STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415129	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	99 Hillside Avenue Providence, RI 02906

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 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. 47939 Based on surveyor observation, record review and staff interview it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to wound care for 1 of 2 residents reviewed for burns, Resident ID #2. Findings are as follows: Record review of a community reported complaint received by the Rhode Island Department of Health on 9/20/2024 alleges that Resident ID #1 had reported that the facility was not adhering to the medical treatment plan related to his/her bilateral lower extremity wounds. Review of a policy titled Skin Care Non-Pressure Wound Assessment which states in part, .Residents with non-pressure injuries .are assessed, documented and provided appropriate treatment to promote healing . ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. Post op surgical site incisions are evaluated and documented on a least weekly .until it is resolved .documentation of non-pressure ulcers include Location, measurement .type of wound .partial thickness [damage of the first two layers of skin], full thickness [extends beyond the first layers of skin], draining amount, drainage color, odor . appearance of the wound bed, appearance of wound edges, appearance of peri wound, pain, effectiveness of treatment. Review of a policy titled Weekly Body Audit which states in part, All residents will have a body audit to address any skin issues on a weekly basis. If an alteration in skin integrity .is discovered, it will be documented on the Weekly Skin Audit form as soon as the nurse observes the area. Monitoring of any area will continue until the area is resolved . Record review revealed that Resident ID #2 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, dementia, muscle wasting and surgical aftercare following surgery. 1. Record review of a hospital continuity of care form revealed that the resident was discharged from the hospital on 9/6/2024 after receiving a surgical procedure for his/her burns with wound debridement (removal of dead tissue) of left hand and left thigh with an allograft procedure (a transplant of tissue from one person to another) to his/her left thigh. Record review of an admission document titled Weekly Skin Audit dated 9/6/2024, failed to indicate that the resident had a burn with an allograft to his/her left thigh. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a document titled non-pressure wound evaluation dated 9/11/2024 failed to indicate that the resident had a burn with allograft to his/her left thigh, per the facility's policy. Record review of a burn clinic document titled Continuity of Care Consultation and Referral Form dated 9/16/2024 revealed the resident was evaluated at a burn clinic with a recommendation for daily treatment to the left hip. The recommendations included to apply a wet to dry dressing (a dressing applied wet and removed when dry). Further record review failed to reveal evidence that the burn clinic's recommendations on 9/16/2024 were reviewed with the provider and acted upon until it was brought to the facility's attention on 9/24/2024 by the surveyor, indicating the left hip wet to dry dressing treatment was not completed for 8 days. During a surveyor observation and simultaneous interview on 9/24/2024 at 1:35 PM with Licensed Practical Nurse (LPN), Staff A, she revealed that she was the nurse on shift caring for the resident and was not aware of the burn clinic's treatment recommendation to the left hip. Staff A, assessed the resident's skin in the surveyor's presence and indicated the resident's right foot had four areas that were uncovered with no treatment in place. Staff A was unsure of the type of wounds that were present on his/her right foot. 2. Record review of an admission Weekly Skin Audit dated 9/6/2024, revealed the resident had four blistered areas to his/her right foot with different stages of healing, pink in color with no fluid which were not covered. Record review of a weekly skin audit dated 9/13/2024 failed to reveal evidence of the above mentioned blisters to his/her right foot. During a surveyor interview on 9/24/2024 at 2:42 PM with the facility's Wound Nurse, she was unable to explain why the burn clinic's recommendation for treatment to the resident's left hip had not been reviewed with the provider or acted upon. Additionally, she indicated she was not aware of the blisters on the resident's right foot and acknowledged she had not yet assessed them. During a surveyor interview with the Nurse Practitioner on 9/24/2024 at 3:31 PM, he revealed that he would have agreed with the wound recommendations made by the burn clinic as they are the specialists. He indicated the recommendations from the burn clinic should have been reviewed with the provider and acted upon. Additionally, he would have expected the resident to have a treatment in place for his/her blisters to the right foot. During a surveyor interview on 9/24/2024 at approximately 3:50 PM with the Director of Nursing Services, she revealed it would be her expectation for the wound nurse to follow up with all new admissions to ensure treatment orders are in place for residents with wounds. Additionally, she revealed she would investigate why the burn clinic recommendations were not reviewed with the provider and put into place for 9/20/2024. Further, she acknowledged the skin assessments completed on 9/6/2024, 9/11/2024 and 9/13/2024 did not accurately reflect the status of the resident's skin.