

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 07/25/2025
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.			
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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. (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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record and staff interview it was determined that the facility failed to ensure that in preparation for a room change each resident/responsible party received written notice, including the reason for the change before the resident room was changed for one of ten (Resident R153). Findings include: Federal regulatory guidance under 483.10(e)(6) notes that moving to a new room or changing roommates is challenging for residents. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move. Review of Resident R153 was admitted to the facility on [DATE]. Review of Resident R153 clinical record MDS (minimum data set a periodic assessment of resident needs) dated 6/28/25, indicated diagnosis of schizophrenia (mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) , anxiety disorder (are a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation) and seizure disorder (a sudden burst of electrical activity in the brain. It can cause changes in behavior, movements, feelings and levels of consciousness). Review of Resident R153 clinical record progress notes indicated: 7/9/25: Resident R153 and/or responsible party was notified of room change on 07/09/2025, 10:00 AM. 7/9/25: Resident R153 not adjusting well to room change. Resident keeps returning to previous room refusing to leave. Staff explained to resident that she was in a different room, but resident continued to refuse to leave. When staff attempted to assist resident into her w/c resident was yelling no, no, I'm not leaving. Social Worker, and Supervisor, notified. 7/9/25: Resident R153 yelling and calling roommate vulgar names. Staff assisted resident to a quiet area where she could calm down. Resident continued behavior. Social worker and Supervisor aware. 7/9/25: Resident R153 is demanding her old room be given back to her. Yelling and swearing at staff. Demanding they stop toileting Residents to go get her pop and cookies. Putting call light on incessantly. Attempts to redirect unsuccessful most times. Upset her roommate is swearing at her and calling her names like fat retard for one. 7/10/25: Reported to this nurse that resident was up in her chair all night d/t roommate being rude. Resident would not return to her room, she was sleeping in the dining room in her chair. Resident kept attempting to go back into her previous room that is now occupied. Resident was in another resident's bathroom refusing to leave because she wanted her room back. Staff assisted resident to Dogwood unit at approximately 11am. Medication given to nurse. Resident then proceeded to ride the elevator back down to Cardinal unit twice insisting she wanted her room back. Aide assisted resident upstairs each time. 7/10/25: Resident R153 went to roommates side of the room and took her glasses and attempted to hide them on her side of the room. NA told resident that it was inappropriate to steal things and to stay on her side of the room. 7/11/25: Resident R153 and/or responsible party was notified of room change on 07/11/2025, 11:00 AM. 7/11/25: On Friday afternoon, I spoke multiple times with the Resident R153 about her room changes. She had recently moved into a semi-private room and began using abuse language with the new roommate. She was subsequently moved to another semi-private room and was in this room when I spoke with her. She refused to stay in the current room because it smells (the room did not have a bad odor in my opinion). I asked her if we clean the room and remove the odor, then would you live there? After a long pause, she said that couldn't live there because she doesn't like the roommate. When I asked what the resident specifically disliked about the roommate, she refused to answer the question. I explained to her that Medicaid only pays for a semi-private room and that there is no medical reason for her to have a private room. I emphasized that a single room is not an option. She then said that she would agree to move closer to the nurse's station. I explained that there were no open rooms, but once one opens, that we would move her there. I asked that, in the meantime, she seek a peaceful relationship with her new roommate. 7/11/25: Resident R153 has been moved from her private room due to the need for another resident to have a private room for safety reasons. Resident R153 is very upset and refused to move. We got her into another room on Cardinal but she then parked herself in her old room and refused to leave. We eventually got her moved upstairs to Dogwood and she was stealing from her roommate. Final move to another room per roommate's daughter's request. Resident R153 is not happy and wishes to be back on Cardinal where she knows residents and staff. States she is willing to share a room if</p>		

