

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  12/03/2025
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)
F 0693  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of three residents (R1). Findings include: Review of facility policy Enteral Feeding via Pump, Gravity, Bolus dated 4/1/25, indicated on the formula label, document initials, date and time the formula was hung/administered, and initial that the label was checked against the order. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with the diagnoses of right hip fracture, post-surgery, and pain. Review of a physician order dated 10/13/25, indicated enteral feed order one time a day Isosource HN at 60 milliliters (ml) per hour; up at 10:00 p.m. down at 6:00 a.m. Review of a physician order dated 10/10/25, indicated free water flush via enteral feeding tube, 100 ml of free water every four hours to maintain patency. During an observation on 10/16/25, at 11:12 a.m. Resident R1's enteral feeding bag was observed with no label, initials, date or time. The water bag used for flushes was dated 10/13/25, three days old. During an interview on 10/16/25, at 11:15 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed there was not a label on the enteral feeding formula, and that the water bag used for flushes was dated for three days ago. During an interview on 10/16/25, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to ensure that residents with an enteral feeding tube received appropriate treatment and services to prevent potential complications for one of three residents (R1). 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.</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
---	-------	-----------