STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415023	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny View Nursing Home	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview, the facility failed to provide the necessary supervision to prevent the elopement of a cognitively impaired resident. This failure placed the resident in a situation of Immediate Jeopardy, as the resident exited the facility, undetected with another resident's visitor, and remained unsupervised in the community for approximately six hours.During this time, the resident's whereabouts were unknown, placing the resident at risk for serious harm, injury, or death. The resident was not located until s/he arrived independently at his/her former residence, where his/her spouse currently resides. The spouse then notified the facility of the resident's presence. The resident was subsequently transported to the hospital for medical clearance. Additionally, upon the resident's return to the facility, the facility failed to test the wander guard device the resident was wearing at the time of elopement and instead discarded the device without verifying its functionality, thereby eliminating the opportunity to assess whether the device functioned as intended and obscuring the facility's ability to determine the cause of the elopement. This deficient practice demonstrates the facility's failure to protect the resident from immediate risk and ensure a safe environment, resulting in a situation that was likely to cause serious harm, impairment, or death.Findings are as follows:Record review of a facility reported incident submitted to the Rhode Island Department of Health on 3/26/2026 states that Resident ID #1 was noted to be missing from the facility. Additionally, the report revealed that the resident was found at his/her previous address with his/her spouse after s/he was dropped off by another resident's visitor.Review of an undated policy titled Elopement Procedure 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 are to be monitored at all times. Their presence within (or absence from) the facility is to be accounted for. The charge nurse on each unit is responsible to know the whereabouts of the residents on his/her unit. Whenever a resident leaves the facility (with family or to an outside appointment), it must be noted on the sign out sheet which is kept at the receptionist desk in the lobby.Record review of an undated facility policy titled Wander guard System and Assessments; checks revised on 2/7/2025 states in part, . [the facility] will maintain a safe environment for all residents. Those residents identified as an elopement risk will wear a wander guard bracelet to assure optimal safety.Record review revealed the resident was admitted to the facility in August of 2024 with diagnoses including, but not limited to, dementia, cognitive communication deficit, and anxiety disorder.Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored a 4 out of 15 on his/her Brief Interview for Mental Status (BIMS) score, indicating severe cognitive impairment.Record review of a care plan dated 9/6/2024 revealed the resident wears a wander guard bracelet (a safety mechanism intended to monitor and prevent at-risk residents from exiting unsupervised) following his/her attempts to leave the facility. Interventions include but not limited to, ensure the wander guard device is in place, assess the functioning, the battery status of the device weekly, and provide visual checks or supervision for the resident's safety. Further review revealed a revised dated 7/5/2025 which indicated the resident is at risk for altered cognition (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415023	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny View Nursing Home	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	with periods of forgetfulness and confusion related to his/her diagnosis of dementia and cognitive impairment.Record review of physician orders revealed the following:7/11/2025: Check placement of the Tektone (wander guard/elopement prevention device) bracelet every shift on the left ankle.1/30/2026: Check the functionality of the Tektone device weekly on Fridays.Record review of the March 2026 Treatment Administration Record (TAR) indicated that staff documented the wander guard device as in place during first and second shifts on 3/25/2026, reflecting that the resident was wearing the bracelet. Further review of the TAR showed documentation that the device's functionality was checked and noted as operational on 3/20/2026.During a surveyor interview on 3/26/2026 at approximately 11:00 AM with Licensed Practical Nurse (LPN), Staff A, she revealed that she was the 7:00 AM to 3:00 PM shift nurse on 3/25/2026. Additionally, she revealed that she had observed the wander guard on the resident's left ankle when s/he was being accompanied to the activities room for the Bingo at approximately 2:30 PM on 3/25/2026.During a surveyor interview conducted on 3/26/2026 at 12:38 PM, LPN, Staff B, stated that she last observed the resident on 3/25/2026 at approximately 3:30 PM in the activity room. At that time, the resident was wearing a wander guard bracelet on his/her left ankle and was seated with a visitor engaged in conversation.Staff B reported that at approximately 4:30 PM, when she went to escort the resident to dinner, she was unable to locate him/her. She further stated that at approximately 5:00 PM, she contacted the resident's spouse to determine if s/he had taken the resident from the facility. The spouse informed Staff B that s/he did not have the resident and was unaware that the resident was missing.Additionally, Staff B stated that after speaking with the resident's spouse, she notified the management team that the resident could not be located. The management team subsequently initiated the facility's elopement protocol. According to Staff B, a comprehensive search was conducted, including a room-to-room sweep of the facility as well as a search of the immediate surrounding neighborhood, including gas stations, local stores, and the mall. Staff B further reported that upon returning to the facility at approximately 6:30 PM, law enforcement was on site and actively interviewing the Director of Nursing Services (DNS) Additionally, Staff B reported that law enforcement initiated a Silver Alert at approximately 8:00 PM. However, at approximately 9:00 PM, the resident's spouse contacted the facility to report that an individual had dropped the resident off at the family's home. During a surveyor interview on 3/26/2026 at approximately 2:00 PM, the resident's spouse reported being shocked when the resident arrived at the front door unaccompanied. The