nurse on 10/21/25 at 2:27pm revealed: -Hospice provided care 3 times a week and provided showers for Resident #2. -Resident #2 had issues with edema which prevented her from walking and was bedridden now. Interview with the MA on 10/21/25 at 8:55am revealed: -Resident #2 did not have a hand bell or signaling device in her room. -The staff went into Resident #2's room every 20 minutes. Interview with the Manager on 10/21/25 at 9:56am revealed: -Resident #2 was unable to get up on her own. -Resident #2 did not have a hand bell or signaling device in her room. -The staff placed Resident #2 in a room nearby where staff could hear her if she called out for help. Refer to the interview with the PCA on 10/21/25 at 11:35am. Refer to the interview with the MA on 10/21/25 at 8:55am. Refer to the interview with the Manager on 10/21/25 at 9:56am.	D 119		

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D 119	Continued From page 5 Refer to the interview with the Administrator on 10/21/25 at 2:55pm. _____ Interview with a PCA on 10/21/25 at 11:35am revealed: -Residents shouted for assistance if they needed help with something. -Sometimes other residents would get staff to assist residents that needed something. -She did not know how a resident would get assistance if they could not yell out. Interview with the MA on 10/21/25 at 8:55am revealed: -The residents did not have a device to signal for help. -The residents would yell out if they needed assistance. -They had bells in the facility but had not given any bells out to any of the residents. -The staff go into resident rooms every 20 minutes. Interview with the Manager on 10/21/25 at 9:56am revealed: -Residents just "yell" for help when they need something. -They have never had a signaling device in the 12 years she had worked at the facility. -They had 2 residents who were non-ambulatory who never had a signaling device in their room to call for help. Interview with the Administrator on 10/21/25 at 2:55pm revealed: -None of the residents had a signaling device. -He never heard that all residents needed to have a signaling device and was never asked about it. -A signaling device would have been the only way	D 119		

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D 119	Continued From page 6 to alert staff if a resident had an emergency. _____ The facility failed to ensure hand-signaling devices were available for Residents #7 and #2 who required assistance with personal care, resulting in residents having to yell for staff when they needed assistance. Resident #7 did not have a strong voice and felt "terrible" having to yell for assistance and saturated in her own urine, waiting on staff to do their next round, and Resident #2 needed pain medication, repositioning, and getting up out of bed, and felt "awful" having to yell for staff assistance. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/21/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 6, 2025.	D 119		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to ensure residents were treated with	D 338		

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D 338	Continued From page 7	D 338		

dignity and respect related to not having a signaling device to call for staff assistance, yell and seek out staff for themselves and other residents when assistance was needed, including 2 of 7 sampled residents who fell in the bathroom during the middle of the night (#3) and a resident who had to get out of bed during the night to look for staff (#6).

The findings are:

Interview with 6 residents on 10/21/25 from 8:46am - 11:35am and 10/22/25 at 10:02am revealed:
-One resident said she did not have a call bell or signaling device in her room,and she had to "holler" for staff when she needed something.
-Her voice was not very strong, it was difficult for her to holler, and that made her feel "terrible".
-A second resident reported that she did not have a way to get help when needed.
-She never had a call bell or signaling device so if she needed help, she would have to yell.
-She had to yell for help when she was in pain, getting comfortable in bed, or getting up out of bed and that made her feel "awful"
-A third resident revealed if she needed help from staff she had to "holler" for help and then staff would come "after a while".
-A fourth resident did not have a call bell or signaling device to alert staff when he needed assistance and it annoyed him to have to get up in the middle of the night to find staff.
-A fifth resident did not have a call bell or signaling device to alert staff when she needed assistance and was not sure how she would get help from staff if she fell in her room.
-A sixth resident revealed residents yelled from their rooms to get assistance from staff.
-Sometimes residents would have to go find staff

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to assist their roommates.
-Residents would "look out for each other".

