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	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare Summit Commons, LLC	99 Hillside Avenue Providence, RI 02906

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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 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interviews, the facility failed to ensure residents were free from physical abuse for 2 of 4 residents reviewed, Resident ID #s 3 and 4, as evidenced by not implementing effective, enhanced interventions despite documented intrusive wandering by Resident #3 on 12/26/2025, 12/27/2025, 1/10/2026, and 1/12/2026. This failure led to a resident to resident physical altercation on 1/13/2026, in which Resident #4 forcefully pushed Resident #3, resulting in a fall and a left femoral neck fracture that required surgical repair. Additionally, the facility failed to ensure a resident was free from sexual abuse for 1 of 4 residents reviewed, Resident ID #5. On 1/27/2026 when Resident #6, who has severe cognitive impairment and a history of sexually inappropriate behavior, was found attempting to engage in sexual intercourse with Resident #5, who has a severe cognitive impairment and lacks the capacity to consent. Upon staff intervention Resident #6 became aggressive, brandishing scissors and threatening staff.Findings are as follows:Record review of a facility policy titled Abuse Prohibition Policy dated September 2020 states in part, . facility has the responsibility to ensure each resident has the right to be free from Abuse.Abuse means the willful infliction of injury.resulting in physical harm, pain or mental anguish.Adverse event is an undesirable and usually unanticipated event that caused.serious injury, or risk thereof.sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault. Sexual abuse is non-consensual sexual contact of any type with a resident. 1. Review of a facility-reported incident submitted to the Rhode Island Department of Health (RIDOH) on 1/14/2026 revealed that Resident ID #3, who has a diagnosis of severe dementia with psychosis, wandered into the room of Resident ID #4, these residents reside on a secured unit. Despite being instructed to leave, Resident ID #3 remained in Resident ID #4's room. Resident ID #4 then grabbed Resident ID #3 by both of his/her wrists and forcefully shoved them, which caused Resident ID #3 to lose his/her balance, strike the wall, and fall to the floor. Resident ID #3 yelled out, alerting staff. Both residents were subsequently transported to the hospital.Record review revealed that Resident ID #4, was admitted to the facility in December of 2025 with a diagnosis including, but not limited to, dementia.Record review of an admission Minimum Data Set (MDS) Assessment for Resident ID #4 dated 12/29/2025 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident has intact cognition.Record review of a progress note dated 1/13/2026 at 9:36 PM revealed that Resident ID #4 reported Resident ID #3 entered his/her room and refused to leave, resulting in an altercation. Resident ID #4 was noted to have skin tears on both of his/her wrists and admitted to pushing Resident ID #3 to the floor.Record review revealed Resident ID #3, was admitted to the facility in December of 2025 with a diagnosis including, but not limited to, severe dementia with behavioral disturbance.Record review of an admission MDS Assessment for Resident ID #3 dated 1/1/2026 revealed a BIMS score of 0 out of 15, indicating the resident has severely impaired cognition. Additional review revealed (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 0600 Level of Harm - Actual harm Residents Affected - Some	the resident required supervision or touch assistance for ambulation. Further, review of section E -behavior revealed that s/he experienced wandering for up to six days during the review period and the wandering significantly intruded on the privacy or activities of others.The facility was aware of Resident ID #3's ongoing, intrusive wandering behaviors, as evidenced by multiple documented progress notes, including but not limited to: - 12/26/2025: Resident wandered throughout the unit and entered other residents' rooms; requiring frequent redirection. - 12/27/2025: Resident repeatedly entered other residents' rooms despite redirection; requiring continuous staff monitoring. - 1/10/2026: Resident wandered into other residents' rooms; redirection had little effect. - 1/12/2026: Resident observed wandering and entering other residents' rooms.