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	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cent	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure a resident had the right to refuse medications and treatments for 1 of 1 resident reviewed who refused medications, Resident ID #2.Findings are as follows:Record review of a facility reported incident submitted to the Rhode Island Department of Health on 12/6/2025, alleged that Resident ID #2 had reported that a staff member held him/her down by the shoulders and grabbed his/her mouth to give him/her medications.Record review of a facility policy titled Informed Consent - Resident Refusal of Treatment dated April of 2015, states in part, .It is the residents right to refuse recommendations for medications and treatments including dietary made by the physician, consultants or interdisciplinary team.Record review revealed Resident ID #2 was admitted to the facility in October of 2025 with diagnoses including, but not limited to, myxedema coma (a serious complication of severe caused by an underactive thyroid) and dysphasia (difficulty swallowing).Record review of an admission Minimum Data Set assessment dated [DATE], revealed the resident has a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition.Record review of the physician's orders revealed the following:- Carvedilol (a medication prescribed to treat high blood pressure) 12.5 milligram (MG) Give 1 tablet by mouth, two times a day- Melatonin (a medication used to aid in sleep) 10 MG 1capsule, at bedtime- Trazodone (a prescription antidepressant) 50 MG 1 tablet by mouth, one time a day- Ensure Plus (a nutritional supplement) 240 milliliters, two times a dayRecord review of the resident's progress notes revealed:- 12/8/2025 - Resident reported that s/he had been forced to take his/her medications on Saturday 12/6/2025. The resident stated that s/he had a male Nursing Assistant holding him/her while a female was pushing medication into his/her mouth- 12/6/2025 - Resident was noted to be crying and upset, the resident indicated that a woman had spoken harshly to him/her- 11/25/2025 - Resident refused 9:00 AM and 1:00 PM medications, education provided on the importance of taking medications and resident still refused- 11/24/2025 - Education provided to resident on importance of medication; resident refused some but not all medications- 11/23/2025 - A progress note authored by the resident's medical provided stated .Offer refused medications at time of daughter's visit, Notify a clinician of any change in condition.Record review of the facility's five-day investigation revealed a statement dated 12/8/2025, authored by Medication Technician, Staff A, revealed in part, she made several attempts throughout the shift to get the resident to take their medication. At approximately 9:00 PM Staff A, returned to the resident's room to give him/her medications, s/he continued to refuse so Staff A proceeded to mix the medications (Carvedilol, melatonin, and trazadone) in a small amount of a prescribed Ensure shake. The resident proceeded to yell and was warding off Staff A with (his/her) hands, so Staff A then asked another staff person to hold the resident's arm so she could administer the medications in the shake. The resident spit out the sip, and Staff A then accepted this as a refusal. Staff A also noted that the resident was agitated. During a surveyor interview on 12/10/2025 at 1:59 PM, with Nursing Assistant, Staff B, he revealed that on 12/6/2025, five staff members attempted to get the resident to take his/her medications. Staff A had asked him to assist because the resident was swinging his/her arms and legs, so he gently held his/her hands to prevent him/her from hurting themselves. Additionally, he stated that he attempted to verbally encourage the resident to take the medications, and the resident replied, don't make me, and he then proceeded to leave the room.During a surveyor interview on 12/11/2025 at 12:16 PM, with the Director of Nursing Services, she revealed that it was her expectation that Staff A would have accepted the resident's refusal of medications, documented, and reported it to nursing. Additionally, it was her expectation that medications would not be mixed into a resident's nutritional shake to be administered unless ordered by the residents' medical provider.During a surveyor interview on 12/12/2025 at 9:21 AM, with Nurse Practitioner, she revealed that it was her expectation that medications would not be mixed into nutritional shakes to coerce residents to take them. She further indicated that it was her expectation the resident's medication refusal would be documented and reported to herself or the medical provider.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on clinical record review and residents and staff interview, the facility failed to ensure ongoing monitoring of residents' weights to accurately assess weight status and identify potential health concerns related to weight changes for 1 of 1 resident reviewed who experienced a significant weight gain, Resident ID #1.Findings are as follows:Record review of a facility policy titled Weights, dated August 2015, states in part, .residents/patients are weighted weekly X4: Newly admitted .Thereafter, residents will be weighed monthly, unless clinically indicated.weights are documented in the resident's/patient's medical record . Record review revealed Resident ID #1 was admitted to the facility in July of 2025, with a diagnosis of progressive Multiple Sclerosis (MS, a disease of the central nervous system).Record review of a care plan dated 7/21/2025 revealed, the resident has a potential for impaired nutrition status due to the diagnosis of MS.Record review of the resident's electronic medical record revealed the following weights had been obtained:- 7/14/2025 -192.4 pounds (lbs.)- 7/30/2025 - 191.2 lbs.- 8/6/2025 - 192.8 lbs.- 8/20/2025 - 192.6 lbs.