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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415023 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Sunny View Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 83 Corona Street Warwick, RI 02886 | |

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) |
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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that the Minimum Data Set (MDS) Assessment accurately reflected the resident's status for 1 of 2 residents reviewed who are assessed an an elopement risk, Resident ID #5.</p> <p>Findings are as follows:</p> <p>Record review revealed Resident ID #5 was readmitted to the facility's semi-secure unit in March of 2025 with diagnoses including, but not limited to, mild cognitive impairment and muscle weakness.</p> <p>Record review revealed that a care plan was initiated on 6/9/2025 indicating the resident requires the use of a TekTONE elopement prevention bracelet related to episodes of attempting to leave the facility with approaches/interventions including, but not limited to, ensuring that the TekTone elopement prevention bracelet is in place and its functionality, providing visual checks/supervision for safety.</p> <p>Review of the quarterly MDS Assessments dated 2/26/2025 and 4/3/2025 section Restraints and Alarms failed to reveal evidence that the resident was coded as having a TekTone elopement prevention bracelet in place.</p> <p>During a surveyor interview on 6/23/2025 at approximately 1:00 PM with the MDS Coordinator, she acknowledged that the resident wears a TekTone bracelet related to being at risk for elopement. Additionally, she revealed that they was coded inaccurately in the Section P Restraints and Alarms of the MDS.</p> <p>During a surveyor interview on 6/23/2025 at approximately 2:00 PM with the DNS, she was unable to provide evidence that Resident ID #5 was coded as having a TekTone elopement prevention bracelet in the section P of his/her MDS assessment.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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 record review and staff interview, it has been determined that the facility failed to ensure that each resident receives assistive devices to prevent accidents relative to the placement of a TekTone device (a device that allows at-risk residents to move freely about a facility, while preventing them from exiting the facility) for 1 of 1 resident who successfully eloped from the facility and sustained a major injury, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of the facility policy titled Elopement Assessment dated 10/27/2022 states in part, .It is the facility policy to maintain a safe and secure environment for all residents. In order to achieve this goal residents who are at risk for wandering/elopement need to be identified and a care plan developed with interventions to minimize or eliminate the risk as outlined below .Residents who are at risk for elopement include those with dementia, confusion .may warrant close watching .if the resident is assessed to be at risk for elopement, then the necessary and appropriate intervention must be put in place immediately to keep the resident safe i. e , wander guard bracelet, frequent checks, etc .</p> <p>Review of an additional facility's policy titled Wanderguard [TekTone device] System and Assessments Checks dated 2/7/2025 states in part, .The bracelet will be checked each shift to assure placement, the nurse will sign this as checked in the treatment record .</p> <p>Record review of a facility reported incident sent to the Rhode Island Department on Health on 6/16/2025 revealed that Resident ID #1 was found in the rear parking lot of the facility by a staff on the overnight shift on 6/12/2025. S/he was noted to have a large hematoma above the left eye and his/her left leg was externally rotated and s/he complained of pain. S/he was tranferred to an acute care hospital where s/he was diagnosed with a left hip fracture.</p> <p>Record review revealed Resident ID #1 was admitted to the facility's semi-secure unit in March of 2022 and readmitted in April of 2025 with diagnoses including, but not limited to, altered mental status, cognitive communication deficit, insomnia, and muscle weakness.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored a 6 out of 15 on his/her Brief Interview for Mental Status (BIMS) assessment, indicating severe cognitive impairment.</p> <p>Record review of a care plan dated 6/9/2025 revealed the resident is at risk for wandering and elopement related to diagnoses of dementia and cognitive decline with a goal for the resident to remain on the unit at all times unless leaving with staff or family. Staff interventions include but are not limited to, Frequent visual checks .Redirect away from exits .Engage in activities if applicable .</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>Record review of a physician's order dated 4/17/2025 revealed to check the placement of the TekTone elopement prevention bracelet every shift. Further review revealed that the frequency of this order was transcribed incorrectly. The order was transcribed to be completed once daily on Mondays, indicating that the placement would be checked one time a week and not every shift as ordered by the physician.