- 1/13/2026 at 6:11 PM: authored by the covering Nurse Practitioner, Staff A, revealed a telehealth visit was completed with the resident which indicated that the nurse called to report an altercation between two residents. Resident ID #3 wandered into Resident ID #4's room. Resident ID #3 was told to leave, and s/he did not. Resident ID #4 grabbed both of Resident ID #3's wrists and shoved him/her down to the floor. Resident ID #4 was in fear for his/her life. Resident ID #4 has skin tears to the backs of both hands. Resident ID #3 has red marks on both wrists that look like fingertip bruises starting to appear. Additional review revealed a psychiatry consultation was ordered for worsening condition and dangerous behaviors. - 1/13/2026 at 9:28 PM, authored by Licensed Practical Nurse, Staff B, revealed Resident ID #3 entered Resident ID #4's room and altercation occurred. During the altercation Resident ID #3 was pushed and fell to the ground. Resident ID #3 noted to have visible hand/finger marks on his/her wrists. Resident ID #3 could not walk after falling and complained of pain. The resident was sent to the hospital.Despite repeated documented incidents demonstrating escalation and ineffective redirection, record review failed to reveal evidence that the facility implemented new or enhanced interventions to mitigate the known risk of resident-to-resident altercations.Record review of a hospital continuity of care form revealed Resident ID #3 was admitted to the hospital on [DATE] secondary to a left femoral neck fracture which required a left hip hemiarthroplasty (joint replacement surgery where only one half of the joint is replaced). Additional review revealed a Physical Therapy evaluation was completed with the resident with the recommendations to utilize a Hoyer lift (a mechanical device utilized by staff to aid in transferring) for transfers upon discharge from the hospital.During a surveyor interview and observation on 1/29/2026 at approximately 3:10 PM, Resident ID #4 revealed that Resident ID #3 wandered into his/her room, s/he told Resident ID #3 to get out, and Resident ID #4 grabbed his/her bilateral hands and would not let go. Resident ID #4 indicated his/her right hand started to bleed. S/he indicated that s/he stood up from his/her wheelchair and pushed Resident ID #3 to the floor. The resident was observed with a scabbed area to his/her left hand and a resolved skin tear area on the right hand.During a surveyor interview on 1/29/2026 at 4:40 PM with the Director of Nursing Services (DNS), she acknowledged that Resident ID #3 wanders related to his/her cognition. She was unable to provide evidence that new interventions were put into place following Resident ID #3's wandering into other resident's rooms noted on 1/10/2026 and 1/12/2026. Additionally, she acknowledged that Resident ID #3 grabbed both of Resident ID #4's hands that resulted in skin tears, which led to Resident ID #4 pushing Resident ID #3 to the floor which also resulted in Resident ID #3 sustaining a left-femur fracture that required surgical repair.The facility's failure to implement appropriate interventions following witnessed incidents on 1/10/2026 and 1/12/2026, during which Resident ID #3 entered other residents' rooms and caused distress, placed Resident ID #3 at risk for resident-to-resident physical abuse. This failure resulted in a physical altercation in which Resident ID #3 was pushed by Resident ID #4, causing a fall and resulting in a left femur fracture. Additionally, Resident ID (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	#4 sustained skin tears to the backs of his/her hands.2. Review of a facility reported incident submitted to the RIDOH on 1/27/2026 revealed at approximately 10:45 PM, Resident ID #s 5 and 6 were observed undressed from the waist down attempting to engage in sexual intercourse with one another. Staff intervened and Resident ID #6 became very aggressive and combative, waving a pair of scissors, threatening staff while swinging the scissors. Record review for Resident ID #6 revealed s/he was admitted to the facility in November of 2025 with diagnoses including, but not limited to, Alzheimer's Disease and vascular dementia.Record review of an MDS Assessment for Resident ID #6 dated 11/19/2025 revealed a Brief Interview for Mental Status Assessment (BIMS) score of 5 out of 15, indicating the resident has severe cognitive impairment. Further review revealed s/he can ambulate with supervision and/or touch assistance.Record review of a care plan dated 11/29/2025 revealed Resident ID #6 exhibits sexually inappropriate behavior towards other residents including hugging and kissingRecord review revealed the following nursing progress notes: - 11/28/2025 at 4:46 PM Resident ID #6 was observed yelling and aggressively moving towards the Nursing Assistant (NA) appearing as if s/he was going to hit her. The NA reported that Resident ID #6 had touched Resident ID #5 on the chest/breast area and tried to kiss the resident after s/he tried to move his/her head. - 1/28/2026 at 12:43 AM - Resident ID #6 was found engaging in inappropriate behavior with Resident ID #5. The resident was observed engaging in sexual intercourse with Resident ID #5. The resident had his/her pants and underpants lowered, attempting to engage in sexual activity with Resident ID #5.Record review revealed Resident ID #5 was readmitted to the facility in July of 2025 with diagnoses including, but not limited to, senile degeneration of the brain.Record review of a quarterly MDS assessment dated [DATE], revealed Resident ID #5 has a BIMS Score of 0 out of 15, indicating severe cognitive impairment. Additional review revealed s/he wanders daily and can ambulate with supervision and/or touch assistance.Record review of Resident ID #5's care plan dated 5/21/2019 revealed a behavioral problem exhibited by wandering the unit, with interventions including, but not limited to, provide for the immediate safety of the resident or other residents.Record review of a progress note dated 1/28/2026 at 12:57 AM for Resident ID #5 revealed s/he was found lying