

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/14/2025
NAME OF PROVIDER OR SUPPLIER  Sunnyview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  107 Sunnyview Circle Butler, PA 16001	

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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>36115</p> <p>Based on a review of facility documents, an audit conducted by the State Ombudsman Office and staff interviews, it was determined that the facility failed to notify the State Ombudsman Office of resident transfers and discharges for eight of eight months (a review period of from the facility's completed Medicare/Medicaid Recertification and State Licensure Survey completed on 6/21/24) (6/24, 7/24, 8/24, 9/24, 10/24, 11/24, 12/24, and 1/25) as required.</p> <p>Findings include:</p> <p>A request to review facility documents on 2/12/25, of the facility's compliance in notifying the State Ombudsman Office revealed the facility failed to provide documented evidence of notifying the State Ombudsman Office of residents transfers and discharges for the time period of 6/24, through 1/25.</p> <p>A review of an audit conducted 2/3/25, by the State Ombudsman Office revealed that the facility failed to notify the State Ombudsman Office of resident transfers and discharges.</p> <p>During an interview on 2/12/25, at 11:55 am the Director of Nursing confirmed that the facility failed to report resident transfers and discharges to the State Ombudsman Office for eight months from 6/24, through 1/25, as required.</p> <p>PA Code: 201.29(f)(g) Resident rights</p>

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
---	-------	-----------