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<p>F 0560</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect a residents' right to refuse some types of non-requested transfers within the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interview it was determined that the facility to ensure that a room change was not completed for staff convenience for one of ten residents (Resident R153). Findings include: Review of Resident R153 was admitted to the facility on [DATE]. Review of Resident R153 clinical record MDS (minimum data set a periodic assessment of resident needs) dated 6/28/25, indicated diagnosis of schizophrenia (mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior), anxiety disorder (are a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation) and seizure disorder (a sudden burst of electrical activity in the brain. It can cause changes in behavior, movements, feelings and levels of consciousness). Review of Resident R153 clinical record - Census indicated she had been in a private room from 6/21/24 till 7/10/25. During an interview on 7/24/25, at 12: 05 p. m. Social Worker Employee E23 indicated that Resident R153 was moved to allow for another resident had a private room due to behavioral reasons. SW Employee E23 also indicated that they were aware that resident R153 was in a private room due to the same reasons, but they were under the impression that since Resident R153 only needed the room for behavioral reasons and was not able to pay for the private room it was ok to move her. During an interview on 7/24/25, at 12:10 p.m. SW Employee E23 confirmed that Resident R153 was moved so another resident could take her room due to the same type of concerns Resident R153 experienced, and SW Employee E23 confirmed that this was done to facility needs versus Resident needs for Resident R153 and the facility failed to ensure that a room change was not completed for staff convenience for one of ten residents (Resident R153). 28 Pa. Code 201.29(a)(c.3)(1) resident rights</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and documents, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision, which resulted in an elopement for two of 36 residents (Resident R12 and R37). This failure created an immediate jeopardy situation. Findings include:</p> <p>Review of the facility Elopement Prevention policy last revised 3/26/25, and reviewed 5/25, indicated it is the facility's policy to strive to prevent resident elopement. The facility strives to provide an environment that is free from hazards over which the facility has control and provide supervision and assistance to each resident to prevent avoidable accidents. The facility strives to reduce the risks for elopement while optimizing residents independence to safely attain or maintain their highest practicable physical, mental, and psychosocial well-being. The facility will identify residents at risk for unsafe wandering and exit seeking behavior and develop individualized prevention and management interventions based on exit seeking/elopement evaluation. Elopement represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration, and/or other medical complications, drowning, or being struck by a motor vehicle. The facility will define mechanisms and procedures for assessing or identifying, monitoring, and managing residents at risk for elopement to minimize the risk of the resident leaving a safe area without the staff awareness and/or supervision. Elopement is defined when a resident leaves the physical structure of the facility unattended and without staff knowledge and when a resident leaves the premises or a safe area without the facility's knowledge and supervision. Risk factors must be assessed and interventions implemented. Maintain door alarms and wander control systems in proper working order according to the manufacturer's recommendation. Monitor residents whereabouts of the at-risk residents during rounds. Check, through observation that the resident is wearing an electronic monitoring device as indicated. Electronic monitoring devices will be checked for placement each shift and documented on the TAR (Treatment Administration Record) or MAR (Medication Administration Record) by a licensed nurse and/or by the nursing assistant in their documentation. Electronic monitoring devices will be checked daily for function and documented on the TAR or MAR. If the electronic monitoring device is not found on resident or not working, staff will notify the charge nurse/supervisor to obtain a replacement. If a replacement is not readily available, other supervised monitoring processes will be implemented until a replacement is available.