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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265715	A. Building B. Wing	10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyview Nursing Home & Apartments	1311 E 28th Street Trenton, MO 64683

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to protect one cognitively impaired resident (Resident #1) from physical abuse, when Resident #2, who had a history of multiple instances of physical abuse including slapping, grabbing, and pushing Resident #1 and/or staff did not put any interventions in place to prevent further abuse. On 9/26/25, Resident #2 shoved Resident #1 into a bird aviary which caused broken glass to scratch Resident #1's back. Furthermore, the facility failed to provide protection to all other residents, from the potential of physical abuse, when no safety measures were put into place for Resident #2 after the 9/26/25 incident of abuse. The facility census was 58. The Director of Nursing was notified on 10/2/2025 at 2:49 P.M. of an Immediate Jeopardy (IJ) which began on 8/22/25. The IJ was removed on 10/2/2025, as confirmed by surveyor onsite verification. Review of the facility policy Abuse, Neglect, Exploitation, or Misappropriation Prevention Program, dated 3/23/23, showed:-Residents have the right to be free of abuse. This includes but is not limited to freedom from physical abuse;-The resident abuse, neglect, exploitation program consists of a facility wide commitment to: Protect residents from abuse, neglect, exploitation or misappropriation by anyone, including other residents, family members, friends;-Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.-Provide staff orientation and training programs that include topics such as abuse prevention, and handling verbally or physically aggressive resident behavior. Review of the facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, dated 4/11/23, showed upon receiving any allegation of abuse, the administrator is responsible for determining what actions are needed for the protection of residents. Review of Resident #1's admission Minimum Data Set (MDS- a federally mandated assessment tool completed by facility staff), dated 8/09/25, showed:-He/She had no cognitive loss; -Needed minimal assistance of staff for activities of daily living (ADLs: things completed in a day to care for oneself);-Diagnoses included: Cognitive communication deficit (a communication challenge resulting from impaired thinking skills, such as memory, attention, and problem-solving, rather than a language disorder), congestive heart failure, muscle weakness, reflux, and use of a cardiac pacemaker. Review of Resident #1's Comprehensive Care Plan, dated 8/21/25, showed: -He/She had a potential for falls;-Needed one staff assistance for ADLs;-Attended activities as he/she chose. Review of Resident #2's Level One Nursing Facility Pre-admission Screening for Mental Illness, Intellectual Disability Evaluation, dated 7/30/25 showed:-He/She was hard to redirect, was verbally and physically aggressive, wandered into others rooms, was 1:1 with staff and was given multiple as needed medications for aggression and anxiety.-He/She had medication orders due to physical aggression.-He/She had received several doses of medication to control verbal/physical aggression. Intervention was needed due to his/her physical aggression, throwing things, spitting, and wandering into others rooms and refusing to leave. Review of Resident #2's (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admission MDS, dated [DATE], showed:-He/She had significant cognitive loss;-Needed moderate to extensive assistance for ADLs;-Diagnoses included: Down Syndrome, morbid obesity, reflux, and constipation. Review of Resident #2's Comprehensive Care Plan, dated 8/29/25, showed: -He/She used psychotropic medications (medications that affect the brain and alter mental processes, emotions, and behavior) for behaviors due to Down Syndrome and behaviors;-Assess if his/her behaviors present a danger and intervene as needed; -Set expectations and limits for him/her.-No interventions put into place after incidents of aggression/agitation on 8/22, 8/23, 8/25, 8/28, 9/3, 9/5, and 9/11/25.Review of Resident #2's progress notes, dated 8/20/25 to 9/30/25, showed: -On 8/22/25 at approximately 9:30 P.M., staff heard a noise near the end of the hall. When staff responded, they found Resident #1 in Resident #2's room. Resident #2 grabbed Resident #1 by the arm and pushed him/her into a chair. Resident #2 was assisted to his/her room and checked for injuries. Resident #2 became aggressive and slapped at staff when he/she was not allowed to go into Resident #1's room. Resident #2 remained aggressive to staff while attempting to go into other resident's rooms. Resident #2's primary care physician (PCP) was notified and an order was given for Ativan (a prescription medication used for anxiety and sedation) 1 milligram (mg) by mouth one time only; -On 8/23/25 at 5:06 P.M., Resident #2 and Resident #1 were sitting at the nurse's station. Resident #2 became aggressive with Resident #1. Resident #2 pulled Resident #1's hair and slapped him/her in the face with an open hand. Resident #1 was removed to the Activity Room. Resident #2 kept trying to go after Resident #1. The Director of Nursing (DON) sat with Resident #2 and worked on breathing exercises; -On 8/25/25 at 12:58 A.M., Resident #1 was being domineering to Resident #2. Resident #2 lost his/her temper and hit Resident #1 and lunged at him/her. Certified Nurse Aide (CNA) pulled Resident #1 away and Resident #2 was taken to his/her room; -On 8/25/25 at 5:22 P.M., Resident #2's PCP faxed a note to the facility showing an order for Seroquel (a prescription medication used to treat mental and mood conditions) 25mg twice a day. He/She had concerns about Resident #2's behaviors, safety of Resident #1 and if the facility was appropriate for Resident #2; -On 8/28/25 at 12:54 A.M., Resident #2 attempted to leave the facility and was not easily redirected. Resident #2 grabbed staff by the neck and attempted to throw the staff member down. Administrator was notified and instruction was given to call the emergency room for medication order. Nurse Practitioner (NP) A returned the call and ordered Haldol (a medication used to treat behaviors) 5mg Intramuscularly (IM) one time only. Medication was administered to Resident #2;-On 9/3/25 at 9:30 A.M., Resident #2 went to the nurse's station and threw a chair to the floor; -On 9/5/25 at 12:20 A.M., Resident #2 was sitting at the nurse's station with Resident #1. Resident #2 went to nurse's desk and threw the computer at the nurse, ripped papers up from the desk, threw the computer keyboard and the telephone. Staff had given the resident five sandwiches and two [NAME] bars, but the resident was not redirectable. Resident #1 was taken to the other nurse's station. Resident #2 was assisted to his/her room by staff;-On 9/11/25 at approximately 7:30 P.M., Staff were at the nurse's station talking with another resident family member. Resident #2 pushed the family member aside and grabbed the nurse's station computer. Resident #2 grabbed papers off the desk and ripped them up, and threw things from the nurse's desk. On call physician contacted and orders received for Haldol 5mg IM one time only. Resident #2 was administered the medication in the right arm, with the assistance of three staff members. Resident #2 went to Resident #1's room; -On 9/26/25 at approximately 7:00 P.M., staff were at the nurse's station, heard yelling and a loud bang. When staff arrived at the bird aviary, they found Resident #1 sitting on the floor, his/her back against the aviary and the aviary was broken. Resident #2 was sitting on the couch. Resident #1 said Resident #2 hit him/her and pushed him/her into the bird cage. Resident #1 was assisted off the floor and taken to his/her (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	room. He/She was found to have a scratch to his/her back and no other injuries. Resident #2 remained at the nurse's station and was monitored.Observation and interview on 9/30/25 at 10:30 A.M., showed Resident #2 was in the hallway with staff. Resident #2 said he/she pushed Resident #1 into the bird cage. Resident #2 then walked away to Resident #1's room. Observation on 9/30/25 at 12:30 P.M., showed Resident #1 and Resident #2 were sitting at the dining room table with no staff providing any interventions to ensure the residents safety together or any increased monitoring to ensure resident safety. Observation and interview on 9/30/25 at 3:11 P.M., showed:-Resident #2 was sitting on Resident #1's bed with no staff in room with the residents.-Resident #1 said his/her side was sore and he/she was stiff; He/She knew Resident #2 did not mean to hurt him/her; He/She believed Resident #2 was just overwhelmed. During an interview on 9/30/25 at 3:19 P.M., Resident #2 said: -He/She pushed Resident #1 into the bird cage, because Resident #1 would not give him/her food; -He/She hurt Resident #1 when he/she pushed the resident into the bird cage;-He/She pushed Resident #1 into the bird cage and that was a problem. During an interview on 10/6/25 at 5:00 P.M., Licensed Practical Nurse (LPN) A said: -He/She was the charge nurse on the night of 9/26/25; -He/She did not see the incident and only heard yelling and a loud noise; -When he/she arrived at the bird aviary Resident #1 was on the floor and the glass of the aviary was broken; -Resident #1 was taken to his/her room, Resident #2 was taken to the nurse's station; -Resident #1 had a large scratch to his/her back from the left shoulder blade to the middle of his/her back; -Resident #2 was not placed on checks or monitoring that he/she was aware of; -He/She is afraid Resident #2 would hurt another resident. -The DON would tell staff any interventions to put into place for any resident involved in an altercation; -He/She had not had any residents involved in altercations previously.During an interview on 9/30/25 at 3:55 P.M., the DON said: -He/She was notified of the incident between Resident #1 and #2 on 9/26/25;-The residents were separated and Resident #1 was taken to his/her room;-Resident #2 was not officially placed on increased checks or monitoring after he/she pushed Resident #1 into the bird aviary, but staff did not allow Resident #2 to leave the nurse's station;-He/She believed Resident #1 would pick on Resident #2 until Resident #2 would get angry. -He/She said staff were aware that Resident #2 could go to the MDS office to listen to music or use an ipad when Resident #2 was agitated. No other interventions were put into place.During an interview on 10/2/25 at 8:45 A.M., the Primary Care Provider (PCP) said: -He/She was aware Resident #2 had verbal outbursts by yelling at staff and the resident taking objects and throwing them at staff prior to 9/26/25;-He/She was notified of the altercation between Resident #1 and Resident #2 that occurred on 9/26/25; -He/She did not feel that adequate safety measures were in place to protect Resident #1 after the previous incidents and after this last incident;-He/She was concerned Resident #2 would really hurt Resident #1 sometime -He/She did not feel the facility was an appropriate placement for Resident #2 due to his/her diagnosis and previous behaviors;-He/She would expect the staff to put measures into place after each incident that would prevent other residents, including Resident #1 from injury. During an interview on 10/2/25 at 11:29 A.M., Resident #2's Guardian said: -He/She was aware Resident #2 had behaviors before admission to the facility when the facility told him/her when he/she agreed to take the resident.-He/She felt Resident #2 needed a higher level Department of Mental Health facility not long term care; -Resident #2's behaviors occurred when he/she was told no.-He/She would expect staff to put interventions in place after each incident to protect residents after an incident occurred. Note; At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). Incident 2628901