

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/31/2026
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility policy, review of personnel files, and staff interview, it was determined that the facility failed to properly screen an employee by failing to conduct a timely criminal background check prior to the start of employment for three of five personnel files reviewed (Registered Nurse (RN) Employee E4, Certified Occupational Therapist Assistant (COTA) Employee E7, and Nurse Aide (NA) Employee E8. Findings include: Review of facility policy Abuse Policy- Prevention and Management dated 1/11/26, indicated that the facility must provide a safe environment and protect residents from abuse. All potential employees will be screened for a history of abuse, neglect, or mistreating residents during the hiring process. Screening will consist of, but not limited to: criminal background checks. On 7/29/26, employee personnel files were requested from the facility. Review of RN Employee E4's personnel file indicated a date of hire on 4/20/26. Review of RN Employee E4's personnel file included two criminal background check with the first Date of Request of 11/25/25, five months prior to employee's start date, and the second with a Date of Request of 7/29/26, three months after the employee's date of hire. Review of COTA Employee E7's personnel file indicated a date of hire on 5/1/26. Review of COTA Employee E7's personnel file included a criminal background check with a Date of Request of 6/25/26, more than one month after the employee's date of hire. Review of NA Employee E8's personnel file indicated a date of hire on 5/12/26. Review of NA Employee E8's personnel file included a criminal background check with a Date of Request of 10/14/26, approximately seven months prior to the employee's date of hire. During an interview on 7/30/26, at 12:06 p.m. Human Resources Employee E9 confirmed that Employee E4, and E9 had criminal background checks completed too far in advance to rule out criminal activity in a timely manner prior to the start of their employment, and that Employee E7's background checks was not completed prior to the start of employment. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.19(8) Personnel records.		

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff and resident interviews, it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance for three of eight sampled residents (Resident R9, R12, and R90). Findings include: The facility ADL Care Mobility-Ambulation; Restorative Ambulation Program policy dated 1/27/26, indicated activities of daily living (ADL) documentation will be completed by the nurse aide that provided the assistance (and other licensed nursing personnel that provide assistance) by the end of each shift. Review of the clinical record revealed Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/1/26, indicated diagnoses coronary artery disease (CAD- narrowing of the arteries that reduce blood flow to the heart), hypertension (high blood pressure) and depression. Review of Resident R9's clinical nurse notes and ADL documentation did not indicate that he received a haircut. During an interview and observation on 7/27/26, at 11:12 a.m. Resident R9 was observed with disheveled long hair and a long beard. Resident R90 stated I didn't get a chance to get to go down for a haircut, I never had beard before. Resident R9 stated I shaved every other day, I never had long hair. During an interview on 7/28/26, at 2:03 p.m. Staff Educator, Employee E20 confirmed Resident R9 needed hair services. Review of the clinical record revealed Resident R12 was admitted to the facility on [DATE]. Review of Resident R12's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/14/26, indicated diagnoses cancer, hypertension, and depression. Review of Resident R12's clinical nurse notes and ADL documentation did not indicate that she received a nail care. During an observation on 7/27/26, at 11:52 a.m. Resident R12 was observed with long unclean nails that were curling. During an interview on 7/28/26, at 2:12 p.m. Occupational Therapist, Employee E21 confirmed Resident R12's nails were curling and needed nail services. Review of the clinical record revealed Resident R90 was admitted to the facility on [DATE]. Review of Resident R90's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/7/26, indicated diagnoses coronary artery disease (CAD- narrowing of the arteries that reduce blood flow to the heart), hypertension (high blood pressure) and diabetes (occurs when your blood sugar (glucose) is too high. It develops when your pancreas doesn't make enough insulin or any at all). Review of Resident R90's clinical nurse notes and ADL documentation did not indicate that he received a haircut. During an interview and observation on 7/27/26, at 10:58 a.m. Resident R9 was observed with disheveled long hair and a long beard. Resident R90 stated I was supposed to get my haircut but no one ever showed up. Resident R90 stated he wants everything cut off. During an interview on 7/28/26, at 2:02 p.m. Social Worker, Employee E19 confirmed Resident R90 had not received hair services. During an interview on 5/19/26, at 2:23 p.m. information was disseminated to Registered Nurse, Employee E22 that the facility failed to provide Activity of Daily Living (ADL) assistance to Resident R9, R12, and R90. 28 Pa. Code: 211.12(d)(2)(5) Nursing services.