

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 09/19/2025
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review and interview the facility failed to ensure staff followed facility's policy to timely update one Resident's care plan (Resident #15) out of the 14 sampled residents after the resident eloped from the facility. The facility census was 56. Review of the facilities Emergency Procedure- Missing Resident policy, not dated, showed:-Nursing staff is tasked with updating the care plan after a resident who eloped is found;-The DON is to ensure the care plan is updated. 1.Review of Resident #15's care plan, updated on 08/03/2025, showed:-The resident was at an increased risk for wandering related to repeated attempts to exit the facility;-The resident had impaired decision making related to dementia;-The resident had a diagnosis of depression;-The resident's care plan had not been updated after the resident eloped on 09/13/2025. Review of nursing progress notes, dated 9/19/25 at 8:00 P.M showed the resident eloped out the door on the 100 hall without his/her walker. The resident was then later found behind the facility 25 minutes later without his/her wander guard bracelet (A device that alarms when getting to close to an exit door.) on. During an interview on 9/19/2025 at 9:04 A.M., RN A said that he/she was there the night that resident had eloped and had seen him that night on 9/13/25 on the 100 hall around 8:00 P.M. with his/her walker, later that night he/she went to give him his/her medications and could not find him/her. RN A said there was an order on the resident's MAR (Medication Administration Record) to check the wonder guard shiftily and during report he/she was notified that the resident had a wander guard, but he/she had not had a chance to check it that night. During an interview on 09/19/2025 at 10:04 A.M. the DON (Director of Nursing) said no new measures to prevent the resident from eloping again had been put into place on the care plan after the resident eloped on 09/13/2025. The residents care plan should have been updated regarding the resident's new exit seeking behaviors. During an interview on 09/19/2025 at 10:41 A.M. the MDS (Minimum Data Set) Coordinator said:-The care plan was not updated after the resident eloped on 09/13/2025 and should have been;-The charge nurse on duty during the event was responsible for updating the care plan when an elopement occurs.</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
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