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 _____	R-C 01/14/2026

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 follow-up survey on 01/13/26 with an exit conference via telephone on 01/14/26.	{D 000}		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations and interviews, the facility failed to maintain a hazard-free environment related to two unsecured oxygen tanks in the faciliy's living room and one unsecured oxygen tank in a hallway near the medication cart. The findings are: Observation of the living room during initial tour on 01/13/26 at 9:05am revealed: -There were two approximately 36-inch tall unsecured, empty oxygen tanks sitting upright on	D 079		

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 _____	R-C 01/14/2026

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 079	Continued From page 1	D 079		

the floor behind the sofa.
-There was an oxygen storage crate to stabilize the oxygen tanks next to it that had open slots.

Observation of the hallway next to the Resident Care Coordinator (RCC) office on 01/13/26 at 9:07am revealed:
-There was one approximately 36-inch tall unsecured oxygen tank in the corner next to the medication cart.
-The tank had tubing connected to it that was coiled up around it.

Interview with the RCC on 01/13/26 at 9:07am and 11:22am revealed:
-She did not know why the two tanks in the living room were not in a secure crate.
-A local company provided oxygen tanks and crates to the facility.
-The one tank by the medication cart was placed there when a resident was returned to the facility on 01/09/26.
-The resident came into the facility in a transport wheelchair that had the oxygen tank secured to the back of the wheelchair.
-The resident was transferred to her own wheelchair and taken to her room and the oxygen tank on the back of the transport wheelchair was placed next to the medication cart; but it should not have been left there unsecured.

Interview with a representative with the durable medical equipment (DME) company on 01/13/26 at revealed:
-Oxygen tanks should always be stored in a crate or rack regardless if they were empty or full.
-If an oxygen tank fell over it could become a projectile if the valve was damaged.
-A full oxygen tank was pressurized at 2,000 pounds per square inch (psi).

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 _____	R-C 01/14/2026

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 079	Continued From page 2 -Even an empty tank could cause bodily harm if it fell over and hit someone but did not become a projectile. Interview with the Administrator on 01/14/26 at 1:23pm revealed: -Per facility policy oxygen tanks should remain in secure crates at all times. -The staff knew the oxygen tanks should be in the crates. -He did not know the oxygen tanks were unsecured. The facility failed to properly secure three oxygen tanks in a crate or steadying device to prevent them from being knocked over. This failure put all residents at substantial risk for serious physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/13/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 13, 2026.	D 079		
{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: TYPE B VIOLATION	{D 108}		

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 _____	R-C 01/14/2026

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 108}	Continued From page 3 Based on observations and interviews, the facility failed to prohibit the use of a portable electric heater used in one staff office. The findings are: Observation of the Manager's office on 01/13/26 at 8:32am revealed: -There was a portable electric heater connected to a plug-in outlet extender (a device that increases the number of available sockets from a single wall outlet). -The heater was on and a digital thermostat on the heater read 82 degrees Fahrenheit. Interview with the Manager on 01/13/26 at 11:35am revealed: -The portable electric heater belonged to her. -She brought the portable heater to the facility on 01/12/26 because it was "really cold" in the office. -She used the outlet extender because there were only two electrical outlets available in the room. Telephone interview with the local county Building Inspector on 01/14/26 at 1:09pm revealed: -He was responsible for fire inspections in the county. -Portable heaters were a fire hazard. -The fire code did not allow the use of portable heaters. -Using a plug-in extender with a portable heater increased the risk of fire. -The power draw from the heater could melt the cords and cause a fire. Telephone interview with the Administrator on 01/14/26 at 1:28pm revealed: -Portable heaters were not allowed to be used in the facility.	{D 108}		

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 _____	R-C 01/14/2026

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 108}	Continued From page 4 -The staff knew portable heaters were not allowed to be used in the facility. -The staff were using the heater in the Manager's office without his knowledge. -The staff knew not to use plug-in extenders. _____ The facility failed to prohibit the use of a portable electric heater which was a fire hazard and the heater was connected through a plug-in extender which increased the risk of fire. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/13/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 28, 2026.	{D 108}		