in bed with Resident ID #6 with his/her pants and brief lowered. Resident ID #6 was attempting to engage in sexual intercourse. A skin assessment was completed for Resident ID #5 and his/her perineal area observed with redness. During a surveyor interview on 1/28/2026 at 1:40 PM with the Director of Nursing Services (DNS), Staff L, she revealed that on 1/27/2026 at approximately 11:00 PM, the Nursing Assistant, found Resident ID #5 in Resident ID #6's bed. Resident ID #6 was lying on top of Resident ID #5 with his/her pants down attempting to engage in sexual intercourse. Resident ID #6 was observed with his/her pants and underwear down. The DNS further revealed that when the staff attempted to separate the two residents, Resident ID #6 became aggressive and combative. Both residents were sent to the hospital.During a surveyor interview on 1/29/2026 at 1:46 PM with Resident ID #5's responsible party, s/he indicated that s/he was made aware of a previous interaction between Resident ID #5 and Resident ID #6 that took place in November of 2025, but was assured by facility staff that the residents would be kept separated. Additionally, she revealed that Resident ID #5 does not understand or could not consent to a sexual relationship due to his/her cognitive impairment, therefore, would not want him/her to engage in a sexual relationship with another resident.During a surveyor interview on 1/29/2025 at 4:40 PM with the DNS, Staff L, she was unable to provide evidence that Resident ID #5 was kept free from resident-to-resident sexual abuse.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on clinical record review and staff interview, 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 his/her wheelchair with a black Velcro strap across his/her right arm, Resident ID #2.Findings are as follows:Record review of a community reported complaint submitted to the Rhode Island Department of Health on 6/24/2025 alleges in part, .initially admitted for short term rehab [s/he] was unable to recover from [his/her] stroke.has significant right-side weakness and cannot put a fork to [his/her] mouth .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.Arm restraints .Also included as restraints are facility practices to meet the definition of a restraint, such as: Using devices in conjunction with a chair .that the resident cannot remove easily, that prevents the resident from rising out of the chair. all restraints will have a specific physician order to include: type of device, how often device is to be used and duration of use, frequency of checking and removing (minimum of every two (2) hours).Record review revealed that Resident ID #2 was readmitted to the facility in November of 2025 with diagnoses including, but not limited to, dementia, hemiplegia and hemiparesis (weakness and/or paralysis) following a cerebral infarction (stroke) affecting the left non-dominant side and repeat falls.Review of the Minimum Data Set (MDS) Assessment, dated 12/10/2025, revealed a Brief Interview for Mental Status (BIMS) score of 3 of 15, which indicates severe cognitive impairment. Additionally, the assessment failed to reveal evidence that a restraint was in use. Further, the resident requires supervision or touching assistance with meals.Record review of a care plan last revised on 12/22/2025 revealed the resident is at risk for falls related to cognitive impairment and previous history of falls. Additionally, the resident requires the assistance of two staff members for transfers and ensure proper use of any appliance/device to aid with balance and/or transfers.During a surveyor observation on 1/28/2026 at 12:22 PM the resident was observed sitting in his/her wheelchair with an elevated- arm lateral body support (a device used to improve sitting posture); his/her right arm was connected to the device with a black looped arm strap. Additionally, the resident was observed attempting to feed him/herself with his/her right arm to which movement was restricted. This arm strap remained in place for the duration of his/her meal.During a surveyor interview on 1/28/2026 at 12:46 PM with Nursing Assistants (NA), Staff C, she revealed she was assigned to the resident for the 7:00 AM to 3:00 PM shift on 1/28/2026 and is the primary caregiver for the resident most dayshifts. Additionally, she acknowledged that the black arm strap was attached and holding the resident's right arm to the chair. When asked if the strap should be in place for the resident she stated, the black strap is there every day it's part of the chair.During a surveyor interview on 1/28/2026 at 1:47 PM with the Director of Nursing Services (DNS, Staff L, she indicated she was not aware that there was an arm strap in place for the resident.During a surveyor interview and subsequent observation on 1/28/2026 at 1:55 PM with the Director of Rehabilitation, Staff E, and in the presence of the Director of Nursing Services, Staff L, the Director of Rehabilitation indicated that the resident was currently receiving Physical Therapy services for wheelchair positioning. Additionally, the resident was observed sitting in his/her wheelchair with his/her right arm connected to the lateral support with a black strap. Staff E acknowledged the black strap was in place and he was unaware if it should be. Additionally, he stated, I never saw one like this relative to the device. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff E asked the resident if s/he could remove the arm strap. Further, the Director of Nursing was observed to remove the arm strap prior to the resident attempting to remove it.Record review failed to reveal evidence of a physician's order for a restraint, an assessment for the use of a restraint, any medical symptoms being treated, or interventions attempted prior to the use of a restraint.During a surveyor interview on 1/28/2025 at 2:50 PM with the Nurse Practitioner, Staff F, she indicated that the resident should not have a strap on his/her right arm as that would be considered a restraint.During a surveyor interview on 1/29/2026 at 2:29 PM with the Director of Nursing Services, Staff L, she could not provide evidence that the facility assessed the need for a physical restraint, assessed for the least restrictive alternative, the amount of time the restraint is needed or the re-evaluation of the need for restraints per regulation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on clinical record review and staff interview, the facility failed to ensure that a resident with an injury of unknown origin was thoroughly investigated for 1 of 2 resident reviewed for skin tears and bruising, Resident ID #5.Findings are as follows:Review of a facility policy titled, Abuse prohibition policy states in part, .Identification .incidents.require an incident report, supervisory follow-up and a comprehensive internal facility investigation which shall be performed with subsequent timely notification to the appropriate agencies, as warranted.Record review revealed that Resident ID #5 was readmitted to the facility in July of 2025 with a diagnosis including, but not limited to, dementia.Record review revealed the following progress notes:-11/6/2025 at 5:22 PM -the resident presented with a bruise to his/her right forearm and elbow-11/17/2025 at 3:34 PM -left forearm discoloration and skin tear. S/he was unable to verbalize how skin tear occurred-12/2/2025 at 1:07 PM- a bruise on the right arm and redness on the right elbow were identified. S/he was unable to recall or report how the injury occurred.-12/27/2025 at 1:13 PM- the Nursing Assistant noticed a bruise on the left upper armFurther record review failed to reveal evidence that an investigation had been conducted to determine the origin of the above-mentioned bruises and skin tears.During a surveyor interview on 1/29/2026 at 2:29 PM with the Director of Nursing Services, Staff L, she was unable to provide evidence that an investigation was initiated for the above-mentioned bruises and skin tears.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on surveyor observation, clinical 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 and the comprehensive care plan relative to 1 of 2 residents reviewed who require one to one staff assistance with meals and supplements, Resident ID #2.Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 1/21/2026, alleges the resident has had weight loss and requires supervision with his/her meal and staff just leave his/her food in front of him/her. Additionally, the complaint alleges s/he does not receive his/her supplement. According to Mosby's 4th Edition, Fundamentals of Nursing page 314, which states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. Record review revealed that Resident ID #2 was readmitted to the facility in November of 2025 with diagnoses including, but not limited to, dementia, hemiplegia and hemiparesis (weakness and/or paralysis) following cerebral infarction (stroke) affecting the left non-dominant side and repeat falls.Review of the Minimum Data Set (MDS) Assessment, dated 12/10/2025, revealed a Brief Interview for Mental Status (BIMS) score of 3 of 15, which indicates severe cognitive impairment. Additionally, the resident requires supervision or touching assistance with meals.Record review of a Nutritional Assessment progress note dated 1/10/2026 at 1:46 PM revealed the resident has experienced a gradual weight loss in the past 6 months with varied intakes attributed to the weight loss. Recommendations to continue Glucerna Supplement 237 cc (cubic centimeters) by mouth three times a day.Record review of a care plan last revised on 1/13/2026 revealed the resident requires assistance with activities of daily living related to left side weakness due to a stroke with interventions including, but not limited to, one to one feeding assistance with all meals.Record review reveals the following physician's orders:-1/7/2026 - Glucerna Supplement 237 cc by mouth three times a day-1/10/2026 - 1:1 assist with meals (one staff to one resident assisting with meals)-1/13/2026 -one to one feedingDuring a surveyor observation on 1/28/2026 at 12:22 PM the resident was observed sitting in his/her wheelchair with his/her lunch meal in front of him/her attempting to feed himself/herself. Additionally, the resident was attempting to utilize his/her right arm. His/her right arm was observed to be attached to the support on the right side of his/her wheelchair with a black strap. Additionally, during this continuous observation of the lunch meal the resident's tablemate was overheard stating the following:-12:22 PM [S/he] can't feed [Him/herself]; I want to feed you.