

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Summit Commons Rehabilitation and Health Care Cnt		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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** 41542</p> <p>Based on surveyor observation, record review, staff, and resident interview, it has been determined that the facility failed to ensure that a cognitively impaired resident received adequate supervision to prevent accidents for 1 of 4 residents reviewed for elopement, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of an anonymous community reported complaint submitted to the Rhode Island Department of Health on 10/8/2024 alleges that Resident ID #1 eloped from the facility on 10/7/2024 during the early afternoon. The complaint indicates that management does not disclose when these things happen, and management wanted him/her to wait before filing a complaint.</p> <p>Review of the facility policy titled Leave of Absence (LOA) states in part, Nursing staff will obtain an order for LOA with Responsible Party for a resident/patient on admission .If a resident is their own responsible party they may go on LOA unattended .When the resident is leaving the facility, an attempt will be made to complete the LOA log acknowledging that the resident or person taking the resident on LOA accepts responsibility for his/her well-being .</p> <p>Review of the facility policy titled ELOPEMENT states in part, .The licensed Nurse will conduct an Elopement Risk Assessment on admission, readmission, annually, quarterly, and upon change of condition .When it is determined that a resident may be missing .The senior nursing person on duty at the time will direct a systematic search procedure .The police should be notified as soon as the resident is not located within the facility or on the immediate grounds .Document relevant information in the Resident's medical record, Incident report, and DPH [Department of Public Health] report, as warranted .</p> <p>Review of the elopement binder reveals that the facility is equipped with a wander guard system (a system with three components: bracelets that residents wear, sensors that monitor doors, and a technology platform that sends safety alerts in real time when a resident wearing a sensor approaches an exit door) on the fourth floor.</p> <p>(continued on next page)</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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review revealed the resident was readmitted to the facility in October of 2023 with diagnoses including, but not limited to, mild neurocognitive disorder due to known physiological condition, malignant neoplasm of the stomach (stomach cancer), nicotine dependence, chronic pain syndrome, abnormalities of gait and mobility, adult failure to thrive, opioid use disorder, epilepsy (a brain disorder that causes recurring, unprovoked seizures), viral hepatitis C, and acute embolism and thrombosis (blood clot) of the left lower extremity.</p> <p>Record review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) a score of 9 out of 15 indicating the resident has moderate cognitive impairment.</p> <p>Record review of a care plan dated 10/19/2023 revealed the resident has impaired cognition related to short term memory loss. Additional review of a care plan with a revision date of 5/3/2024 revealed the resident is at risk for falls related to decrease endurance/strength, generalized weakness, and poor safety awareness due periods of forgetfulness.</p> <p>Record review of a nursing progress note dated 10/7/2024, written at 11:20 PM revealed that when staff went to administer the resident his/her evening medications on 10/7/2024, the resident was not in his/her room and the nursing supervisor was immediately notified.</p> <p>Record review of a progress note dated 10/8/2024 at 12:30 AM states in part, This writer was informed at 2045 [8:45 PM] that this resident was unable to be located since 3:00 PM at the beginning of the shift .Every inch of the facility, including the outer parameters were searched and the resident was still not located . ADNS [Assistant Director of Nursing Services] called police department at 23:05 [11:05 PM] .</p> <p>Record review of a progress note dated 10/8/2024 at 5:48 AM revealed the facility received a phone call from Landmark Hospital (Landmark Hospital is approximately 13.4 miles from the facility) indicating that Resident #1 received an evaluation at 4:10 AM in the emergency room and the physician was requesting the facility to fax Resident ID #1's demographics and medication list. The progress notes also indicates that the family was informed of the resident's location.</p> <p>Record review of a progress note dated 10/8/2024 at 11:50 AM revealed the resident returned from the hospital after having been medically cleared after leaving the facility against medical advice.</p> <p>Record review of an Emergency Department (ED) note dated 10/8/2024 at 4:25 AM revealed the resident arrived at the hospital at 4:22 AM by the Woonsocket police. The resident was noted to be confused and admitted to smoking marijuana that night. The ED spoke to the resident's family member and the family member indicated that the resident has poor memory at his/her baseline.</p> <p>Additional review of an ED note dated 10/8/2024 at 5:18 AM from Landmark Hospital revealed that the resident was brought to the ED by the police after s/he reported that s/he was lost. Additionally, this progress note revealed the resident was found by the Woonsocket police at a coffee shop on [NAME] Avenue in Woonsocket. This location is approximately 13.2 miles from the facility. The resident was discharged back to the facility without being treated for any acute medical issues.