spouse stated that the resident appeared visibly confused, was holding a sandwich, and was unable to explain how s/he arrived home. The spouse further reported that the resident was immediately transported to the hospital for evaluation.Review of the Emergency Medical Services (EMS) run report dated 3/25/2026 revealed that per the resident's spouse, s/he arrived at the family's home with a sandwich in his/her hand without a recollection of how s/he got there. Additionally, the EMS report revealed that the resident was transferred to the hospital for an evaluation related to being missing for several hours from the facility.Review of a hospital document titled After Visit Summary, dated 3/25/2026, revealed that the resident presented following elopement from the nursing home. The resident was unable to account for his/her whereabouts during the preceding hours and could not recall whether any falls or injuries had occurred. The resident reported throat and chest pain rated at 10 out of 10, indicating severe, unbearable pain. Further review of the document indicated that the resident arrived at the hospital with an ankle monitoring device in place on the left ankle.Review of a nursing progress note revealed that the resident returned to the facility at 5:00 AM on 3/26/2026. Review of a nursing progress note authored by the Regional Nurse on 3/26/2026 at 8:00 AM revealed that the resident had no recollection of the incident and out of an abundance of caution a new wander guard device was applied to his/her left ankle.Further record review failed to demonstrate that the facility evaluated or tested the resident's prior wander guard device for functionality upon his/her return on 3/26/2026 before issuing a replacement device.During a surveyor interview on 3/26/2026 at approximately 12:00 PM, the Regional Nurse acknowledged that the resident was provided a new wander guard device (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415023	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny View Nursing Home	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	upon return from the hospital that morning. When asked to produce the original device, she stated that it had been discarded without being assessed for proper functioning.During a surveyor interview on 3/27/2026 at 9:22 AM, the Activities Director reported that bingo was held on 3/25/2026 from 2:40 PM to 3:40 PM. She stated that Resident ID #1 was not actively participating in the game but appeared to be engaged in a pleasant conversation with a female companion. The Activities Director further noted that when bingo concluded, nursing staff were called to escort all residents, including Resident ID #1, back to their units. She added that she did not observe the resident or the visitor leave the facility and did not hear the wander guard alarm sound at the exit.During a surveyor interview on 3/27/2026 at 9:30 AM, the Receptionist reported that she worked from 8:00 AM to 4:00 PM on 3/25/2026. She stated that she does not remain at the front desk continuously, as she frequently moves between the desk and the resident units. The Receptionist further indicated that while walking toward the North Unit at approximately 4:00 PM, she observed the resident and a visitor walking together toward the South Unit, which leads to the facility's main entrance/exit. She noted that she did not hear the wander guard alarm sound at the exit.During a surveyor interview on 3/27/2026 at 10:29 AM, the visitor stated that she was at the facility on 3/25/2026 to visit another resident. She admitted that Resident ID #1 expressed a desire to go to his/her home, and she proceeded to remove the resident from the facility, drive him/her to the spouse's house, drop him/her off, and leave without ensuring the resident's safety or notifying staff. The visitor further disclosed that she and the resident exited the facility through the main entrance/exit door, and that the wander guard alarm did not sound during their departure. When asked whether she had been provided a door code to enter or exit the facility, she stated that she had never been given one.During a surveyor interview on 3/27/2026 at approximately 11:00 AM with the Regional Administrator, in the presence of the Regional Nurse, they reported that a family member of another resident had observed the visitor exiting the facility with Resident ID #1 on 3/25/2026 at approximately 4:00 PM through the main entrance/exit door.In a separate surveyor interview on 3/27/2026 at 10:22 AM with that family member, he stated that at approximately 4:00 PM on 3/25/2026, he was sitting on the patio near the facility entrance when he witnessed the visitor leaving the facility with the resident. He noted that the door alarm did not sound as they exited and that he did not see the visitor enter a door code prior to leaving. During a surveyor interview on 3/27/2026 at approximately 2:00 PM with both the Regional Administrator and the Regional Nurse, they were unable to provide evidence that the previous wander guard device was checked or tested for functionality upon the resident's return to the facility before it was disposed of. They acknowledged that the resident had eloped from the facility and that they were unaware of his/her whereabouts for approximately six hours. The Administrator further stated that it was unclear whether the wander guard system had failed, the alarm sounded but staff did not respond, or the visitor had entered the door code. He explained that although the resident was wearing the wander guard device, the door alarm would not activate if a visitor used the code to exit. When asked why a visitor would have the door code, the Administrator confirmed that visitors should not be given the code, as they are not facility employees.The facility failed to ensure the safety of Resident ID #1, who was identified as at risk for elopement. Despite the resident wearing a wander guard device, the resident was able to leave the facility unsupervised for approximately six hours on 3/25/2026, during which time staff were unaware of his/her whereabouts. The facility did not verify the functionality of the resident's wander guard device upon return, and the previous device was discarded without assessment.Interviews with staff and visitors confirmed that the resident exited the facility with a visitor through the main entrance/exit door, and the wander guard alarm did not activate. Additionally, the facility was unable to provide documentation confirming that staff consistently monitored the resident in accordance with facility policy and physician orders.These failures placed the resident in at risk for serious injury, serious harm, serious impairment or death.