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	01/08/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 21613 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 following physician's orders relative to using an insulin pen injector to administer insulin, Resident ID #6. Findings are as follows: Record review of the facility's clinical competency titled, Use of Insulin Pen, undated, revealed the nurse should remove the cap from the insulin pen, wipe the top of the pen with an alcohol wipe where the insulin pen needle is to be attached. Additionally, the nurse should then remove the paper pull tab from the Insulin pen needle (BD AutoShield Duo Applicator) and screw it on to the insulin pen until tight. Record review revealed that Resident ID #6 was admitted to the facility with a diagnosis including, but not limited to, diabetes. Further record review revealed the resident requires the administration of insulin to manage this diagnosis. Additionally, record review revealed the resident has a physician's order dated 12/10/2024 for Lantus (a long acting insulin, absorbed slowly by the body, which takes approximetly 1.5 to 2 hours to start working and lasts for 24 hours, providing a steady amount of insulin during this time) SoloStar 100 units/milliliters Solution pen-injector, inject 10 units subcutaneously in the morning related to diabetes. During a surveyor observation on 1/3/2025 at 7:55 AM of LPN, Staff B, she obtained 10 units of Lantus from the Lantus pen-injector by drawing it out of the pen using an insulin syringe, instead of using the insulin pen needle applicator that is designed to be screwed on to the insulin pen. During a surveyor interview immediately following the above observation, Staff B revealed they do not have the insulin pen needle applicators on the unit. Staff B acknowledged that she obtained the insulin from the insulin pen by drawing it out with an insulin syringe. She indicated that she also obtained the insulin from the pen yesterday using an insulin syringe. During a surveyor interview with Staff B, in the presence of the unit Supervisor, Registered Nurse, Staff C, on 1/3/2025 at 8:05 AM, Staff B acknowledged that she should have used the insulin pen needle applicator with the Lantus pen-injector per the physician order. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 1/3/2025 at approximately 8:15 AM with the DNS, she indicated Staff B should have used the insulin pen needle applicator, as ordered.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. 21613 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents are free from significant medication errors for 1 of 5 residents observed who receive insulin, Resident ID #1. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 12/26/2024, alleged that numerous medication errors involving several residents were being made, including insulin. Review of the facility policy titled, MEDICATION ADMINISTRATION BY ROUTE OR DOSAGE, revised in 3/2017, revealed that licensed nurses should verify medication orders on the Medication Administration Record (MAR) and check against the physician's order. Record review of Drugs.com revealed that Insulin Lispro is the not the same as Novolog, as these insulin's have different chemical structures. Record review revealed that Resident ID #1 was admitted to the facility with a diagnosis including, but not limited to, diabetes. Further record review revealed the resident requires the administration of insulin to manage this diagnosis. During a surveyor observation on 12/30/2024 at 11:46 AM, Licensed Practical Nurse (LPN), Staff A, administered 8 units of Insulin Lispro (a fast-acting insulin that starts to work in approximately 15 minutes after injection, it peaks in approximately 1 hour, and continues to work for 2 to 4 hours), subcutaneously (under skin, tissue layer between skin and muscle) to the resident. The surveyor completed the medication reconciliation after the above observation and the record failed to reveal evidence that the resident had an active order for Insulin Lispro. Further record review revealed this resident has had orders in the past for Insulin Lispro but these orders were discontinued, most recently on 12/21/2024. During a surveyor interview on 12/30/2024 at 12:10 PM with Staff A, she acknowledged that she administered Insulin Lispro without a physician's order. Staff A further explained that she administered the Insulin Lispro because she thought it was the same insulin as Novolog. She indicated that the resident has an order for Novolog which is to be given in the afternoon. During a surveyor interview on 12/30/2024 at 12:40 PM with the Director of Nursing Services (DNS), she was unable to provide evidence that the resident had an order for Insulin Lispro to be given on 12/30/2024. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a surveyor interview on 12/31/2024 at 10:45 AM with the resident's physician, he revealed that Insulin Lispro and Novolog are fast acting insulin's but these insulin's have different chemical structures. The resident's physician further revealed that he would expect that the ordered insulin would be the insulin that is administered. During a surveyor interview on 1/8/2025 at 1:25 PM with the DNS, she revealed that the resident was previously on Insulin Lispro and when Staff A went to administer the insulin on 12/30/2024 she did not see the prescribed insulin in the medication cart, so she went to the medication refrigerator and took out a discontinued bottle of Insulin Lispro and administered it to the resident. The failure of the facility to administer the correct insulin to the resident had the potential to place the resident at risk for serious injury, impairment, harm or death.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 21613 Based on record review and staff interview, it has been determined that the facility failed to document all required components of the facility-wide assessment. Findings are as follows: Review of a facility provided document titled, Facility Assessment, reviewed and approved on 8/7/2024, failed to reveal that the facility developed and maintained a plan to maximize recruitment and retention of direct care staff as required. During a surveyor interview on 1/3/2025 at approximately 4:00 PM with the Administrator, he acknowledged that the facility assessment failed to develop and maintain a plan to maximize recruitment and retention of direct care staff.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 21613 Based on record review, and staff interview, it has been determined that the facility failed to maintain medical records that are complete in accordance with professional standards and practices for 1 of 2 residents reviewed for blood sugar parameters for insulin administration, Resident ID #1. Findings are as follows: Record review revealed that Resident ID #1 was admitted to the facility with a diagnosis including, but not limited to, diabetes. Further record review revealed the resident requires the administration of insulin to manage this diagnosis. Record review revealed the resident has a physician order dated 12/31/2024 for NovoLog (a fast-acting insulin with an onset of effect within approximately 15 minutes, peak effect in approximately 30-90 minutes and duration of approximately 3-7 hours) Injection Solution 100 unit/milliliter (ML), inject as per blood sugar sliding scale and to contact provider if blood sugar is more than 351 milligrams per deciliter (mg/dL). Review of the resident's January 2025 Treatment Administration Record (TAR) revealed the resident's blood sugar on 1/3/2025 at 7:30 AM was 395 mg/dL. Record review failed to reveal evidence that the provider was contacted. During a surveyor interview on 1/3/2025 at 3:02 PM with Licence Practical Nurse (LPN), Staff A, she revealed that she failed to document that she contacted the provider in the resident's medical record. Additionally, review of the January 2025 TAR revealed the resident's blood sugar on 1/2/2025 at 4:30 PM was 442 mg/dL. Record review failed to reveal evidence that the resident's provider was contacted. During a surveyor interview on 1/3/2025 at 3:35 PM with LPN, Staff E, she revealed that she failed to document that she contacted the provider in the resident's medical record. During a surveyor interview on 1/3/2025 at approximately 4:00 PM with the Director of Nursing Services, she was unable to provide evidence that the resident's medical record was complete in accordance with professional standards and practices.