-12:35 PM [S/he] can't feed [Him/herself]During this continuous observation Nursing Assistant, NA, Staff D, was overheard telling the resident table mate, [S/he] is gonna feed him/herself.During a surveyor interview on 1/28/2025 at 12:44 PM with Staff D, when asked if staff assist the resident with meals, she revealed that when the resident is seated in the dining room staff set up the resident for the meal. Additionally, she acknowledged that the resident was not being assisted one to one until it was brought to her attention by the surveyor.During a surveyor interview with the charge nurse Registered Nurse, Staff G, he indicated he was assigned to the resident that shift but was unaware that the resident required one to one assistance with his/her meals. Additionally, he acknowledged that the resident has a physician order for one-to-one feed.During a subsequent surveyor observation on 1/28/2026 at 1:10 PM the resident was observed sitting in his/her wheelchair with a brown liquid observed in front of him/her in a 4-ounce plastic cup. The surveyor asked the resident if s/he was going to drink the liquid. S/he was observed to attempt to lift the plastic cup but was unable to.During a surveyor interview immediately following the above observation with Medication Technician, Staff H, she acknowledged that the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	liquid was his/her ordered Glucerna supplement. Staff H was then observed to assist the resident with drinking his/her supplement after it was brought to her attention by the surveyor.During a surveyor interview on 1/28/2026 at 1:47 PM with the DNS, Staff L, she revealed it would be her expectation that staff would assist the resident with his/her lunch meal one to one, as ordered. Additionally, she revealed it would be her expectation that the resident would have been assisted with the administration of his/her supplement prior to it being brought to the staff's attention by the surveyor.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on clinical record review and staff interview, it has been determined that the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote wound healing and prevent new ulcers from developing for 2 of 2 resident reviewed, who has an actual pressure injury (localized damage to the skin and/or underlying soft tissue usually over a bony prominence), Resident ID #'s 2 and 3.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 1/21/2026 alleges that Resident ID #2 had developed a pressure area on his/her buttocks while residing in the facility.Review of an undated facility policy titled, Prevention & Management of Pressure Injuries, states in part, .Resident with pressure injuries and those at risk for skin breakdown are identified, assessed and provided appropriate treatment to encourage healing and/or maintenance of skin integrity.Resident will have a weekly body audit completed by the licensed staff.Pressure injuries are assessed and documented on at least weekly.Pressure injury assessment includes:LocationMeasurement in centimeters-length, width and depth.Stage.Drainage AmountDrainage ColorOdor if present after cleaningAppearance of wound bedAppearance of wound edgesAppearance of the peri wound.1a. Record review revealed that Resident ID #3 was admitted to the facility in December of 2025 with diagnoses including, but not limited to, dementia and muscle weakness.Record review of an admission Minimum Data Set (MDS) Assessment Section M Skin Condition, dated 12/29/2025, revealed the resident was admitted with a Stage 3 pressure ulcer (full-thickness skin loss where subcutaneous fat is visible). Record review revealed a physician's order dated 12/27/2025 requiring weekly skin assessments to be completed every Wednesday during the 3:00 PM-11:00 PM shift.Review of the December 2025 and January 2026 Treatment Administration Records indicated that skin checks were documented as completed on the following dates: - 12/31/2025 - 1/7/2026 - 1/21/2026 - 1/28/2026However, review of the weekly body audits for Resident ID #3 failed to demonstrate that the Stage 3 pressure injury was assessed to include the wound location, measurements, drainage, odor, or description of the wound bed, wound edges, or peri-wound area on the following dates: - 12/31/2025 - 1/7/2026 - 1/14/2026 - 1/21/2026 - 1/28/2026Record review of the December of 2025 and January 2026 Treatment Administration Records revealed the skin checks were signed off as completed on the following dates: - 12/31/2025 - 1/7/2026 - 1/21/2026 - 1/28/20261b. Review of the contracted Wound Physician's progress note for Resident ID #3 dated 12/29/2025 revealed a recommendation for daily treatment of the resident's left lateral heel Stage 3 pressure ulcer, including cleansing with normal saline, application of SSD (Silvadene), and coverage with a silicone dressing daily.Review of the record revealed a physician's order dated 12/30/2025 to cleanse the resident's left heel with normal saline, apply Silvadene, and cover with a silicone dressing daily.Review of a follow-up progress note dated 1/5/2026 and signed on 1/7/2026 by the facility's contracted Wound Physician revealed a revised recommendation for daily treatment of the resident's left lateral heel Stage 3 pressure ulcer, including cleansing with normal