</p> <p>Review of the resident's MDS Assessments Summary dated 4/18/2025 section P Restraints and Alarms failed to reveal evidence that the resident was coded as having a TekTone elopement prevention bracelet in place.</p> <p>Review of the June 2025 Treatment Administration Record revealed the resident's TekTone bracelet was last checked on 6/9/2025 during the 11:00 PM to 7:00 AM shift, which was three days prior to the elopement incident on 6/12/2025 night.</p> <p>Record review of a progress note dated 6/13/2025 at 1:36 AM authored by Registered Nurse, Staff A, revealed that the resident was found by staff in the rear parking lot at approximately 11:15 PM lying on the ground. The TekTone monitoring device was not located on the resident. The resident was alert and confused, with a large hematoma (a collection of blood outside of a blood vessel, often caused by injury) above his/her left eye, his/her left leg was noted to be externally rotated and s/he was complaining of pain.</p> <p>Further record review revealed the resident was transferred to an acute care hospital and was diagnosed with a left hip fracture.</p> <p>Review of a physician's order dated 4/23/2025 revealed that the resident is to receive the following medications at bedtime every day:</p> <ul style="list-style-type: none"> - Melatonin 5 MG (milligrams) for insomnia - Trazodone 12.5 MG for insomnia - Eliquis 2.5 MG for blood clot - Tylenol 1000 MG for pain - Omeprazole 40 MG for stomach ulcer or heart burn - Latanoprost eye drops 0.005% for glaucoma - Methenamine hippurate 1 gram for urinary tract infections prevention. <p>Review of the June 2025 Medication Administration Record failed to reveal evidence that the above-mentioned bedtime medications were signed off as administered on 6/12/2025 before his/her elopement incident.</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 a surveyor interview on 6/18/2025 at 1:26 PM with Staff A, he indicated that the resident's bedtime medications were not administered because s/he wasn't in his/her room at 11:15 PM at the time of the administration. When Staff A was asked as to why he waited until 11:15 PM to give the resident his/her bedtime medications, he indicated that it was a busy night and that he had not see the resident from the start of his shift (9:00 PM) until s/he was found outside of the facility. Additionally, Staff A, revealed that the resident did not have a TekTone elopement prevention device on when s/he was found on the ground outside of the facility on the night of 6/12/2025.</p> <p>During a surveyor interview with Nursing Assistant (NA), Staff B, on 6/18/2025 at 3:22 PM, he stated that he had last seen the resident in his/her room at approximately 10:30 PM during the rounds on the evening of 6/12/2025. Additionally, Staff B stated that he was unable to recall if the resident had a Tektone monitoring device on him/her during evening rounds.</p> <p>During a surveyor interview with NA, Staff C, on 6/20/2025 at 4:24 PM, he revealed that on 6/12/2025 at approximately 11:40 PM, he was routinely checking the outside of the facility when he saw something on the ground behind the kitchen. However, he thought it was a trash bag that was left out by staff. He indicated that when he got closer, he observed Resident ID #1 laying on the ground, calling for help. Further, Staff C revealed that he ran back into the building to alert the staff on Resident ID #1s unit that s/he was outside. This indicates that approximately 1 hour and 10 minutes had passed since s/he was last seen by staff in the facility.</p> <p>During a surveyor interview on 6/18/2025 at 12:03 PM with Director of Nursing Service, she indicated that she was unsure which door the resident exited the facility from. She indicated that the resident may have exited the building from the exit door closest to his/her room. Additionally, she revealed that all exit doors would have locked if the resident had been wearing a TekTone device. Furthermore, she acknowledged that the resident did not have a TekTone device on when s/he was found on the ground outside of the facility on 6/12/2025 at 11:15 PM. Lastly, she was unable to provide evidence that the facility's policy to check the TekTone device each shift to assure placement was followed.</p> <p>During a surveyor interview on 6/23/2025 at approximately 1:00 PM with the Nurse Practitioner, she revealed that two weeks prior to the elopement, it was reported to her that the resident had taken off the Tektone bracelet. Additionally, she indicated that she would have expected the staff to frequently check the TekTone elopement bracelet every shift daily for the safety of the resident.</p> <p>The facility's failures to follow their policy to ensure placement of the TekTone device every shift, and correctly transcribe the physician's order to verify the placement of a TekTone bracelet three times daily, resulted in a cognitively impaired resident who was identified as a wander risk, not having a TekTone device in place. Because the assistive device was not in place, s/he was able to exit the facility through unlocked doors (that would have locked if s/he had been wearing a TekTone device), placing him/her at risk for more than minimal harm, impairment, or death.