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident family interview and documentation, and staff interview it was determined that the facility failed to assist a resident family with forming a family group and failed to follow up on a family concern for one of two resident family (Resident Family R110). Findings include: Review of facility documentation admission Agreement - Statement of Resident Rights dated 12/16/25, indicated: A Resident has the right to have family members or other resident representatives meet in the facility with the families or resident representatives of other residents in the facility. During an interview on 7/27/26, at 1:24 p.m. Resident Family R110 indicated that in May 2026, he had been interested in attending resident group and or starting a family group for the fourth floor. Resident Family R110 indicated that he had spoken with administration about this concern and sent them an email in May regarding the concern but nothing has happened - he has tried to work with the ombudsman but he doesn't have the contact information for other families and can't be around on the unit 24/7 to catch all the families. During the interview Resident Family R110 indicated that the facility had not assisted him or given him information for starting a Resident Family group. Resident Family R110 was unaware if the facility had any responsibility in assisting family members with starting a resident family group. Review of Resident Family R110 information addressed to the NHA indicated: This letter is to inform you that I have been in contact with the [NAME] County, LTC Ombudsman, about starting a Family Council @ Sunnyview Rehabilitation and Nursing Center for the secured Nursing Care unit. [NAME] County Ombudsman has sent me several links to assist me in getting started. Again, this will only be for the secured Nursing Care unit. I have had discussions with several family members of the residents, and they are interested in forming this Council. Our goal is to positively affect quality of life improvements, an alternate to filing complaints with outside agencies, consolidate common concerns, come up with ideas for how to address concerns/issues, keep the facility staff from being overwhelmed by a barrage of individual complaints, and build a trusting relationship between families and the facility. Review of the concern log from May 2026 to current failed to include an above concern from Resident Family R110. During an interview on 7/31/26, at 9:24 a.m. ANHA (Assistant Nursing Home Administrator) Employee E26 indicated: the ANHA and NHA were aware of the concerns from Resident Family R110, and that the concerns about starting a family group were not included on the concern log. ANHA, indicated that the isn't a family group at the facility and they did not assist Resident Family R110 with forming a family group and the facility failed to follow up on a family concern and failed to assist a family member with forming a family group. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18(e) (4) Management. 28 Pa. Code: 201.29(a) Resident rights.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of five units (Cardinal Unit). Findings include: Review of the facility's policy Medication Administration/Disposition last reviewed 1/27/26, indicated confidentiality of the resident's health information will be maintained during the medication administration process, the electronic health record will be in privacy mode when the nurse is away from the medication cart. If paper documentation is used it will be maintained in a closed binder. During an observation on 7/29/26, at 9:55 a.m. Licensed Practical Nurse (LPN) Employee E11 left the screen up on the laptop and papers that displayed resident personal information on top of the medication cart outside of room [ROOM NUMBER]. The information was available to anyone passing by. During an interview completed on 7/29/26, at 10:19 a.m. LPN Employee E11 confirmed that laptop screen was not closed and papers that displayed resident personal information were on top of the medication cart outside of room [ROOM NUMBER] and that the facility failed to maintain the confidentiality of residents' medical information on one of five units (Cardinal Unit). 28 Pa. Code: 201.29(c.3) Resident Rights. 28 Pa. Code: 211.12(d)(1)(3) Nursing services.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and review of facility documents and staff and resident interviews, it was determined that the facility failed to protect a resident from abuse for two of eight residents reviewed (Resident 92 and R201). Findings include: Review of facility policy Abuse Policy-Prevention and Management dated 1/27/26, indicated the facility prohibits the mistreatment, neglect, and abuse of residents. The facility must provide a safe resident environment and protect residents from abuse. Abuse if willful infliction of injury, intimidation resulting in physical harm, pain and/or mental anguish. Physical abuse includes spitting, roughly holding, and hitting. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from a BIMS assessment suggest the following distributions: 13 - 15: cognitively intact 8 - 12: moderately impaired 0 - 7: severe impairment Review of the clinical record indicated Resident R92 was admitted to the facility on [DATE], with diagnoses that include need for assistance with quadriplegia, chronic pain, and muscle weakness. Review of Resident R92's MDS dated [DATE], revealed the diagnoses remain current. Further review of the MDS, Section C, Cognitive Patterns; Question C0500 indicated Resident R92 had a BIMS of 15, indicating cognitively intact. Review of facility documents indicated on 6/20/26, at approximately 4:00 a.m. Resident R92 reported that doors were being slammed in the hallway during the night while he was trying to sleep. He yelled to quit slamming the doors and Nurse Aide (NA), Employee E8 entered the resident's room asking who said that. When Resident R92 confirmed he yelled to quit slamming the doors, NA, Employee E8 got in the resident's face with both middle fingers in the air and told the resident f*ck you. NA, Employee E8 then stepped back pointed to his penis and told the resident to suck my d*ck. Resident R92 stated he wanted a supervisor and put the call bell on for the nurse 3-4 