

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 06/30/2025
NAME OF PROVIDER OR SUPPLIER Summit Commons Rehabilitation and Health Care Cent		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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, and resident and staff interviews, it has been determined that the facility failed to maintain a safe temperature range of 71 to 81 degrees Fahrenheit (&deg;F) in the facility as the 5th floor of the facility reached a temperature of 88 &deg;F and the 3rd floor reached a temperature of 85 &deg;F.</p> <p>Findings are as follows:</p> <p>Record review of a facility policy titled, HOT WEATHER EMERGENCY FAILURE OF AIR CONDITIONER states in part, .If the ambient air temperatures in resident areas are 82 degrees or higher, all personnel within the facility will be assigned duties aimed at reducing the exposure and/or effects of excessive heat and humidity. Room changes will be made necessary to decrease danger to fragile residents .</p> <p>Record review of two community reported complaints received by the Rhode Island Department of Health on 6/24/2025 alleged that the facility has no air conditioning.</p> <p>Record review revealed that the weather in Providence, Rhode Island on 6/25/2025 was 93&deg;F.</p> <p>During surveyor observations of the facility on 6/25/2025 the facility was noted to be uncomfortably warm.</p> <p>During a surveyor observation od Resident ID #2 on 6/25/2025 at 10:50 AM, he/she was seen exiting his/her room and appeared to be breathing heavily. S/he told a staff member that it's too hot in here and my air conditioner is broken. The surveyor observed the resident's face to be red, he/she was perspiring and his/her shirt was wet. After this observation the surveyor immediately went to notify the Administrator of her findings.</p> <p>During a surveyor observation on 6/25/2025 at 11:08 AM, in the presence of the Administrator of the 5th floor dining room, the temperature registered at 86 &deg;F. The facility was not aware of the temperature until it was brought to their attention by the surveyor.</p> <p>During a surveyor interview on 6/25/2025 at 11:14 AM with Resident ID #2 s/he stated that s/he felt that they were going to die of heat stroke. S/he further revealed that the air conditioning in their room was not working and reported this to the facility staff multiple times.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a document dated 6/22/2025 in the maintenance log located at the 5th floor nurses station revealed that Resident ID #2 reported that his/her air conditioner was not working.</p> <p>Ambient temperature readings of the facility on 6/25/2025 at 12:55 PM, in the presence of the acting Maintenance Director, revealed the following:</p> <ul style="list-style-type: none"> - 5th floor Dining room: 88 &deg;F - 5th floor Resident room [ROOM NUMBER]: 86 &deg;F - 5th floor Common area: 82 &deg;F - 3rd floor Dining room: 84 &deg;F - 3rd floor Common Areas: 82 &deg;-85 &deg;F <p>During a subsequent interview with the acting Maintenance Director, in the presence of the Administrator, he revealed that the air conditioning units were too small for the area and would require industrial fans to help circulate the cold air. Additionally, he acknowledged that the above temperatures exceeded 82 &deg;F.</p> <p>This failure had the potential to cause more than minimal harm as the residents were at risk for dehydration, heat exhaustion, injury, or death.</p>

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free from physical restraints that are not required to treat the resident's medical symptoms for 1 of 1 resident reviewed for an actual restraint, as the resident was observed in bed with a bed sheet tied across his/her abdomen, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Restraint Management states in part, .Physical Restraints: Is any manual, mechanical or physical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to: Leg restraints, Arm restraints, Hand mitts, Waist ties .Also included as restraints are facility practices to meet the definition of a restraint, such as: Tucking in, or using Velcro to hold a sheet, fabric or clothing tightly so that the resident's movement is restricted .</p> <p>Record review of a facility reported incident submitted to the Rhode Island Department of Health on 6/24/2025 states in part, The resident was observed with a blanket secured around [his/her] waist. At this time, it is unclear whether this positioning may have restricted [his/her] movement or function as a form of restraint .</p> <p>Record review revealed that Resident ID #1 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, cerebral infarction (stroke) and anxiety.