

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/03/2025
NAME OF PROVIDER OR SUPPLIER  Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE  1311 E 28th Street Trenton, MO 64683	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (continued on next page)		

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.

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

TITLE

(X6) DATE

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interview, the facility failed to protect one cognitively impaired resident (Resident #1) from physical abuse, when Resident #2, who had a history of multiple instances of physical abuse including slapping, grabbing, and pushing Resident #1 and/or staff did not put any interventions in place to prevent further abuse. On 9/26/25, Resident #2 shoved Resident #1 into a bird aviary which caused broken glass to scratch Resident #1's back. Furthermore, the facility failed to provide protection to all other residents, from the potential of physical abuse, when no safety measures were put into place for Resident #2 after the 9/26/25 incident of abuse. The facility census was 58. The Director of Nursing was notified on 10/2/2025 at 2:49 P.M. of an Immediate Jeopardy (IJ) which began on 8/22/25. The IJ was removed on 10/2/2025, as confirmed by surveyor onsite verification. Review of the facility policy Abuse, Neglect, Exploitation, or Misappropriation Prevention Program, dated 3/23/23, showed:-Residents have the right to be free of abuse. This includes but is not limited to freedom from physical abuse;-The resident abuse, neglect, exploitation program consists of a facility wide commitment to: Protect residents from abuse, neglect, exploitation or misappropriation by anyone, including other residents, family members, friends;-Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.-Provide staff orientation and training programs that include topics such as abuse prevention, and handling verbally or physically aggressive resident behavior. Review of the facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, dated 4/11/23, showed upon receiving any allegation of abuse, the administrator is responsible for determining what actions are needed for the protection of residents. Review of Resident #1's admission Minimum Data Set (MDS- a federally mandated assessment tool completed by facility staff), dated 8/09/25, showed:-He/She had no cognitive loss; -Needed minimal assistance of staff for activities of daily living (ADLs: things completed in a day to care for oneself);-Diagnoses included: Cognitive communication deficit (a communication challenge resulting from impaired thinking skills, such as memory, attention, and problem-solving, rather than a language disorder), congestive heart failure, muscle weakness, reflux, and use of a cardiac pacemaker. Review of Resident #1's Comprehensive Care Plan, dated 8/21/25, showed: -He/She had a potential for falls;-Needed one staff assistance for ADLs;-Attended activities as he/she chose. Review of Resident #2's Level One Nursing Facility Pre-admission Screening for Mental Illness, Intellectual Disability Evaluation, dated 7/30/25 showed:-He/She was hard to redirect, was verbally and physically aggressive, wandered into others rooms, was 1:1 with staff and was given multiple as needed medications for aggression and anxiety.-He/She had medication orders due to physical aggression.-He/She had received several doses of medication to control verbal/physical aggression. Intervention was needed due to his/her physical aggression, throwing things, spitting, and wandering into others rooms and refusing to leave. Review of Resident #2's admission MDS, dated [DATE], showed:-He/She had significant cognitive loss;-Needed moderate to extensive assistance for ADLs;-Diagnoses included: Down Syndrome, morbid obesity, reflux, and constipation. Review of Resident #2's Comprehensive Care Plan, dated 8/29/25, showed: -He/She used psychotropic medications (medications that affect the brain and alter mental processes, emotions, and behavior) for behaviors due to Down Syndrome and behaviors;-Assess if his/her behaviors present a danger and intervene as needed; -Set expectations and limits for him/her.-No interventions put into place after incidents of aggression/agitation on 8/22, 8/23, 8/25, 8/28, 9/3, 9/5, and 9/11/25.Review of Resident #2's progress notes, dated 8/20/25 to 9/30/25, showed: -On 8/22/25 at approximately 9:30 P.M., staff heard a noise near the end of the hall. When staff responded, they found Resident #1 in Resident #2's room. Resident #2 grabbed Resident #1 by the arm and pushed him/her into a chair. Resident #2 was assisted to his/her room and checked for injuries. Resident #2 became aggressive and slapped at staff when he/she was not allowed to go into Resident #1's room. Resident #2 remained aggressive to staff while attempting to go into other resident's rooms. Resident #2's primary care physician (PCP) was notified and an order was given for Ativan (a prescription medication used for anxiety and sedation) 1 milligram (mg) by mouth one time only; -On 8/23/25 at 5:06 P.M., Resident #2 and Resident #1 were sitting at the nurse's station. Resident #2 became aggressive with Resident #1. Resident #2 pulled Resident #1's hair and slapped him/her in the face with an open hand. Resident #1 was removed to the Activity Room. Resident #2 kept trying to go after Resident #1. The Director of Nursing (DON) sat with Resident #2 and worked on breathing exercises: -On 8/25/25 at 12:58 A M Resident #1 was</p>		