times but NA, Employee E8 turned it off telling him he has been doing this for 14 years. He states the aide was so close to his face he could feel spit. It was indicated the resident's roommate verified the accusations. Review of NA, Employee E8's witness statement dated 6/20/26, indicated Resident R92 yelled at him for slamming a door. NA, Employee E8 told Resident R92 this is a business, you are going to hear people shutting doors. Review of Resident R11 witness statement dated 6/20/26, stated NA, Employee E8 was slamming doors and became verbally confrontational with Resident R92. During the interaction, Resident R11 heard the nurse aide tell Resident R92 to suck his dick and state f*ck you, I don't give a sh*t. Resident R11 also stated he heard NA say It's a business here, not your home. Review of Resident R148 witness statement dated 6/20/26, indicated NA, Employee E8 had chair sitting by their room. Resident R148 had headphones in but heard two male voices yelling around 3:00 a.m. During an interview on 7/27/26, Resident R92 stated he typically leaves his door open at night when he sleeps. On 6/20/26, during the overnight shift Resident R92 told NA, Employee E8 to not shut his door the whole way and he still did. Then while everyone was sleeping, he woke up to someone slamming doors. Resident R92 then yelled out to quit slamming the doors and NA, Employee E8 entered into his room and started yelling fu*k you, fu*k you, you can suck my di*k. NA, Employee E8 told Resident R92 that this isn't his home, it's a business. It was indicated Resident R92 had been at the facility for seven years and this is the first time something like that occurred. Review of the clinical record indicated Resident R201 was (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted to the facility on [DATE], with diagnoses that include depression, cancer, and Review of Resident R201's MDS dated [DATE], revealed the diagnoses remain current. Further review of the MDS, Section C, Cognitive Patterns; Question C0500 indicated Resident R201 had a BIMS of 15, indicating cognitively intact. Review of facility documents indicated on 6/20/26, during the overnight shift, Resident R201 requested an aide to empty his urinal and place it back under his brief. She was not sure how to do this and requested help from NA, Employee E8. NA, Employee E8 told Resident R201 that aides are not taught to do that with a urinal. NA, Employee E8 was using the F word repeatedly and when Resident R201 asked him to stop, NA, Employee E8 got close to the resident's face and purposefully spit in his face. NA, Employee E8 then threw the urinal bottle at the wall across from bed. NA, Employee E8 was suspended pending outcome of investigation and other residents on aides assignment were interviewed. Review of RN Supervisor, Employee E12 witness statement dated 6/20/26, revealed at approximately 4:00 a.m. RN Supervisor, Employee E12 entered Resident R201's room and he reported he activated his call light and asked NA, Employee E14 to empty urinal and place it back under his brief. NA, Employee E14 was not sure how to proceed and requested NA, Employee E8 assistance. Resident R201 stated that NA, Employee E8 loudly told Resident R201 that NA's were not taught to do this with a urinal. It was indicated NA, Employee E8 was using the F word and Resident R201 asked him to stop. NA, Employee E8 allegedly moved his face close to the resident's and said F*ck you. NA, Employee E8 then spit in Resident R201's face and threw the urinal across the room. Review of NA, Employee E8's witness statement dated 6/20/26, indicated he entered Resident R201's room to answer call light and was mad that colored people didn't put his urinal in his brief like he wanted and eluded to calling NA, Employee E8 a nigg*r. It was indicated Resident R201 called NA, Employee E8 colored people and said you don't want me to say the other word. Review of NA, Employee E14 witness statement dated 6/20/26, revealed Resident R201 rung his call light and asked to have the urinal placed back in his brief. NA, Employee E14 told Resident R201 she couldn't do that and he got upset, so she called for another aide. NA, Employee E8 came to assist and NA, Employee E14 went back to making rounds. Review of NA, Employee E15 witness statement dated 6/20/26, indicated Resident R201 rang his call bell at 3:10 a.m. and started to tell NA, Employee E15 that some black guy refused to do anything with his urinal because they were not trained to do that. Resident R201 stated NA, Employee E8 started going off and cursing. Resident R201 stated NA, Employee E8 spit in his face twice on purpose. NA, Employee E15 then notified the RN Supervisor. During an interview on 7/27/26, at 12:55 p.m. Resident R201 confirmed the allegations of abuse that occurred on 6/20/26. It was indicated NA, Employee E8 was yelling to go fu*k yourself, and refused to urinal back under brief. NA, Employee E8 then grabbed his shoulder and spit in his face. NA, Employee E8 was then walked out once the RN Supervisor was made aware of the incident. It was indicated the next day the doctor put an order for eye drops for five days. During an interview on 7/29/26, at 10:04 a.m. RN Supervisor, Employee E16 stated she worked 7 a.m. on 6/20/26, and was notified of the incident that occurred overnight with NA, Employee E8. It was indicated RN Supervisor, Employee E12 obtained witness statements prior to sending NA, Employee E8 home and calling the police. Then in morning all residents were interviewed and Resident R92 was identified as a victim as well. NA, Employee E8 was then placed on do not return list. During an interview on 7/29/26, at 12:43 p.m. Registered Nurse Supervisor, Employee E12 stated it was approximately 3 a.m. on 6/20/26, when a NA came in for their shift and was made aware of the altercation that occurred between NA, Employee