</p> <p>Review of the facility's Elopement-Management policy last reviewed 4/1/25, indicated the interdisciplinary team will reevaluate cognitively impaired residents who have attempted, unsuccessfully or successfully, to leave the facility without staff knowledge. With the assistance of the resident and/or resident representative, individualized intervention will be developed and initiated to manage the elopement behavior. Review and revise individualized interventions that may prevent further elopement attempts.</p> <p>Review of Resident R12's admission record indicated he was admitted on [DATE], with diagnoses of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), anxiety, and age-cognitive decline.</p> <p>Review of Resident R12's active physician order dated 1/25/25, revealed the resident required an assist of one person and a front wheeled walker.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident R12's Exit Seeking/Elopement Evaluation/Wandering assessment dated [DATE], revealed the resident was not an elopement risk. The first question asked if the resident was ambulatory or able to self-propel in a wheelchair and if no, may stop evaluation. It was documented the resident was not ambulatory and the resident's elopement assessment was not completed.</p> <p>Review of Resident R12's Exit Seeking/Elopement Evaluation/Wandering assessment dated [DATE], revealed the resident was an elopement risk. It was revealed the resident had exit-seeking behaviors and expressed a desire to leave. The summary and plan stated to utilize wander detection system and care plan for risk of elopement.</p> <p>Review of Resident R12's care plan dated 2/12/25, revealed the resident has a memory problem and tend to wander which may get me into situations where I am lost or could be injured. Interventions included I have problems with my memory. I am always asking for someone to help me and wander aimlessly. Please remind me to not go on elevator or leave the unit unless supervised by staff/family. I now wear a wander guard bracelet to keep me safe. Please make sure it is in working order. If not, please have it replaced immediately. If I do get off the unit unsupervised, please make sure the staff and family are aware.</p> <p>Review of Resident R12's MDS (Minimum Data Set a periodic assessment of care needs) dated 4/23/25, indicated the diagnoses were current. Section C-Cognitive Patterns revealed the resident BIMS (Brief Interview for Mental Status) was 4, severe cognitive impairment.</p> <p>Review of Resident R12's clinical record on 5/7/25, 5/8/25, 5/9/25, 5/12/25, and 5/27/25, revealed Resident R12 displayed exit-seeking behaviors. The facility failed to update Resident R12's care plan. Resident R12's care plan was not revised until 5/30/25, for the resident chewing off wander guard. No new interventions were added.</p> <p>Review of Resident R12's May 2025 TAR revealed on 5/28/25, and 5/29/25, Resident R12's electronic monitoring device was not checked on night shift. It was documented to see nurses note.</p> <p>Review of Resident R12's progress note dated 5/28/25, revealed wander guard not on person.</p> <p>Review of Resident R12's progress note dated 5/29/25, revealed Resident removed device.</p> <p>Review of Resident R12's clinical record revealed the resident had exit-seeking behaviors on 5/30/25.</p> <p>Review of Resident R12's care plan dated 5/30/25, revealed Resident R12 was an elopement risk and had been witnessed attempting to chew off band. No new interventions were implemented to prevent the resident from eloping.</p> <p>Review of Resident R12's progress note dated 6/1/25, at 10:27 a.m. entered by Licensed Practical Nurse, Employee E12 stated Resident found by staff in basement trying to exit outside. Resident brought back to unit and 15-minute checks started. No wander guard on.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident R12's progress note dated 6/1/25, at 10:37 a.m. entered by Registered Nurse (RN), Employee E5 stated this RN found Resident R12 in the basement. Resident R12 was wandering around. When RN, Employee E5 questioned Resident R12, Resident R12 stated I'm stretching my legs I need to walk around. When Resident R12 was asked what unit they resided on, Resident R12 replied one, and would not tell this RN what unit they were from nor would the resident tell this RN their name. Resident R12 was escorted to the elevator and taken to the second floor where staff indicated the resident was from the third floor.</p> <p>Review of Resident R12's progress note dated 6/1/25, at 11:15 a.m. entered by LPN, Employee E12 revealed the wander guard was placed underneath the resident's wheelchair, due to the resident continuing to remove from self.</p> <p>Review of Resident R12's progress note dated 6/1/25, at 3:30 p.m. revealed the resident's daughter was notified of the resident's elopement and the resident will be moving to another unit for safety reasons and this unit being more secure.</p> <p>Review of information submitted to the Department of Health on 6/2/25, stated on 6/1/25, at approximately 10:00 a.m. Resident R12 was found in the basement by staff ambulating with the use of their wheelchair. The resident was last seen by staff 10-15 minutes prior. A room change was completed, and the resident was moved to the secure Dementia unit. The resident stated to staff I wanted to go outside, and I will do it again.