</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 5/12/2025, revealed a Brief Interview for Mental Status (BIMS) score of 00 of 15, which indicates severe cognitive impairment. Additionally, the MDS revealed that the resident can reposition in bed independently and is dependent on staff for personal hygiene.</p> <p>Record review of a care plan last updated on 5/22/2025 revealed the resident is at risk for falls related to generalized weakness, diagnosis of a stroke, and cognitive impairment. Additionally, the resident requires the assistance of two staff members for transfers and rubber mats on the left side of the bed for safety.</p> <p>Further record review revealed that the resident had the following unwitnessed falls from his/her bed on the following dates:</p> <p>6/4/2025</p> <p>6/5/2025</p> <p>6/7/2025</p> <p>6/10/2025</p> <p>6/16/2025</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>6/21/2025</p> <p>During a surveyor interview on 6/25/2025 at 8:15 AM with the Speech Language Pathologist, Staff A, she indicated that she went into the resident's room on 6/23/2025 at approximately 11:00 AM, the resident's upper body was turned, and s/he appeared uncomfortable and restless. She asked the resident if s/he was uncomfortable, and the resident nodded his/her head yes. When she removed the top sheet, she noticed a sheet tied to the bottom straps of the perimeter mattress loops going from one side to the other, across his/her abdomen.</p> <p>During a surveyor interview on 6/25/2025 at 8:26 AM with Nursing Assistants (NA), Staff B, and C, they revealed that they provided morning care on 6/23/2025 at approximately 9:30-10:00 AM and noticed that a sheet was tied to the mattress across the resident's waist. Additionally, Staff B revealed she removed it to provide care and then placed it back on the resident once care was completed.</p> <p>During a surveyor interview on 6/25/2025 at 11:52 AM with NA, Staff D, he revealed that he was the resident's NA on 6/22/2025 during the 11:00 PM-7:00 AM shift. Additionally, he revealed that he did observe the sheet tied to the resident's mattress on both sides going across the resident's abdomen, removed it to provide care, and then put it back in place. He was unaware why it was being used and stated, I've never seen that done before, I do not know why I didn't take it off. I just assumed they wanted it on.</p> <p>Record review failed to reveal evidence of a physician's order for a restraint, an assessment for the use of a restraint, medical symptoms being treated, or interventions attempted prior to the use of a restraint.</p> <p>During a surveyor interview on 6/25/2025 at 11:10 AM with the Director of Nursing Services, she acknowledged that Resident ID #1 was physically restrained. She indicated the facility was actively investigating and could not identify the staff member responsible for tying the sheet to the resident's mattress. Additionally, she acknowledged the overnight staff on 6/22/2025 and the first shift staff 6/23/2025 provided written statements that they removed the bed sheet and then reapplied the bed sheet after providing care to the resident.</p> <p>This failure had the potential to cause more than minimal harm, placing the resident at risk for entrapment, suffocation, strangulation, serious injury, or death. Although Resident ID #1 was cognitively impaired, s/he retained the ability to move independently in bed, which further increased the risk of such adverse outcomes.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that a person-centered comprehensive care plan was developed for 1 of 1 resident reviewed for nutrition where significant weight loss had occurred, Resident ID #3.</p> <p>Findings are as follows:</p> <p>Record review revealed that the resident was originally admitted to the facility in April of 2025, with diagnoses including, but not limited to, end stage renal disease and dysphagia (difficulty swallowing).</p> <p>Record review of a physician's order dated 4/10/2025 revealed a diet order for a mechanical soft, ground texture with nectar thick liquids.</p> <p>Record review of a Care Area Assessment (CAA), dated 4/16/2025 revealed that the resident required a therapeutic and mechanically altered diet. The CAA further revealed that the above was triggered on the Minimum Data Set Assessment and will proceed to the care plan.</p> <p>Record review of the resident's comprehensive care plan failed to reveal evidence of a focused CAA for nutrition, including a person specific approach with descriptive individual resident needs that includes person centered interventions that the facility would implement to assist the resident, including the level of assistance needed.