E8 and Resident R201. It was indicated NA, Employee E12 was swearing and purposely spit on the resident. RN Supervisor Employee E12 immediately went in to assess the Resident R201. NA, Employee E8 was asked to write their own statement and was notified he was (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspended and was walked out of the facility. During a phone interview on 7/29/26, at 1:44 p.m. NA, Employee E14 stated she was unsure what happened once she left Resident R201's room. NA Employee E8 was unavailable for interview. Review of NA Employee E8's employee file indicated they were hired through agency. They last received Abuse training on 10/6/25. During an interview on 7/29/26, at approximately 3:00 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to protect two of eight residents from abuse (Resident 92 and R201). Pa. 28 Code 201.18(b)1(2)Management		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interviews, it was determined that the facility failed to notify a physician's of a resident with a hyperglycemic episode (high blood sugar) for one of two residents (Resident R11). Findings include: Review of the facility policy Hyperglycemia Management-Diabetes Management last reviewed 1/27/26, indicated the facility will quickly and safely respond to the needs of the resident exhibiting signs and symptoms of hyperglycemia (blood sugars above target levels). The facility will manage the resident's diabetes to prevent hyperglycemia based on physician orders and monitoring. Early signs of hyperglycemia include dizziness. The charge nurse will contact the physician if blood glucose is greater than 360 (if not on sliding scale coverage) or other specific blood glucose parameters identified by the physician order or if signs and symptoms are noted. Review of the clinical record revealed Resident R11 was admitted to the facility on [DATE]. Review of Resident R11's care plan dated 9/1/25, indicated the resident has diabetes and to administer medication as ordered by doctor. Monitor/document for side effects and effectiveness. Review of Resident R11's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/3/26, indicated diagnoses high blood pressure, anxiety, and diabetes (occurs when your blood sugar (glucose) is too high. It develops when your pancreas doesn't make enough insulin or any at all). Review of Resident R11's physician order dated 6/30/26, indicated to administer NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart-a rapid-acting insulin used to control blood sugar). Inject as per sliding scale: if 401 - 999 = 6 units call provider over 401 milligrams per deciliter (mg/dl) Review of Resident R11's July's Treatment Administration Record revealed the following blood sugar during Novolog administration:-7/2/26, Blood sugar 408 (mg/dl)-7/3/26, Blood sugar 500 (mg/dl)-7/22/26, Blood sugar 440 (mg/dl)-7/23/26, Blood Sugar 430 (mg/dl)-7/27/26, Blood Sugar 428 (mg/dl) Review of Resident R11's clinical record failed to include evidence the physician was notified of the blood glucose above 401 (mg/dl) as ordered. During an interview on 7/28/26, at 11:30 a.m. Resident R11 was asked if he ever displays signs and symptoms of low or high blood sugar and stated he sometimes feels dizzy. During an interview on 7/31/26, at 10:23 a.m. Certified registered Nurse Practitioner (CRNP), Employee E25 stated it is expected the facility notifies a physician for Resident R11 if his blood glucose is above 401. It was indicated there is a direct number staff can call to contact himself or any other provider. CRNP, Employee E25 stated he does not recall any notifications for the month of July. During an interview on 7/31/26, at 10:28 a.m. Registered Nurse, Employee E22 stated each time a physician is notified of a change in condition or parameters outside of an order, it should be documented in the clinical record. During an interview on 7/31/26, at 10:48 a.m. Registered Nurse, Employee E22 and Staff Educator, Employee confirmed no there was no evidence a physician was notified of Resident R11's elevated blood sugar as ordered on the following dates:-7/2/26, Blood sugar 408 (mg/dl)-7/3/26, Blood sugar 500 (mg/dl)-7/22/26, Blood sugar 440 (mg/dl)-7/23/26, Blood Sugar 430 (mg/dl)-7/27/26, Blood Sugar 428 (mg/dl) During an interview on 7/31/26, at 12:02 p.m. information was disseminated to the Director of Nursing and Assistant Director of Nursing, Employee E1 that the facility failed to notify a physician of a resident high blood sugar for one of two residents as ordered (Resident R11). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1) Management.28 Pa. Code: 211.10 (c)(d) Resident Care policies.28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain that residents received proper treatment for pressure ulcers for one of three residents (Resident R12). Findings include: Review of facility policy Physician Orders, Verbal and Telephone dated 1/27/26, indicated nurses are to confirm order transcription either through the electronic health record. The nurse will transcribe physician orders onto the electronic health record on the Treatment Administration Record. Review of facility policy Negative Pressure Wound Therapy, Wound Vac dated 1/27/26, indicated a physician order is necessary to provide this treatment. The facility will utilize equipment ordered by the physician. Review of the clinical record revealed Resident R12 was admitted to the facility on [DATE]. Review of Resident R12's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/14/26, indicated diagnoses cancer, stage IV sacral pressure ulcer (occurs when prolonged pressure, often over bony prominences such as the heels, sacrum, hips, or tailbone, causes localized tissue damage and necrosis, but the true depth of the wound is obscured by dead tissue or other coverings), and depression. Section M: Skin Conditions indicated