1. Review of Resident #3's current FL2 dated 06/13/25 revealed:
-Diagnoses included hypertension and chronic obstructive pulmonary disease (COPD).
-Resident #3 was semi ambulatory and continent of bowel and bladder.

Review of Resident #3's Resident Register revealed an admission date of 11/16/17.

Review of Resident #3's Care Plan dated 10/06/25 revealed she was independent with transfers and required supervision with ambulation and toileting.

Interview with Resident #3 on 10/21/25 at 10:00am revealed:
-She got up during the night on 10/19/25 and walked independently to the bathroom and fell.
-She was not injured but could not get up from the floor.
-Her roommate, Resident #6, got up out of bed and left the room to get help for her.
-Staff then came to the bathroom and assisted her up from the floor.
-There was no way to call out for help other than to "holler" for staff or to walk down the hall.

Refer to the interview with a personal care aide (PCA) on 10/21/25 at 11:35am.

Refer to the interview with the medication aide (MA) on 10/21/25 at 8:55am.

Refer to the interview with the Manager on 10/21/25 at 9:56am.

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Refer to the telephone interview with the Administrator on 10/21/25 at 2:55pm.

2. Review of Resident #6's current FL2 dated 09/24/25 revealed:
-Diagnoses included chronic pain, chronic obstructive pulmonary disease (COPD), and diabetes.
-Resident #6 required the use of a rollator or wheelchair for ambulation.

Review of Resident #6's Resident Register revealed an admission date of 10/04/25.

Review of Resident #6's record revealed there was not a Care Plan.

Interview with Resident #6 on 10/22/25 at 9:25am revealed:
-Her roommate, Resident #3, fell in the bathroom a couple of nights earlier (10/19/25).
-She did not know what time the roommate fell.
-She got out of bed and ambulated with her walker down the hall to get assistance.
-She used her walker and not the wheelchair because she "needed the exercise" although it could be difficult.
-There was not a signaling device in her room and she did not know why.
-It would have been easier to have a signaling device in her room so that she would not have to get out of bed at night.

Refer to the interview with a PCA on 10/21/25 at 11:35am.

Refer to the interview with the MA on 10/21/25 at 8:55am.

Refer to the interview with the Manager on

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D 338	Continued From page 10 10/21/25 at 9:56am. Refer to the telephone interview with the Administrator on 10/21/25 at 2:55pm. _____ Interview with a PCA on 10/21/25 at 11:35am revealed: -Residents shouted for assistance if they needed help with something. -Sometimes other residents would get staff to assist residents that needed something. -She did not know how a resident would get assistance if they could not yell out. Interview with the MA on 10/21/25 at 8:55am revealed: -The residents did not have a device to signal for help. -The residents would yell out if they needed assistance. -They had bells in the facility but had not given any bells out to any of the residents. Interview with the Manager on 10/21/25 at 9:56am revealed: -She did not know that Resident #3 fell in the bathroom during the night on 10/19/25. -Residents just "yell" for help when they need something. -They have never had signaling devices in the 12 years she had worked at the facility. Telephone interview with the Administrator on 10/21/25 at 2:55pm revealed: -None of the residents had a signaling device. -He never heard that all residents needed to have a signaling device and was never asked about it. -A signaling device would have been the only way to alert staff if a resident had an emergency.	D 338		

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D 338	Continued From page 11 Attempted telephone interview with the third shift MA on 10/22/25 at 10:12am was unsuccessful. Refer to Tag D 0119 10A NCAC 13 F .0311(j) Other Requirements (Type B Violation). _____ The facility failed to provide a signaling device to all the residents which resulted in residents having to yell out from their rooms to get staff assistance for themselves and their roommates and get up out of bed to seek out staff in the facility and Resident #3 laying on the bathroom floor after a fall without a way to signal for help leading to Resident #6 getting out of bed at night to seek out staff for her roommate. This failure was detrimental to the health, safety, and welfare of all the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/03/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 6, 2025.	D 338		