- 9/3/2025 - 192.0 lbs.Record review failed to reveal evidence of a current physician's order to obtain or monitor his/her weight monthly, per the facility policy. During an interview with the Nurse Practitioner on 12/12/2025, at 9:12 AM, she stated it was her expectation that residents should be weighed monthly unless otherwise indicated. She further stated she was unaware that the resident's weights had not been obtained since 9/3/2025.During a surveyor interview on 12/12/2025, at approximately 1:30 PM, with the Director of Nursing Services, she acknowledged that the facility had not performed ongoing monitoring of the resident's weight status to detect potential health concerns.Additional record review of a fax submitted to the Rhode Island Department of Health on 12/12/2025, following a surveyor interview at approximately 2:30 PM, revealed a weight had been obtained on 12/12/2025 and the resident was found to have had a weight gain of 24.3 lbs. since the last weight obtained on 9/3/2025.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and staff and resident interview, the facility failed to provide a qualified dietitian for 4 of 4 residents reviewed who did not receive dietary consultations to evaluate individual nutritional needs, Resident ID #s 1, 2, 3, and 4.Findings are as follows:Record review of a community reported complaint submitted to the Rhode Island Department of Health on 9/30/2025, alleged concerns with the quality of care provided.A. Record review revealed Resident ID #1 was admitted to the facility in July of 2025 with a diagnosis of progressive Multiple Sclerosis (MS, a disease of the central nervous system).Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition.Record review of a care plan initiated on 7/21/2025 revealed that the resident has a potential for impaired nutritional status due to a diagnosis of MS. Record review revealed a physician's order dated 11/11/2025 for a dietary consult related to his/her MS diagnosis and to discuss his/her nutritional needsRecord review of progress notes for Resident ID #1 revealed the following entries: - 7/10/2025 at 5:51 PM authored by Nurse Practitioner/ Wound Care Certified, revealed a recommendation for a Registered Dietician consultation to optimize nutrition - 9/21/2025 at 9:37 PM authored by Advanced Registered Nurse Practitioner, following a wound evaluation, a recommendation to encourage appropriate dietary supplementation to promote wound healing and skin integrity - 10/16/2025 at 10:50 PM revealed the resident returned from a neurologist appointment with a recommendation for a dietary consult for protein supplementation - 11/11/2025 authored by Physician Assistant at 2:30 PM, revealed that the resident requested a dietary referral, stating that one had not yet been completed since admission. S/he reported difficulty maintaining muscle mass and strength due to MS. An order for dietitian referral had been placed for assessment and recommendationsRecord review failed to reveal evidence that a dietary consult was obtained to evaluate the individual nutritional needs of the resident since admission, as ordered, and after multiple providers recommended dietary consult. During a surveyor interview on 12/11/2025 at 1:15 PM, with the resident, s/he revealed that s/he had not yet received a consultation by a dietitian or nutritionist as s/he had requested to address concerns.B. Record review revealed Resident ID #2 was admitted to the facility in October of 2025 with diagnosis including, but not limited to, myxedema coma (a serious complication of a severely underactive thyroid) and dysphasia (difficulty swallowing).Record review of a care plan initiated on 11/6/2025 revealed that the resident is at risk for aspiration (when food, liquid, or other material enters a person's airway and lungs).Record review failed to reveal evidence that a dietary consult was obtained to evaluate the individual nutritional needs of the resident since his/her admission. C. Record review revealed Resident ID #3 was admitted to the facility in July of 2025 with diagnoses including, but not limited to, type two diabetes and Alzheimer's disease.Record review of a care plan initiated on 7/21/2025 revealed that the resident had a potential for impaired nutrition status due to diagnosis of Alzheimer's disease, type two diabetes mellitus and s/he receives a therapeutic diet.Record review revealed that the resident was discharged from the facility in September of 2025. Further record review failed to reveal evidence that a dietary consult was obtained to evaluate the individual nutritional needs of the resident during their admission to the facility.D. Record review revealed Resident ID #4 was admitted to the facility in August of 2025 with a diagnosis including, but not limited to, dysphasia. Record review revealed the resident was discharged from the facility in October of 2025. Further record review failed to reveal evidence that a dietary consult was obtained to evaluate the individual nutritional needs of the resident during their admission to the facility.During a surveyor interview on 12/11/2025 at 2:21 PM, with the Director of Nursing Services (DNS), she indicated that it was her expectation that residents would be seen by a dietitian on admission, quarterly, and as indicated. She further revealed that the facility had not had a dietitian on staff for several months and was unable to recall the date when the dietitian was last at the facility to clinically assess the residents' individual nutritional needs.During a surveyor interview on 12/12/2025 at 9:21 AM, with the Nurse Practitioner, she revealed she was unaware that the above-mentioned residents had not received dietary consultations as indicated.During a surveyor interview on 12/12/2025 at 2:24 PM, with the DNS, in the presence of the Administrator, she acknowledged that the facility failed to provide the services of a dietitian, as needed, to evaluate the induvial nutritional needs of the residents.