the resident had one stage IV pressure ulcer. Review of Resident R12's care plan dated 4/1/25, indicated the resident is at risk for pressure ulcer development and to administer treatments as ordered and monitor for effectiveness. Review of Resident R12's wound care consult dated 6/8/26, revealed Certified Nurse Practitioner (CRNP), Employee E23 assessed Resident R12's sacral pressure ulcer and it was discussed with staff that the resident's wound vac was ordered last week, still pending arrival. CRNP, Employee E23 provided an order to apply wound vac at continuous pressure at 125 mmHg, and to change twice a week. Plan of care and education discussed with facility staff. Review of Resident R12's wound care consult dated 6/11/26, revealed Certified Nurse Practitioner (CRNP), Employee E23 assessed Resident R12's sacral pressure ulcer and it was indicated the resident's wound vac arrived on 6/8/26, and was applied however nursing was having difficulty with the vac. There was an error code and the machine kept beeping throughout the night. Nursing removed the wound vac and placed saline moistened gauze and covered with a dry dressing daily since. They have asked for my assistance in looking at the wound vac today, however it is not functioning properly. Wound representative was called and it was indicated a replacement will be sent. Review of Resident R12's physician order dated 6/12/26, indicated to apply wound vac therapy dressings three times a week and as needed. Attach wound therapy at 125 mmHg every Monday for stage IV pressure ulcer. The order entered in Resident R12's clinical record was scheduled to be changed every Monday. Review of Resident R12's June 2026 Treatment Administration Record revealed Resident R12's wound vac was changed on 6/15/26, and 6/22/26. During an interview on 7/30/26, at 10:30 a.m. Wound Care Nurse, Employee E24 confirmed she is responsible for entering orders from the wound care consultant into the resident's clinical records. Wound Care Nurse, Employee E24 confirmed CRNP, Employee E23 ordered Resident R12's wound vac to be changed twice a week, and the resident's wound vac was changed only once a week. During an interview on 7/31/26, at 11:59 a.m. the Assistant Director of Nursing, Employee E1 and Director of Nursing confirmed the facility failed to provide wound care treatment as order ordered by CRNP, Employee E23. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10 (c)(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services.		

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 07/31/2026
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 Sunnyview Circle Butler, PA 16001	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based a review of facility policy, clinical record review and staff interview, it was determined that the facility failed to complete a comprehensive nutritional assessment for two of five residents (Resident R89 and R115). Findings include: Review of facility policy Nutritional Assessment, dated 1/27/26, indicated the facility will ensure that the resident maintains, to the extent possible, acceptable parameters of nutrition and hydration status and that the facility:- Provides nutritional and hydration care and services to each resident, consistent with resident's comprehensive assessment;- Recognizes, evaluates, and addressed the needs of every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition and hydration. Resident will receive an admission nutritional assessment by a registered dietitian (RD), to determine nutritional problems and risks. A nutritional assessment will be initiated within 72 hours of admission and completed by the Assessment Reference Date (ARD). Review of facility provided job description for Registered Dietitian (RD) revealed the RD must be a qualified individual whose primary purpose in this position is to plan, organize, coordinate and evaluate the nutritional components of the dietary service for the facility. Essential job functions: completes clinical duties and documentation accurately and timely. Review of Resident R89's clinical record indicated that she was admitted to the facility 7/13/26. Review of Resident 89's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/19/26, indicated diagnoses of left femur (thigh bone) fracture, falls, and pulmonary disease. Review of Resident R89's clinical record indicated an admission MDS was completed on 7/19/26. Review of Resident R89's clinical record failed to reveal that a comprehensive nutritional assessment had been completed by a RD for the MDS dated [DATE]. Review of Resident R115's clinical record indicated that she was admitted to the facility 7/11/26. Review of Resident 115's MDS dated [DATE], indicated diagnoses of dependance on renal dialysis (clinical purification of the blood, as a substitute for normal kidney function), sepsis (emergency condition caused by the body's overwhelming response to an infection), and colostomy (surgical procedure that creates an opening (stoma) in the abdomen to allow stool to exit the body when it cannot pass through the anus). Review of Resident R115's clinical record indicated an admission MDS was completed on 7/17/26. Review of Resident R115's clinical record failed to reveal that a comprehensive nutritional assessment had been completed by a RD for the MDS dated [DATE]. During an interview on 7/27/26, at 10:25 a.m., Food Service General Manager (FSGM) Employee E10 was unable to identify whom the current clinical RD was, that the position was employed directly by the facility and the Nursing Home Administrator would be able to identify whom was currently employed in this position. During an interview on 7/28/26, at 11:15 a.m., the Nursing Home Administrator (NHA) revealed that the facility currently does not have a RD on staff due to recent resignation of prior RD. During an follow-up interview on 7/28/26, at 1:53 p.m., the NHA confirmed that the prior RD resigned on 7/8/26 and has been unable to hire a new RD since then, with 2 full time RD positions available. NHA then confirmed that the facility failed to have a RD currently employed on staff to complete the essential job functions of the position. During an interview on 7/29/26, at 10:18 a.m., the Director of Nursing (DON) confirmed that an admission nutritional assessment by a RD had not been completed for Resident R89 and Resident R115 as required. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observations, staff and resident interviews, it was determined that the facility failed to provide appropriate respiratory care for two of five residents (Residents R111 and R217). Findings Include: Review of the facility policy Oxygen Administration last reviewed 1/27/26, indicated oxygen equipment will be checked daily for: Correct set up of equipment. Date tubing when initiated, and at least every two weeks when changed, more often if malfunction or visibly soiled. All tubing will be changed and dated every two weeks or more often if malfunction or visibly soiled. Review of the clinical record indicated Resident R111 was admitted to the facility on [DATE]. Review of Resident R111's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/16/26, indicated diagnoses of chronic obstructive pulmonary disease (COPD- makes it hard to breathe), coronary artery disease (CAD- reduces blood flow to the heart) and anxiety. Review of Resident R111's physician orders dated 6/22/26, indicated home non-invasive ventilator (a device used to deliver positive pressure through a nasal mask, full face mask or mouthpiece helping to rest lung muscles and improve breathing) to be applied at night. Settings are as followed, Oxygen 5 liters, Tidal (volume of air moved into or out of the lungs) 450 milliliters (ml), max pressure 35, expiratory positive airway pressure (EPAP) min/max 5/15, Pressure Support (PS) min/max, Autotrak, Average Volume-Assured Pressure Support (AVAPS) speed 5 centimeters of water (cmH2O/min). During an observation completed on 7/28/26, at 9:22 a.m. Resident R111 was resting in bed the mask to her non-invasive ventilator was sitting on top of her bedside stand, the mask was not stored in a bag as required. During an interview completed on 7/28/26, at 9:27 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed that the mask was sitting on top of the bedside stand not stored in a bag as required and that the facility failed to provide appropriate respiratory care for Resident R111. Review of the clinical record indicated Resident R217 was admitted to the facility on [DATE]. Review of Resident R217's MDS dated [DATE], indicated diagnoses of chronic respiratory failure with hypoxia (lungs cannot maintain sufficient oxygen levels), coronary artery disease and anxiety. Review of Resident R217's physician order dated 11/13/24, indicated oxygen at 2 liters per minute continuously. Review of Resident R217's physician order dated 12/18/24, indicated change oxygen set-up and tubing every 2 weeks on night shift. During an observation completed on 7/27/26, at 11:26 a.m. Resident R217 was resting in bed an oxygen nasal cannula (thin flexible tubing with two prongs that fit into the nostrils) was visible in her nose. The nasal cannula tubing was dated 6/29/26. During an interview completed on 7/27/26, at 12:28 p.m. LPN Employee E3 confirmed the oxygen tubing was dated 6/29/26, and that the facility failed to provide appropriate respiratory care for Resident R217. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, clinical record review, and staff interview, it was determined that the facility failed to conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for one of three residents (Residents R3). Findings include: Review of facility policy Bed Rails (Enabler/Assist Bars, Grab Bar, Halo/Donut)-Restraint/Non-restraint) policy dated 1/27/26, indicated the resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and if these alternatives were effective to meet the resident's assessed needs. The bed rails may be used to: Assist residents to participate in Assistance of daily living (ADL) care. Assist the resident in transfer to or from bed. Improve the residents' mobility and independent function. Assessment will be completed with admission, re-admission, quarterly, annually, with significant change in condition and if/when bed rails are added or removed. Review of the clinical record revealed Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/8/26, indicated diagnoses of diabetes (high blood sugar), hyperlipidemia (high fat in the blood) and depression. Review of physician orders dated 2/23/26, indicated side rails (right enabler) for positioning. Review of Resident R3's quarterly packet-V 14 bed rail evaluation dated 3/18/26, revealed bed rails are not recommended at this time. Review of Resident R3's quarterly packet-V 14 bed bed rail evaluation dated 6/19/26, revealed bed rails are not recommended at this time. Review of Resident R3's current comprehensive care plan revealed the resident has an ADL (activities of daily living) self-care deficit related to decline in overall function secondary to illness. Side Rails (right enabler) for positioning. During an observation on 7/26/26, at 11:21 a.m. revealed a bed rail - right enabler bar on Resident R3's bed. During an interview completed on 7/30/26, at 2:50 p.m. Registered Nurse (RN) Employee E4 confirmed that the bed rail evaluations were not accurate that the facility failed to conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for one of three residents (Residents R3). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store all drugs and biologicals in a safe, secure, and orderly manner and in two of seven medications carts (Cardinal South Hall and Cardinal East Hall) and two of four medication rooms (Cardinal Medication Room and Roseview Medication Room). Findings include: Review of the facility policy Medication Storage last reviewed 1/17/25, indicated medications and biologicals are stored safely, securely and properly, following manufacturer recommendations of those of the suppliers. The nursing staff is responsible for maintaining medication storage (medication carts and medication rooms) and preparation areas in a clean, safe and sanitary manner. Review of the facility's policy Medication Administration/Disposition last reviewed 1/27/26, indicated medications shall be administered in a safe a timely manner. When opening a multi-dose container, the date opened shall be recorded on the container. During an observation completed on 7/28/26, at 11:50 a.m. the Cardinal South Hall medication cart contained the following: 2 bottles of artificial tears opened and not labeled with a date as required. 2 bottles of latanoprost eye drops opened and not labeled with a date as required. 1 bottle of brimonidine eye drops opened and not labeled with a date as required. During an interview completed on 7/28/26, at 11:57 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed the above findings and that the facility failed to store all drugs and biologicals in a safe, secure, and orderly manner in the Cardinal South Hall medication cart. During an observation completed on 7/28/26, at 11:58 a.m. the Cardinal East Hall medication cart contained the following: 6 bottles of artificial tears opened and not labeled with a date as required. 2 bottles of latanoprost eye drops opened and not labeled with a date as required. 1 bottle of miebo eye drops opened and not labeled with a date as required. 2 tubes of erythromycin ophthalmic ointment opened and not labeled with a date as required. 1 bottle timolol eye drops opened and not labeled with a date as required. 1 package Ipratropium Bromide/albuterol opened and not labeled with a date as required. 1 Stiolito Respiimat inhaler opened and not labeled with a date as required. 1 bottle fluticasone nasal spray opened and not labeled with a date as required. 1 albuterol sulfate inhaler opened and not labeled with a date as required. 1 airsupra inhaler opened and not labeled with a date as required. During an interview completed on 7/28/26, at 12:08 p.m. LPN Employee E3 confirmed the above findings and confirmed that the facility failed to store all drugs and biologicals in a safe, secure, and orderly manner in the Cardinal East Hall medication cart. During an observation completed on 7/28/26, at 12:09 p.m. the Cardinal Units medication room refrigerators freezer contained ice build-up. During an interview completed on 7/28/26, at 12:13 p.m. LPN Employee E3 confirmed that the Cardinal Units medication room freezer contained ice build-up. During an observation completed on 7/28/26, at 12:30 p.m. the Roseview Medication rooms refrigerator contained: 1 bottle of liquid Neurontin opened and not labeled with a date as required. The area under the sink contained a blue tote. During an interview completed on 7/28/26, at 12:34 p.m. LPN Employee E13 confirmed the above findings and that the facility failed to store all drugs and biologicals in a safe, secure, and orderly manner in the Roseview Medication room. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.9 (a)(1) Pharmacy services. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interviews it was determined that the facility failed to currently employ a qualified Registered Dietitian (RD). Findings include: Review of facility provided job description for Registered Dietitian (RD) revealed the RD must be a qualified individual whose primary purpose in this position is to plan, organize, coordinate and evaluate the nutritional components of the dietary service for the facility. Essential job functions: completes clinical duties and documentation accurately and timely. During an interview on 7/27/26, at 10:25 a.m., Food Service General Manager (FSGM) Employee E10 was unable to identify whom the current clinical RD was, that the position was employed directly by the facility and the Nursing Home Administrator would be able to identify whom was currently employed in this position. During an interview on 7/28/26, at 11:15 a.m., the Nursing Home Administrator (NHA) revealed that the facility currently does not have a RD on staff due to recent resignation of prior RD. During a follow-up interview on 7/28/26, at 1:53 p.m., the NHA confirmed that the prior RD resigned on 7/8/26 and has been unable to hire a new RD since then, with 2 full time RD positions available. NHA then confirmed that the facility failed to have a RD currently employed on staff to complete the essential job functions of the position. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1)(6) Management.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, resident interviews, and meal observations, it was determined that the facility failed to provide resident selected menu items for two of five residents (Residents R90 and R203). Findings include: Review of the facility policy Dining and Food Preferences last reviewed 1/27/26, indicated that the individual dining, food and beverage preferences are identified for all residents. The individual tray assembly ticket will identify allergies, food and beverage preferences or special request and adaptive equipment as appropriate. Review of the clinical record revealed Resident R90 was admitted to the facility on [DATE]. Review of Resident R90's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/7/26, indicated diagnoses coronary artery disease (CAD- narrowing of the arteries that reduce blood flow to the heart), hypertension (high blood pressure) and diabetes (occurs when your blood sugar (glucose) is too high. It develops when your pancreas doesn't make enough insulin or any