</p> <p>Surveyor review of the facility's video surveillance footage on 10/10/2024 at 1:59 PM revealed the resident exited the facility with his/her walker on 10/7/2024 at 2:41 PM.</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 failed to reveal evidence that the facility implemented safety measures to ensure the resident's well-being upon his/her return to the facility after his/her successful elopement on 10/8/2024 until it was brought to the facility's attention by the surveyor on 10/9/2024. Additionally, the facility failed to conduct an elopement assessment upon the resident's return following a change in condition as indicated in the facility's policy.</p> <p>During a surveyor interview with the Administrator and the Regional Director of Nursing on 10/9/2024 at 10:30 AM, they both indicated that this was not an elopement, that the resident was his/her own responsible party/decision maker and that s/he was out on an LOA. The Administrator revealed that the resident walks down the street daily for a coffee or cigarettes and that s/he has always returned. When questioned by the surveyor as to why the facility initiated their elopement policy/procedure on 10/7/2024, including calling the police department, if they felt this was an LOA, they were unable to answer.</p> <p>Record review failed to reveal evidence that an order was obtained for Resident ID #1's LOA that the facility indicated that s/he took on 10/7/2024.</p> <p>Additional record review of the LOA log for 10/7/2024 failed to reveal evidence that this resident had left the facility.</p> <p>During a surveyor interview with Licensed Practical Nurse, Staff A (who was on duty from 3:00 PM to 11:00 PM on 10/7/2024 when the resident was identified as missing), on 10/8/2024 at 3:00 PM she revealed that she had seen the resident at the beginning of the shift and that it was a very busy night. Staff A indicated that she was not aware the resident was missing until 8:45 PM when the Medication Technician went to administer the resident's medications and s/he was not in the room. Staff A indicated that she notified the nursing supervisor immediately and that the supervisor initiated their elopement policy/procedure. The Providence Police were notified of the missing resident on 10/7/2024 at 11:05 PM by the ADNS.</p> <p>During a surveyor interview with the ADNS on 10/9/2024 at approximately 9:30 AM, she revealed that she was notified at 9:00 PM on 10/7/2024 that Resident ID #1 was missing. She notified the Administrator, and she then went to the facility to assist. The ADNS indicated that the resident was unable to be located and therefore she called the Providence Police Department at 11:05 PM.</p> <p>During a surveyor interview with the resident's family member on 10/10/2024 at 10:06 AM, s/he revealed that the facility contacted him/her on 10/7/2024 at approximately 9:00 PM to let him/her know that the resident was missing. S/he also revealed that the Woonsocket police called him/her notifying him/her that the resident was found in Woonsocket at coffee shop and flagged down the police because the s/he was lost.</p> <p>During a surveyor interview with the resident on 10/10/2024 at 9:40 AM s/he indicated that s/he had gone for a long walk to downtown Providence and got lost, so s/he flagged down the police who took him/her to the hospital. S/he had no idea that s/he was found in Woonsocket and had no recollection of how s/he had gone from Providence to Woonsocket.</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>This resident left the facility on [DATE] at 2:41 PM with his/her walker. The facility did not know the resident was missing until approximately 8:45 PM on 10/7/2024, which was 6 hours after s/he had left the facility. The facility initiated their elopement policy/procedure at approximately 8:45 PM but the police were not called until 11:05 PM. The whereabouts of the resident was unknown from 2:41 PM until the resident flagged down a Woonsocket police officer at a coffee shop as s/he indicated s/he was lost (time unknown). The facility was unaware of how the resident traveled approximately 13.2 miles from his/her facility in Providence to Woonsocket during the evening, night, and early morning hours of 10/7/2024 into 10/8/2024. The resident was treated at Landmark Hospital at approximately 4:10 AM and was discharged back to the facility without being treated for any acute medical issues. When the resident returned on 10/8/2024 to the facility approximately 14 hours after s/he went missing the facility failed to implement any safety measures to ensure his/her well-being in the facility including safety checks, providing a wander guard, or putting him/her on the secured unit. Additionally, the facility did not follow their elopement policy/procedure relative to conducting an elopement assessment after the resident had successfully eloped. The facility's failure to recognize this incident as an elopement placed him/her at risk for more than minimal harm, impairment, or death as they did not implement any interventions to keep him/her safe.</p> <p>Due to the facility's failure to investigate this incident, they had no pertinent information available to share with the surveyors during the investigation of this complaint. The information found in this statement of deficiencies was gathered by the surveyors.</p> <p>41729</p>		