saline, application of A & D ointment, and leaving the wound open to air.Review of the clinical record revealed a physician's order dated 1/12/2026 to cleanse the resident's left lateral heel with normal saline, apply A & D ointment, and leave the wound open to air.Review of the clinical record failed to reveal evidence that the order for Silvadene to the resident's left heel had been discontinued.Review of the January 2026 Treatment Administration Records revealed that Resident ID #3 received the Silvadene treatment and the A & D treatment from 1/13/2026 through 1/28/2026, for a total of 16 days.During a surveyor interview with the Nurse Practitioner, she stated that it would have been her expectation that the contracted Wound Physician's recommendation for A & D ointment be implemented and the Silvadene to be discontinued immediately.2.Record review revealed (continued on next page)

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	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare Summit Commons, LLC	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident ID #2 was readmitted to the facility in November of 2025 with diagnoses including, but not limited to, dementia, hemiplegia and hemiparesis (weakness and/or paralysis) following a cerebral infarction (stroke) affecting the left non-dominant side.Record review of a Quarterly Minimum Data Set (MDS) Assessment Section M Skin Condition, dated 12/10/2025, revealed the resident is at risk for developing pressure ulcers/injuries.Record review of the weekly body audits revealed a skin check was completed on 12/19/2025, indicating no skin impairment. Further review of the weekly skin checks failed to reveal evidence that a weekly skin check was completed after 12/19/2025 through 1/11/2026. Record review revealed a Pressure Injury Evaluation form was completed on 1/12/2026 which indicated Resident ID #2 had a newly identified stage 2 pressure area (a partial-thickness skin loss with dermis exposure and the wound bed presenting as viable, red, or moist) to his/her coccyx (a small triangular bone at the base of the spinal column).Record review of the weekly body audits completed on 1/20/2026 and 1/24/2026 for Resident ID #2 failed to reveal evidence that the Stage 2 pressure injury was assessed to include the location, measurements, drainage, odor or the appearance of the wound bed, including the edges or the peri wound. Record review of a weekly body audit completed on 1/24/2026 failed to reveal evidence that any skin impairment was identified for the resident. During a surveyor interview on 1/28/2026 at 2:29 PM and 4:02 PM with the Director of Nursing Services, Staff L, she indicated it would be her expectation for weekly skin checks to be completed and any pressure area to assessed with documentation including the location, measurements, drainage, odor or the appearance of the wound bed, including the edges or the peri wound.

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	415129	A. Building B. Wing	02/12/2026

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on clinical record review and staff interview, the facility failed to complete an annual performance review for every Nursing Assistant (NA), at least once every 12 months, for 4 of 4 NA personnel records reviewed, Staff H, I, J, and K.Findings are as follows:Record review of the personnel records failed to reveal evidence that an annual performance evaluation was completed for the following NA's:-Staff H, hired on 3/19/2015.-Staff I, hired on 10/11/2022.-Staff J, hired on 5/4/2021.-Staff K, hired on 11/7/2024.During a surveyor interview with the Director of Nursing Services, Staff M, on 2/11/2025 at approximately 2:00 PM, she was unable to provide evidence that performance evaluations were completed for Staff H, I, J, and K within the last 12 months.

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	02/12/2026

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Adviniacare Summit Commons, LLC	99 Hillside Avenue Providence, RI 02906

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on record review and staff interview the facility failed to develop, implement, and maintain an effective training program, for existing staff, consistent with their expected roles, relative to education pertaining to emergency preparedness, as required per the facility assessment, for 4 of 5 staff reviewed, Staff H, I, J, and K. This failure has the potential to impact 163 of 163 residents and an indeterminable number of staff and visitors.Findings are as follows:According to the Facility Assessment, last revised 2/5/2026, the facility assessment indicates staffing is adjusted based on staff education to ensure the residents' health and safety are maintained.Record review failed to reveal evidence that the following staff completed emergency preparedness training: - Staff H, hired on 3/19/2015. - Staff I, hired on 10/11/2022. - Staff J, hired on 5/4/2021. - Staff K, hired on 11/7/2024.During a surveyor interview on 2/11/2026 at approximately 2:00 PM, with the Director of Nursing Services, Staff M, she was unable provide evidence of emergency preparedness training for Staff H, I, J and K. Additionally, she revealed it would be her expectation that training relative to emergency preparedness was completed for the above-mentioned staff.