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	05/14/2025

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 0689 Level of Harm - Actual harm 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** 41542 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that the resident's environment remained as free of accident hazards as possible for 1 of 1 resident reviewed, who sustained a fall with injury from a shower chair that broke when staff attempted to pull the shower chair into the shower stall, resulting in fractured ribs and an admission to the Trauma Intensive Care Unit (TICU), Resident ID #4. Findings are as follows: Review of a facilty reported incident submitted to the Rhode Island Department of Health on 5/8/2025 revealed the resident had a fall and was sent to the Emergency Department (ED) for an evaluation and was admitted to the hospital with fractured ribs. Review of a community reported complaint submitted to the Rhode Island Department of Health on 5/13/2025 alleged a Nursing Assistant (NA) was attempting to shower Resident ID #4 when the shower chair broke and the resident fell to the floor. Record review revealed Resident ID #4 was admitted to the facility in July of 2021 with a diagnosis including, but not limited to, a history of falls with fractures. Record review of an Annual Minimum Data Set assessment dated [DATE], revealed the resident is dependent on staff for showers, personal hygiene, and bed mobility. Record review of a care plan last updated on 3/22/2024 revealed the resident is at risk for falls related to decreased endurance and strength, impaired sense of balance and unsteady gait. Additionally, the resident requires the assistance of two staff members for transfers. Review of a progress note dated 5/8/2025 at 10:00 AM, revealed the resident had a fall and was sent to the ED for an evaluation and was admitted to the hospital with rib fractures. Record review of a hospital document titled, ED To Hospital admitted d 5/7/2025 at 2:49 PM, indicated that a NA was attempting to help the resident shower when the chair gave way, and the resident fell to the ground. The report also revealed the resident denied hitting his/her head, but complained of right-sided chest wall tenderness. (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
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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 0689 Level of Harm - Actual harm Residents Affected - Few	Further review of the ED documentation revealed a physician's note dated 5/7/2025 at 8:11 PM stating Panscan [a term used to describe full-body imaging] notable for rib fractures .We've consulted trauma and spine team. Anticipate TICU admit. Review of the facility's investigation revealed statements from staff indicating that the front wheels of the shower chair lifted off the ground when NA, Staff A, attempted to pull the resident into the shower stall backwards. The chair tipped backwards, and Staff A was unable to lift the resident back up, so she lowered the resident to the ground and simultaneously, the back of the chair snapped in half. Additionally, statements indicated that no visible injuries were observed but that the resident complained of pain afterwards. During a surveyor observation of the 5th floor shower room in the presence of the Director of Nursing Services (DNS), on 5/14/2025 at approximately 10:30 AM, revealed the entrance into the shower stall had a pronounced incline/ramp with an approximate four inch rise over a short distance angled at approximately 45 degrees leading into the shower stall. Review of the manufactures manual for the shower chair last revised in January 2008 revealed the following: -Never allow the user to lean outside the frame of the equipment -Never allow the user to suddenly shift weight in any way creating a tipping hazard for the user and the equipment -Do not use this equipment on an incline, always make sure all casters are in constant contact with the flooring surface -The improper use of this equipment or failure to comply with all directions and warnings may result in death or injury During a surveyor interview on 5/14/2025 at 10:46 AM with Staff A, she indicated that on 5/7/2025 at approximately 10:00 AM, she, and NA, Staff B, assisted the resident from the hoyer lift (a mechanical device designed to assist caregivers in safely transferring residents or individuals with limited mobility) to the shower chair and then Staff B left with the hoyer. Staff A indicated that she could not pull the shower chair over the pronounced incline into the shower stall and so she attempted to pull the resident into the shower stall backwards in the chair, and that's when the chair started to tip. Staff A indicated that she was unable to lift the resident back up because of his/her weight, so she lowered the resident to the ground backwards and the back of the chair snapped in half on the way down and the resident fell to the floor. During a surveyor interview on 5/14/2025 at approximately 12:20 PM with the DNS, she acknowledged that the resident experienced an accident that resulted in physical injury from the result of Staff A's attempt to pull the resident in a shower chair up an incline into the shower shall.