at all). Review of Resident 90's physician orders dated 7/31/25, indicated for a regular Consistent Carbohydrate Diet (CCHO) diet with regular texture and consistency. During a lunch observation completed on 7/27/26, at 1: 47 p.m. a review of Resident R90's lunch meal ticket indicated: -4 ounces (oz) tomato juice During observation of lunch tray, Resident R90 failed to receive 4 oz of tomato juice During an interview on 7/27/26, at 1:49 p.m. Nurse Aide, Employee E18 confirmed Resident R90 failed to receive 4 ounces of tomato juice as meal ticket indicated. Review of the clinical record revealed Resident R203 was admitted to the facility on [DATE]. Review of Resident R203's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/6/26, indicated diagnoses coronary artery disease (CAD- narrowing of the arteries that reduce blood flow to the heart), hypertension (high blood pressure) and hyperlipidemia (high fat in the blood). Review of Resident 203's physician orders dated 11/29/25, indicated no added salt diet, regular texture, regular consistency. During a lunch observation completed on 7/27/26, at 12: 44 p.m. a review of Resident R203's lunch (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meal ticket indicated: Savory chicken noodle soup Barbecued beef White bread Deli ham and cheese on white Potato chips Saltine crackers Hot chocolate Pear crisp Chocolate milk Whole milk Mayonnaise Observation of lunch tray received: Deli ham and cheese sandwich on white Peanut butter and jelly sandwich on white Hot chocolate Pear crisp Chocolate milk Whole milk Mayonnaise During an interview completed on 7/27/26, at 12:47 p.m. Registered Nurse (RN) Employee E2 confirmed that Resident R203's lunch tray did not match Resident R203 requested items and stated, I will call down to the kitchen and they will send the correct items up and confirmed that the facility failed to provide resident selected menu items for Resident R203. (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/27/26, at approximately 3:00 p.m. the Director of nursing and Nursing home Administrator confirmed the facility failed to provide resident selected menu items for two of five residents (Residents R90 and R203). 28 Pa Code: 201.18(b)(1)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined that the facility failed to maintain food service equipment in accordance with professional standards for food service sanitation on one of five nursing unit nutrition pantries (Rehab Unit). Findings include: Review of facility Food and Nutrition policy Equipment; Safety dated 1/27/26, indicated that it is the center policy that all foodservice equipment is clean, sanitary, and in proper working order. During an observation conducted 7/30/26, at 1:55 p.m. of the Rehab Unit's nutrition pantry, revealed a build-up of dried food debris splatters throughout the interior surfaces of the microwave. During an observation and interview conducted on 7/30/26, at 2:26 p.m. with Rehab Unit Manager (UM) Employee E6, she confirmed that above observation and that the facility failed to maintain food service equipment in accordance with professional standards in the Rehab unit nutrition pantry. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to prevent cross contamination during a medication pass for one of three resident's (Resident R33). Findings include: Review of the facility's policy Medication Administration/Disposition last reviewed 1/27/26, indicated staff shall follow established facility infection control procedures for the administration of medications. Review of the clinical record revealed Resident R33 was admitted to the facility on [DATE]. Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/27/26, indicated diagnoses of anemia (low iron in the blood), depression and anxiety. During a medication pass observation completed on 07/29/26, at 9:55 a.m. Licensed Practical Nurse (LPN) Employee E11 was preparing Resident R33's medications. LPN Employee E11 dropped Resident R33's Buspar tablet on to informational papers that were placed on the top of the medication cart. LPN Employee E11 placed on gloves, picked up the medication, and placed the tablet into the medication cup for administration. During an interview completed on 7/29/26, at 10:19 a.m. LPN Employee E11 confirmed dropping Resident R33's Buspar tablet onto the informational papers that were placed on the top of the medication cart. Picking the Buspar tablet up and placing it into the medication cup for administration and that the facility failed to prevent cross contamination during a medication pass for one of three residents' (Resident R33). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/31/2026
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 0579 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide information about how to apply for and use Medicare and Medicaid benefits. Based on observations and a staff interview, it was determined that the facility failed to display (for residents and/or their responsible person) written information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the building, where postings are available (First Floor). Findings include: During an observation on 7/30/26, at 10:30 a.m. on the First Floor had a bulletin board with required, posted information, that is conveniently located for residents and visitors. However, it failed to include information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid, and was confirmed by the Assistant Nursing Home Administrator. During an interview on 7/30/26, at 11:40 a.m. the Assistant Nursing Home Administrator Employee E26 confirmed the facility failed to display (for residents and/or their responsible person) written information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the building, where postings are available (First Floor). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.		