</p> <p>During a surveyor interview on 6/24/2025 at 12:00 PM with the Speech Pathologist, Staff A, she revealed that the resident has been receiving speech services related to his/her diagnosis of dysphagia. She further revealed that the resident was in the process of getting a Modified Barium Swallow test (MBS, a procedure that evaluates swallowing function and identifies potential swallowing disorders) scheduled because s/he does not like the ground texture or thickened liquids and often refuses it.</p> <p>During a surveyor interview on 6/24/2025 at approximately 1:20 PM with the Director of Nursing Services, she revealed that the facility does not currently have a Registered Dietitian (RD) but does have a Corporate Dietician who helps when needed. She further revealed that the facility has not had an RD since approximately March of 2025.</p> <p>During a surveyor interview on 6/25/2025 at approximately 3:00 PM with the Assistant Director of Nursing and the Administrator, they acknowledged that the resident's comprehensive care plan failed to contain a focused care area for nutrition to encompass specific approaches, the resident's individual needs, and specific interventions.</p> <p>Cross reference F 692, F 698</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight, for 1 of 1 resident reviewed, who experienced actual weight loss, Resident ID #3.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint received by the Rhode Island Department of Health on 6/19/2025 alleges that the resident is a dialysis patient and when s/he arrived for treatment s/he had an uncovered bleeding wound to his/her elbow and that s/he had severe malnutrition per the dialysis's Registered Dietician (RD). The RD at the dialysis center noted severe wasting of the thigh and calf muscles, which worsened since the last treatment. Additionally, the report alleges that the resident stated, [s/he] was not being cared for [s/he] is not being given protein supplements that the RD had requested .</p> <p>During a surveyor interview on 6/24/2025 at 10:51 AM with the complainant and the dialysis center's RD they revealed that their team had attempted to contact the nursing facility regarding the resident's weight loss for 3 weeks. Additionally, she revealed that they did speak with the facility on 6/19/2025 to express their concerns but on 6/22/2025 the resident appeared lethargic and severely malnourished. Additionally, they revealed that the facility does not communicate weight loss, or falls and the communication sheets provided just state, routine dialysis.</p> <p>Record review of a facility's policy titled, WEIGHTS states in part, .Weight [sic] are documented in the resident's/patient's medical record and/or the weight book. If a significant weight loss/gain is identified (>[greater than] 5% in 30 days or >10% in 6 months), the IDT [Interdisciplinary Team], dietician, physician and family are notified. All residents with a significant weight loss are reviewed by the interdisciplinary team and the resident/responsible party and interventions implemented as appropriate and are monitored weekly .</p> <p>Record review revealed that Resident ID #3 was originally admitted to the facility in April of 2025, with diagnoses including, but not limited to, end stage renal disease and dysphagia (difficulty swallowing).</p> <p>Record review of a physician's order dated 4/10/2025 revealed a diet order for a mechanical soft, ground texture with nectar thick liquids.</p> <p>Further record review revealed the s/he was hospitalized from [DATE]-[DATE], related to a fall resulting in a left ankle fracture and left thumb fracture.</p> <p>Additionally, the resident was hospitalized on [DATE] with a diagnosis of left arm pain and mitral valve vegetation (an abnormal growth on the mitral valve, often resulting from an infection of the heart valves and the inner lining of the heart chambers) and failure to thrive.</p> <p>Record review revealed the following weights:</p> <p>-5/23/2025 155.1 pounds (lbs.)</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-5/25/2025 154.4 lbs</p> <p>-6/1/2025 144.7 lbs</p> <p>-6/21/2025 145.4 lbs</p> <p>Record review revealed the resident experienced a 6.25% (9.7 lbs.) significant weight loss in one month from 5/23/2025 to 6/1/2025.</p> <p>Further record review failed to reveal evidence that a reweigh was obtained or the weight loss was reported to the provider on 6/1/2025 or 6/21/2025.</p> <p>Record review of a nursing progress note dated 6/17/2025 states in part, Resident refused dinner, and the assigned CNA (certified nurses aid) reported that [s/he] has been refusing for some time now .</p> <p>Record review of a progress note dated 6/19/2025 authored by the social worker revealed that the facility received a call from the dialysis center, and they had concerns with the resident's declining health and dietary concerns.