</p> <p>Cross reference F 842.</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that resident records are complete and accurately documented, relative to the monitoring of an elopement prevention device, a TekTone device (a device that allows at-risk residents to move freely about a facility, while preventing them from exiting the facility), for 1 of 1 resident reviewed who eloped from the facility and sustained a hip fracture, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a facility's policy titled Wanderguard [TekTone device] System and Assessments checks states in part .The bracelet will be checked each shift to assure placement, the nurse will sign this as checked in the treatment record .</p> <p>Record review of a facility reported incident submitted to the Rhode Island Department on Health on 6/16/2025 revealed that Resident ID #1 was found in the rear parking lot of the facility by a staff on the overnight shift on 6/12/2025. S/he was noted to have a large hematoma above the left eye, his/her left leg was externally rotated and s/he complained of pain.</p> <p>Record review revealed the resident was admitted to a semi-secured unit of the facility in March of 2022 and readmitted in April of 2025 with diagnoses including, but not limited to, altered mental status, cognitive communication deficit, muscle weakness, and insomnia.</p> <p>Review of the Quarterly Minimum Data Set Assessment revealed the resident scored a 6 out of 15 on his/her Brief Interview for Mental Status assessment, indicating severe cognitive impairment.</p> <p>Record review of a care plan dated 6/9/2025 revealed the resident is at risk for wandering and elopement related to diagnoses of dementia and cognitive decline with a goal for the resident to remain on the unit at all times unless leaving with staff or family. Staff interventions include but are not limited to, Frequent visual checks .Redirect away from exits .Engage in activities if applicable .</p> <p>Record review of a physician's order dated 4/17/2025 revealed to check the placement of the TekTone elopement prevention bracelet every shift. Further review revealed that the frequency of this order was transcribed incorrectly. The order was transcribed to be completed once daily on Mondays, indicating that the placement would be checked one time a week and not every shift as ordered by the physician.</p> <p>Record review of the June 2025 Treatment Administration Record revealed the placement of the TekTone device was last checked on 6/9/2025 on the 11:00 PM to 7:00 AM shift which was 3 days prior to the resident's elopement on 6/12/2025.</p> <p>Record review failed to reveal evidence that the resident's TekTone device was being checked every shift as ordered since it was last checked on 6/9/2025.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Record review of a progress note dated 6/13/2025 at 1:36 AM authored by Registered Nurse, Staff A, revealed that the resident was found by staff in the rear parking lot at approximately 11:15 PM lying on the ground. The TekTone monitoring device was not located on the resident. The resident was alert and confused, with a large hematoma (a collection of blood outside of a blood vessel, often caused by injury) above his/her left eye, his/her left leg was noted to be externally rotated and s/he was complaining of pain.</p> <p>Further record review revealed the resident was transferred to an acute care hospital and was diagnosed with a left hip fracture.</p> <p>During a surveyor interview on 6/18/2025 at 1:26 PM with Registered Nurse, Staff A, he revealed that the resident didn't have the TekTone elopement prevention device on when s/he was found on the ground outside of the facility on the night of 6/12/2025.</p> <p>During a surveyor interview with Nursing Assistant, Staff A, on 6/18/2025 at 3:22 PM he stated that he was unable to recall if the resident had a TekTone monitoring device on him/her on the last round during the evening shift of 6/12/2025.</p> <p>During a surveyor interview with the Director of Nursing Services, on 6/18/2025 at approximately 3:30 PM, she revealed that the order dated 4/17/2025 was transcribed in error, and the TekTone monitoring device should have been checked for placement every shift, every day.</p> <p>During a surveyor interview on 6/23/2025 at approximately 1:00 PM with the Nurse Practitioner, she revealed that two weeks prior to the resident's elopement, it was reported that the resident had taken off the TekTone elopement prevention device. Additionally, she indicated that she would have expected the staff to follow the physician order which is to check the device placement daily on every shift for the safety of the resident.</p> <p>Due to the facility's failure to accurately transcribe and implement a physician's order regarding the monitoring the placement of the TekTone device, a cognitively impaired resident-identified as a known wander risk, exited the facility, fell and sustained a hip fracture. This failure placed the resident at risk for more than minimal harm, impairment, or death.</p> <p>Cross reference F689</p> |