</p> <p>Review of Resident R12's investigation on 7/21/25, revealed Resident R12 eloped on 6/1/25, and was found in the basement trying to exit out of a door by RN, Employee E5. Resident R12 stated I wanted to go outside, and I will do it again. It was indicated the Resident did not have their wander guard on when found. A review of the facility's documentation for checking the operation of door monitors and patient wandering systems failed to reveal the Resident Monitoring System was checked on 5/30/25. It was written I was off 5/30/25. Number 2 elevator down was documented under the remarks section. A further review revealed a work order was entered on 5/30/25, at 8:17 a.m. by Maintenance Director, Employee E17 for the #2 elevator wander control. The room/area was listed as the basement. The priority was assigned medium. Service for elevator called was documented in the comment section.</p> <p>Review of RN, Employee E5's witness statement dated 6/1/25, revealed around 9:30 to 9:45 a.m. RN, Employee E5 went downstairs to look for supplies. Resident R12 initially was seen coming from the intermediate side towards the skilled side of the building. RN, Employee E5 was unfamiliar with Resident R12, so I didn't think much of it then. Shortly after RN Employee E5 went back towards the skilled side and went into the cage for supplies, while in there, RN, Employee E5 heard the door open and close. RN, Employee E5 heard feet shuffling. Once RN, Employee E5 came out from the cage, Resident R12 was observed looking for something and was asked what they were doing. Resident R12 stated they were exercising and needed to walk around, then Resident R12 went over to the exit door just to the left of the dock door and attempted to push on the door, which didn't open. While walking back to the elevator Resident R12 looked at RN, Employee E5's badge and said, I'm not sure I want to tell you my name. When RN, Employee E5 and Resident R12 got on the elevator, the electronic monitoring system didn't alarm at that time, and went to the 2nd floor. The door opened, still no alarm. RN, Unit Manager, Employee E18 was at the nursing station and thought the resident was a resident from the third floor who continues to take their monitor off. RN, Unit Manager, Employee E18, RN, Employee E5, and Resident R12 went to the third floor, and once there, again the alarm did not go off. LPN, Employee E12 recognized Resident R12 and was notified the resident was found in the basement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review LPN, Employee E5's witness statement dated 6/2/25, revealed around 10:00 a.m. on 6/1/25, they were made aware Resident R12 was found in the basement trying to exit a door outside. No wander guard was on the resident due to her removing days prior. Resident was last seen in room during breakfast and medication pass around 10 minutes prior to staff bringing the resident back to the unit. Resident R12's wander guard was placed under their wheelchair, due to resident stating If you put that thing on me I will throw it in the garbage.</p> <p>Review of Nurse Aide (NA), Employee E15's witness statement dated 6/3/25, stated Resident R12 was last seen around at 9:15 a.m.</p> <p>During an interview on 7/21/25, at 10:20 a.m. NA, Employee E21 was asked how does the facility prevent residents from eloping and replied, We have wander guard, ones who wander the alarm goes off, elevator locks, and we have to put a code in. When asked if the facility has enough staff to supervise residents, NA, Employee E21 replied We have our days, some days residents can have their moments, act up, on those days we can always use more people.</p> <p>During an interview on 7/21/25, at 10:24 a.m. LPN, Employee E7 was asked how to prevent resident's from eloping and response They have wander guards. It was indicated they are checked daily. LPN, Employee E7 indicated they were not working when Resident R12 eloped on 6/1/25, however they were reeducated to make sure the resident's wander guards work. LPN, Employee E7 stated Resident R12 has one, I am not sure what happened, I know they turned up the sensitivity.</p> <p>During an interview on 7/21/25, at 1:50 p.m. Maintenance Director, Employee E17 stated there are wander guard monitoring systems in each elevator and they are checked Monday through Friday. If Maintenance Director, Employee E17 is not working, then staff would be assigned to complete the checks. In order for the wander guard system to pass a test, it must alarm, and the elevator car cannot travel. Staff must enter in a code. Maintenance Director, Employee E17 confirmed elevator #2 wander guard system was not working on 5/30/25.