</p> <p>Record review of a nursing progress note dated 6/20/2025 revealed new orders to start weekly weights, labs, a gastroenterologist consult related to weight loss, decreased appetite and failure to thrive.</p> <p>During a surveyor interview on 6/24/2025 at 12:23 PM with the resident's Nurse Practitioner, she revealed that she was not aware of the above stated resident's weights obtained by the facility and initiated orders related to the dialysis center's concerns. She further revealed that if a resident experiences a significant weight loss, she would have expected the facility to notify her immediately after the weight was obtained on 6/1/2025 and interventions could have been implemented prior to 6/19/2025.</p> <p>During a surveyor interview on 6/24/2025 at approximately 1:20 PM with the Director of Nursing Services, she revealed that the facility does not currently have a Registered Dietitian (RD) but does have a Corporate Dietician who helps when needed. She further revealed that the facility has not had an RD since approximately March of 2025.</p> <p>During a surveyor interview on 6/25/2025 at 2:58 PM with the Assistant Director of Nursing Services, she acknowledged that there was not a reweigh obtained after the weight loss was identified and could not provide evidence that the provider was notified.</p> <p>Cross reference F 656 and F 698</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to ensure that adequate pain management was provided to a resident who required such services, consistent with professional standards of practice, and the resident's goals and preferences for 1 of 1 resident reviewed for pain, Resident ID #4.</p> <p>Findings are as follows:</p> <p>Review of a community reported complaint submitted to the Rhode Island Department of Health on 6/18/2025 alleged in part that Resident ID #4 was discharged from a hospital and admitted to the facility on [DATE]. S/he returned to the hospital on 6/18/2025 because s/he did not receive his/her medications as prescribed. S/he alleges that s/he waited approximately 5.5 hours and then was informed s/he was already given them and then later told that the facility did not order them from the pharmacy.</p> <p>Record review revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, left knee osteomyelitis (an infection in the bone) and a sacral pressure ulcer (also known as bedsore).</p> <p>Review of a hospital document titled, Continuity of Care (COC) - Post-Acute Facility dated 6/16/2025 states in part, .Pain plan .Dilaudid [hydromorphone, an opioid pain medication] 4 milligrams (MG) every 4 hours for moderate to severe pain .Dilaudid 4 MG once daily as needed for break through .</p> <p>Review of a physician's order dated 6/16/2025 revealed to administer hydromorphone 4 MG every 24 hours as needed (PRN) for breakthrough pain.</p> <p>Review of an additional physician's order dated 6/16/2025 revealed to administer hydromorphone 4 MG every 4 hours PRN for pain.</p> <p>Further record review revealed that this order was discontinued on 6/17/2025 at 9:05 PM, indicating that this resident has one PRN hydromorphone order daily.</p> <p>Review of a Nurse Practitioner's note dated 6/18/2025 at 2:23 AM states in part, .the nurse called .to notify us that the patient called 911 and got transferred to the hospital for pain. The patient has an order for hydromorphone 4 MG TAB Q24H [every 24 hours], [s/he] had one at 1745 [5:45 PM] on 6/17/2025. [S/he] requested another this morning and when told it was not due, [s/he] called EMS [Emergency Medical Services] and transferred .Patient not seen .already out of building before we were contacted .</p> <p>Review of a nursing note dated 6/18/2025 at 5:44 AM states in part, .Resident asked this writer for PRN hydromorphone around 0030 [12:30 AM] this morning. At this time resident had only an order to give hydromorphone 4 MG 1 Tab/daily and the medication was not due when the resident was asking for it. Resident said, [s/he] should have had the medication every 4 hours as needed but this order was D/C [discontinued]. Resident was very mad and decided to call 911 .</p> <p>Review of the June 2025 Medication Administration Record (MAR) revealed that the resident received 4 MG of hydromorphone on the following dates and times:</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6/16/2025 at 9:30 PM for complaints of 10 out of 10 pain</p> <p>6/17/2025 at 2:00 AM for complaints of 8 out of 10 pain</p> <p>6/17/2025 at 9:40 AM for complaints of 8 out of 10 pain</p> <p>6/17/2025 at 5:30 PM for complaints of 10 out of 10 pain</p> <p>During a surveyor interview on 6/25/2025 at 1:11 PM with Registered Nurse, Staff E, he revealed that when reviewing the resident's orders there was only a PRN daily hydromorphone order. He was not aware of the discontinued order until after the resident had left the facility. He further revealed he did not know why the order for hydromorphone every 4 hours PRN was discontinued.