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 47939 Based on surveyor observation, record review, resident, and staff interview, it has been determined that the facility failed to ensure that a resident with pressure ulcers receives the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 2 residents reviewed for pressure ulcers, Resident ID #2. Findings are as follows: According to the State Operations Manual, Appendix PP Guidance to Surveyors for Long Term Care Facilities, revised 8/8/2024 which states in part, A pressure ulcer/injury (PU/PI) can occur wherever pressure has impaired circulation to the tissue. A facility must .Identify whether the resident is at risk for developing or has a PU/PI upon admission and thereafter .Implement, monitor and modify interventions to attempt to stabilize, reduce or remove underlying risk factors .If a PU/PI is present, provide treatment and services to heal it and to prevent .It is important that each existing PU/PI be identified, whether present on admission or developed after admission .Any new PU/PI suggests a need to reevaluate the adequacy of prevention measures in the resident's care plan. Record review of a community reported complaint received by the Rhode Island Department of Health on 9/20/2024 alleges that Resident ID #1 had reported that the facility was not adhering to the medical treatment plan related to his/her bilateral lower extremity wounds. Review of a policy titled Prevention & Management of Pressure Injuries which states in part, .Residents with pressure injuries .are identified, assessed and provided appropriate treatment to encourage healing and/or maintenance of skin integrity. Care plans are developed .ongoing monitoring and evaluation are provided to ensure optimal resident outcomes .on admission .pressure injuries are assessed and documented on at least weekly .until it is resolved .pressure injury assessment includes Location, measurement .stage .draining amount, drainage color, odor .appearance of the wound bed, appearance of wound edges, appearance of peri wound, pain, effectiveness of treatment .Stage 3 [full thickness tissue loss, subcutaneous fat may be visible] .pressure injuries should be covered . Review of a policy titled Weekly Body Audit which states in part, All residents will have a body audit to address any skin issues on a weekly basis. If an alteration in skin integrity .is discovered, it will be documented on the Weekly Skin Audit form as soon as the nurse observes the area. Monitoring of any area will continue until the area is resolved .All resident with skin integrity issues will have this addressed on their plan of care. Record review revealed that Resident ID #2 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, dementia, muscle wasting, surgical aftercare following a surgery. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an admission Weekly Skin Audit dated 9/6/2024, revealed the resident had a pressure injury to his/her right knee which was red and pink in color and uncovered. Additional review of the skin audit failed to reveal evidence that the assessment included the measurement, stage, appearance of the wound bed, appearance of the wound edges, appearance of peri wound, pain, indicated if there was or was not presence of drainage or odor, per the facility policy. Record review of a Pressure injury evaluation form dated 9/11/2024, revealed an initial skin evaluation was completed of the resident's pressure injury measuring, 3.4 centimeters (cm) in length by 2.6 cm in width by 0. 3 cm in depth, 50% Eschar (black, brown, or dead tissue), 50% (slough-yellow/white/tan or necrotic tissue), moderate drainage. Additional review of this document indicates that the current treatment was effective, although there was no evidence that a treatment was in place for this pressure injury. Further record review of the September Treatment 2024 Administration Record failed to reveal evidence of a wound treatment order for the resident's right knee pressure injury. Record review of a subsequent weekly skin audit dated 9/13/2024 failed to reveal evidence that the resident had a pressure injury to his/her right knee. Record review of the facility's contracted Wound Physician's progress note dated 9/20/2024 indicated, an evaluation was completed of the resident's right knee, which revealed a stage 3 pressure ulcer measuring 3. 2 cm in length by 1.9 cm in width by 0 cm in depth. The wound base was observed with 25-49% slough (dead tissue). Additional review revealed a recommendation for a daily treatment to cleanse the right knee with wound cleanser, apply honey alginate (highly absorbent wound dressing with medical honey) to the base of the wound and secure with bordered foam dressing (a foam dressing with adherent edges). Record review of the physician's orders failed to reveal evidence that the wound physician's recommendations were acted upon from 9/20/2024 until it was brought to the facility's attention on 9/24/2024 by the surveyor. This indicates that the resident's right knee pressure wound was without a treatment in place for 18 days. During a surveyor observation and simultaneous interview on 9/24/2024 at 1:35 PM with Licensed Practical Nurse (LPN), Staff A, she revealed that she was the nurse caring for the resident and was not aware of the pressure area to the resident's right knee or the above-mentioned wound physician's treatment recommendations. She also acknowledged that there was not a physician's treatment order for the right knee pressure injury. Upon observing the right knee pressure injury in the surveyor's presence, she indicated the resident's right knee had an open area that was currently open to air. Additionally, she was observed palpating (pressing) the residents wound and the resident verbalized s/he was experiencing pain to the area. Staff A, also acknowledged that this resident did not have a current treatment in place for the right knee pressure injury. During a surveyor interview on 9/24/2024 at 2:42 PM with the facility Wound Nurse, she was unable to explain why there was not a treatment order in place for the right knee pressure injury after the recommendation was made by the wound physician on 9/20/2024. Additionally, she was unable to provide evidence that a treatment was in place for the pressure injury to the right knee, until brought to her attention by the surveyor on 9/24/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview with the Nurse Practitioner on 9/24/2024 at 3:31 PM, he revealed that he would agree with the recommendations from the facility's contracted Wound Physician, as she is the specialist. Additionally, he indicated he would have expected a treatment to have been in place for the pressure injury to the right knee. During a surveyor interview on 9/24/2024 at approximately 3:50 PM with the Director of Nursing Services, she revealed it would be her expectation for the wound nurse to follow up with all new admissions to ensure treatment orders are in place for residents with pressure ulcers. Additionally, she was unable to provide evidence that Resident ID #2 had a treatment in place for the pressure injury to his/her right knee from 9/6/2024 until brought to the facility's attention by the surveyor on 9/24/2024. Additionally, she indicated she would be going to assess the wound and put a treatment in place.