</p> <p>During an interview on 7/22/25, at 9:22 a.m. RN, Employee E5 stated if residents are identified as an elopement risk, then a wander guard bracelet is applied to the residents. The bracelets are supposed to be checked every shift that they are on, the night shift checks the function. RN, Employee E5 stated I recall all elevators were functioning when asked if any elevators were out of service on 6/1/25, the day Resident R12 was found in the basement. RN, Employee E5 stated I originally was coming down looking for supplies and walked passed Resident R12 in the basement. I didn't think a whole lot of it. Then as I was near the maintenance part of the basement, I heard feet shuffling, the resident came pass the maintenance door, trying to push it open and get out. RN, Employee E5 seen Resident R12 was looking for a way out and approached the resident. RN, Employee E5 then proceeded to take Resident R12 back onto the elevator to find out where the resident belonged. The nurse on the second floor told RN, Employee E5 maybe Resident R12 was the resident who cuts their wander guard off. Once on the third floor, LPN, Employee E12 identified the resident. It was indicated the elevator alarm did not sound on the second or third floor. RN, Employee E5 confirmed they are the nurse educator and stated, informal education was done, I don't remember doing a whole formal education. Hey, make sure you keep track of people. RN Employee E5 confirmed that the facility failed to reeducate staff on elopement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/22/25, at 9:55 a.m. RN, Employee E18 stated Resident R12 had a wander guard on their chair when asked how the facility prevents residents from eloping. RN, Employee E18 stated the wander guard system did not go off.</p> <p>During an interview on 7/22/25, at 10:49 a.m. LPN, Employee E12 stated Resident R12 continuously tries to elope. LPN, Employee E12 stated when Resident R12 eloped on 6/1/25, the resident did not have a wander guard on. LPN, Employee E12 stated I do not recall any elevators out of service. LPN, Employee E12 stated what I believe Resident R12 took the elevator that is next to the dining room area. LPN, Employee E12 saw Resident R12 enter the dining room. The elevator must open, and Resident R12 got on. LPN, Employee E12 stated we didn't even know Resident R12 made it onto the elevator, I did not realize the wander guard was not on the resident, I assumed the resident was in the dining room.</p> <p>Review of Resident R37 admission record indicated they were admitted on [DATE] and readmitted on [DATE], with diagnosis of paranoid schizophrenia (mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) and muscle weakness.</p> <p>Review of Resident R37 physician orders indicated: Place electronic monitoring device dated 7/1/25.</p> <p>Review of Resident R37 elopement assessment dated [DATE], indicated resident was a risk for elopement, and there was a history of wandering, and the wandering placed the resident at significant risk of getting to a potentially dangerous place.</p> <p>Resident R37 MDS dated [DATE], indicated the diagnosis were current. Section C cognitive patterns revealed the resident BIMS was an 8, which indicated moderately impaired.</p> <p>Review of MAR/TAR indicated:</p> <p>Check electronic monitoring device functioning every night shift. Every night shift -Start Date-07/14/2025.</p> <p>Review of progress note dated 7/20/25, indicated Resident R37 made 2 attempts to elope this afternoon. Staff spoke with him and was able to get him off elevator and back to his room. Resident delusional and insist he can't stay here anymore and does not have a room. Alarming device is on as ordered.</p> <p>Review of Resident R37's progress notes dated 7/20/25, indicated: was on the unit when a staff ran up to this writer and stated that she saw resident walking down the street with his foley catheter in hand. This writer and other staff went to where resident was seen when he was noted to be laying down on the side of the road with other passengers after they state they witnessed resident fall and hit his head. resident was noted to have a large hematoma to his forehead and several abrasions to his face and hands. Resident was assisted to a wheelchair and 911 was called and resident was taken to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of witness statements indicated: Nurse Aide trainee Employee E28 stated I was on the porch visiting with family member when Resident I knew had begun walking outside along with three other people. I first thought it could have been family that he was with, so I gave it a moment until they started talking about how they didn't know him. I then went inside and told the front desk, the lady at the desk ran outside to get him and I slowly followed. She then turned around and said he fell on his face. At that point she went inside to grab help and a wheelchair. I ran down to Resident R37 where two civilians driving by had stopped as I arrived. We kept Resident R37 still and a civilian caller had called 911 for medical help. Soon after a family member, and a nurse and two staff members ran down.