</p> <p>During a surveyor interview on 6/25/2025 at 2:41 PM with the Nurse Practitioner, she revealed that she spoke with the resident on 6/17/2025 to address his/her concerns regarding pain management and verified that s/he had both orders in place for pain management. Additionally, she revealed that if the resident had received the 4 MG of hydromorphone initially for his/her severe pain, his/her pain may have been better controlled, and s/he may not have required transport to the hospital for pain management. Further, she revealed that it would have been her expectation for the nurse to call the on-call provider to report the resident's pain and receive an order at that time.</p> <p>During a surveyor interview on 6/25/2025 at 2:58 PM with the Assistant Director of Nursing Services, she revealed that the order for hydromorphone 4 MG every 4 hours PRN for pain was discontinued in error. Additionally, she was unaware if the nurse attempted to call the on-call provider prior to the resident going to the emergency room.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents who require dialysis (a treatment that removes excess fluid, waste, and toxins from the blood when the kidneys are no longer functioning properly) receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 1 resident reviewed for communication with the dialysis center, Resident ID #3.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint received by the Rhode Island Department of Health on 6/19/2025 alleges that the resident is a dialysis patient and when s/he arrived for treatment s/he had an uncovered bleeding wound to his/her elbow and that s/he had severe malnutrition per the Registered Dietitian (RD). The RD at the dialysis facility noted severe wasting of the quadriceps and calf muscles, which worsened since last treatment. Additionally, the report alleges that the resident stated, "[s/he] was not being cared for. [s/he] is not being given protein supplements that the RD had requested .</p> <p>Review of a facility policy titled, Hemodialysis, states in part, ".Communication between the facility and the hemodialysis center will occur using a communication book/sheet that consist of .Any change of condition from last hemodialysis treatment .changes in weight, medications .behaviors .falls .Documentation will be completed prior to dialysis treatment .</p> <p>During a surveyor interview on 6/24/2025 at 10:51 AM with the complainant and the dialysis center's RD they revealed that their team had been trying to contact the nursing facility regarding the resident's weight loss for 3 weeks. Additionally, she revealed that they did speak with the facility on 6/19/2025 to express their concerns but on 6/22/2025 the resident appeared lethargic and severely malnourished. Additionally, they revealed that the facility does not communicate weight loss, or falls and communication sheets just state, routine dialysis.</p> <p>Record review revealed that Resident ID #3 was originally admitted to the facility in April of 2025, with diagnoses including, but not limited to, end stage renal disease and failure to thrive.</p> <p>Record review revealed that the resident attends dialysis three times a week on Tuesday, Thursday, and Saturday.</p> <p>Record review revealed that the resident had an unwitnessed fall on 5/27/2025.</p> <p>Further record review revealed the resident experienced a 6.25% (9.7 pounds.) significant weight loss in one month, from 5/23/2025 to 6/1/2025.</p> <p>Review of the communication binder and communication sheets for May and June of 2025 and the medical record, failed to reveal evidence that the resident's significant weight loss or the fall that occurred on 5/27/2025, were communicated to the dialysis center.</p> <p>(continued on next page)</p>		

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 06/30/2025
NAME OF PROVIDER OR SUPPLIER Summit Commons Rehabilitation and Health Care Cent		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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 6/24/2025 at 1:48 PM, with the Director of Nursing Services, she acknowledged that the resident's communication binder, communication sheets, and the medical record failed to reveal evidence that the facility notified the dialysis center of the resident's fall or of the significant weight loss.</p> <p>Cross reference F 656 and F 692</p>		