</p> <p>Review of witness statement indicated: LPN Employee E29 Stated Resident R37 was seen in room at 19:37 p.m. during medication pass. Before medication pass was complete Resident R86 stated that there was a commotion downstairs concerning a black gentleman from nursing unit shortly after this LPN heard overhead call at approximately 20:25 pm after speaking with caller on the phone, this LPN sought out RN supervisors and asked about incident. RN said Resident R37 found outside and sent to hospital. Resident R86 stated to LPN Employee E29 mentioned at 22:00 p.m. he saw Resident R37 get into elevator and leave Resident R86 stated no one put code in for elevator to move, after speaking to other staff, all state alarm for elevator did not go off.</p> <p>Review of witness statement indicated: Front desk employee E30 stated: A gentleman came downstairs; no wander guard went off. I did not recognize him, and he walked out with a group of people. A girl from the porch came in and said a resident was out and I ran out to try to get him. As soon as he heard me yell, he sped up. I was not able to keep up with him.</p> <p>Review of witness statement indicated: Resident R86 stated: I saw a white gentleman get in the elevator, with Resident R37. Resident R86 saw gentleman push the elevator button. The door closed and Resident R86 Didn't think anything of it.</p> <p>During an interview on 7/22/25, at 10:37 a.m. the Director of Nursing and Assistant Director of Nursing (ADON), Employee E10 confirmed the facility's elopement risk assessment tool failed to include a comprehensive scoring system. ADON, Employee E10 stated if you feel a resident is at risk, then you can proceed to implement interventions such as an electronic monitoring device or locked unit. The DON confirmed the facility does not have a locked unit. The DON stated, we don't trust it either, we are looking at everyone's charting every morning.</p> <p>On 7/22/25, at 11:57 a.m. the NHA and DON were notified that Immediate Jeopardy was called due to the elopement of Resident R12 on 6/1/25, and Resident R37 on 7/20/25, and facility staff were provided an Immediate Jeopardy template, and a corrective action plan was requested.</p> <p>On 7/22/25, at 2:30 p.m. the NHA confirmed the facility's plan of correction failed to reveal a designee and timeframe for when the elopement tool, resident-specific care plans will be completed, and that staff will be reeducated after the time the IJ was called.</p> <p>On 7/22/25, at 4:06 p.m. the NHA provided the facility's fourth plan of correction.</p> <p>On 7/22/25, at 5:21 p.m. an immediate action plan was received and accepted which included the following interventions:</p> <p>(continued on next page)</p>		

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 07/25/2025
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.

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The Facility is obligated to provide adequate supervision which does not rely on the Wander guard System and is based on the individual resident's assessed needs and the risks identified in the Exit Seeking Elopement Evaluation/ Wandering Tool, which does not replace an electronic monitoring device. (Wander guard System)</p> <p>-Will review and revise the elopement evaluation/wandering assessment to include comprehensive scoring system. To be completed by the Director of Nursing/designee within 24 hours, 7/23/25.</p> <p>-Current residents in-house will be reassessed for exit seeking / elopement by the Director of Nursing/designee within 24 hours, 7/23/25.</p> <p>-Residents will be assessed for exit seeking/elopement by the admitting RN upon admission.</p> <p>-Elopement binder will be revised upon completion of all assessments by the Director of Nursing/designee within 24 hours, 7/23/25.</p> <p>-Per results of assessments, care plans will be updated and implemented with resident-specific interventions by Director of Nursing/designee as warranted.</p> <p>-Elopement policies will be reviewed and revised as necessary by Nursing Home Administrator/designee within 24 hours, 7/23/25.</p> <p>-Wander guard system will continue to be audited by Environmental Director/designee daily.</p> <p>-Education of all facility staff will be conducted by Director of Nursing/designee on Elopement Risk and Supervision of residents within 24 hours, 7/23/25.</p> <p>-QA/QAPI was conducted 7/21 and 7/22/2025 related to plan of correction for F689. Meetings will be conducted 5 days/week until 8/5, 2x/week until 9/2, and monthly thereafter.</p> <p>The Elopement Risk assessment was revised on 7/22/25, to include a comprehensive scoring system. Residents with a risk greater than 12 are considered an elopement risk. Residents identified as elopement risk will have care plan updated to include individualized care interventions.</p> <p>On 7/23/25, 215/215 Residents were reassessed for an elopement risk, using the new Elopement. 27/215 residents were identified as an elopement risk.</p> <p>4 residents were newly admitted to the facility since 7/22/25. 0/4 residents were identified as an elopement risk.</p> <p>Review of elopement binder on 7/23/25, included 27/27 identified elopement risks.</p> <p>27/27 Residents that were identified as an elopement risk had care plans that were updated and implemented with resident-specific care interventions on 7/23/25.</p> <p>On 7/22/25, the Nursing Home Administrator reviewed the facility's Elopement policies. No changes were made.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of facility documents revealed Wander guard system transmission box and all wander guards present on residents were audited on 7/23/25. Daily checks will be completed by Environmental Director Monday through Friday and the designees on the weekends.</p> <p>234/255 educated Both in-person and phone. During in-person interviews on 7/23/25, from 10:36 a.m. to 11:17 a.m. 49 of 49 staff members verified education was completed on elopement risks and supervision. During phone interviews 8/8 staff members confirmed they were educated via phone.</p> <p>Facility conducted a QAPI meeting on 7/22/25. Meetings will be conducted 5 days/week until 8/5/25, 2x/week until 9/2/25, and monthly thereafter.</p> <p>Verification of the facility's Corrective Action Plan revealed all elements of plan were met. The Immediate Jeopardy was lifted on 7/23/25, at 1:45 p.m.</p> <p>During an interview on 7/25/25, at 3:45 p.m., the NHA and DON confirmed that the facility failed to make certain each resident received adequate supervision, which resulted in an elopement for two of 36 residents (Resident R12 and R37), resulting in Immediate Jeopardy.</p> <p>28 Pa. Code &sect; 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code &sect; 211.10(d) Resident care policies.</p> <p>28 Pa. Code &sect; 211.12(d)(5) Nursing Services.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on resident observations, resident and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of eleven of 13 residents (Group Resident (GR)1, GR2, GR3, GR4, GR5, GR6, GR7, Resident R16, R64, R113, and R203). Findings Include: During an interview on 7/21/25, at 10:20 a.m. Nurse Aide (NA), Employee E21 was asked how does the facility prevent residents from eloping (leaving a safe area without permission) and replied: We have Wanderguard (a device that alerts staff when a resident leaves a safe area), ones who wander the alarm goes off, elevator locks, and we have to put a code in. When asked if the facility has enough staff to supervise residents, NA Employee E21 replied We have our days, some days residents can have their moments, act up, on those days we can always use more people. During an interview on 7/21/25, at 10:34 a.m. Resident R203 stated the following: All the meals are cold because they're always late. They sit out there in the hallway before anyone passes them out. During an interview on 7/21/25, at 10:58 a.m. Resident R16 stated the following: When I get washed up, I have to argue with them to wash me. I'm supposed to have showers on Tuesdays. They don't offer to shower me, it rarely happens. During an interview on 7/21/25, at 1:33 p.m. Resident R64 stated the following: I don't get a bath on the weekend. I have to wash myself on the weekend. No one else will give one. I go to church; I have to get myself washed up and ready. We ask staff but they won't do it. They told me they don't shower people on weekends. They don't really care about us. During an interview on 7/21/25, at 1:38 p.m. Resident R113 stated the following: When you ring the buzzer you have to wait so long for an answer. My roommate and I both ring at the same time, it takes at least 15-20 minutes for someone to answer it. During a group interview on 7/22/25, at 2:00 p.m. seven out of seven residents voiced concerns with the facility being short on staff. During an observation on 7/24/25, at 3:09 p.m. State Agency was working in the conference room when two unidentified nurse aides entered the room unannounced to voice an anonymous concern over the facility's staffing. Anonymous NA Employee E25 stated We can have three aides for 60 residents. When asked what they are not able to do when they are short staffed, NA Employee E25 replied We can't answer lights timely, and we barely get showers done. They are always short help, and they never fix it. They don't care. During an interview on 7/25/25, at 11:29 a.m. NA Employee E26 stated the following: I don't feel safe with staffing. There isn't enough staff to do everything you need. Especially if they (residents) need more supervision. During an interview on 7/25/25, at 12:50 p.m. the Nursing Home Administrator confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for eleven of 13 residents. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(e)(6) Management.28 Pa. Code: 211.12(d)(1)(4) Nursing services.</p>		