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	03/26/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and staff and resident interviews, the facility failed to ensure that residents are provided or arranged services in accordance with professional standards of practice, relative to 1 of 1 resident who was admitted from the hospital with a diagnosis of spinal stenosis (the narrowing of one or more spaces within the spinal canal that can put pressure on the spinal cord and nerves, which can cause pain), with a referral to see a neurosurgeon (a medical doctor who diagnoses and treats conditions that affect the nervous system, including your brain, spinal cord and nerves) for spinal injections, which was not arranged, Resident ID #2. Findings are as follows:Record review of a community-reported complaint submitted to the Rhode Island Department of Health on 3/13/2026 alleged, in part, that the facility failed to schedule a necessary surgical follow-up appointment for Resident ID #2, with the resident reportedly waiting approximately five months without resolution.Record review revealed the resident was admitted to the facility in October 2025 with diagnoses including but not limited to, hemiplegia (paralysis affecting one side of the body) and hemiparesis (muscle weakness, numbness or reduced motor control on one side of the body) following a stroke affecting the left non-dominant side, as well as spinal stenosis. Review of a Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 out of 15, confirming the resident is cognitively intact and fully capable of expressing needs and concerns.During a surveyor interview on 3/23/2026 at 12:50 PM with the resident, s/he revealed that s/he had made multiple unsuccessful attempts to contact the facility's appointment scheduler to obtain a neurosurgical consultation for spinal injections, yet no appointment had been arranged.Record review of the Continuity of Care - Post-Acute Facility document dated 10/24/2025 confirmed that, upon discharge, a referral to the spine center was placed to evaluate the need for spinal steroid injections.Further review of the record revealed a provider progress note dated 11/17/2025 which indicated the resident's ongoing chronic lower extremity weakness related to lumbar disc protrusions and reiterated the need for outpatient neurosurgical follow-up. An additional referral was placed at that time.Despite these clear and repeated physician ordered referrals, record review failed to produce any evidence the facility scheduled or facilitated the required follow-up appointment.During a surveyor interview on 3/24/2026 at 10:36 AM with the Unit Secretary, Staff B, in the presence of the Director of Nursing Services (DNS), she acknowledged responsibility for scheduling resident appointments but stated she was unaware of the resident's referrals to the spine center. Both Staff B and the DNS were unable to provide evidence that the facility made efforts to arrange the neurosurgical consultation.

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
	415129	A. Building B. Wing	03/26/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on clinical record review and staff interview, the facility failed to ensure adequate supervision and failed to maintain an effective elopement prevention system for 1 of 1 resident reviewed for elopement risk, Resident #1. The resident was assessed as a high elopement risk, had a documented history of exit-seeking behaviors, requiring a wander guard device (a safety mechanism intended to monitor and prevent at-risk residents from exiting unsupervised) and resides on a secured unit intended to prevent unauthorized egress. Despite the utilization of the wander guard device, the facility's failure allowed the resident to elope undetected from the secured unit and travel approximately two miles away from the facility, including navigating and crossing four lanes of a heavily trafficked roadway before being located. This failure represents a significant breakdown in supervision and safety systems and placed the resident at risk for serious injury or death. Findings are as follows:Record review of a facility reported incident submitted to the Rhode Island Department of Heath on 3/16/2026 revealed that Resident ID #1, who resides on the secured unit, eloped from the facility on foot, was subsequently located by staff, and was returned. Record review revealed Resident ID #1 was admitted to the facility in February of 2026 with diagnoses including, but not limited to, Alzheimer's Disease, dementia, and s/he has a documented history of exit-seeking behaviors.Record review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status score of 00, indicating the resident has severe cognitive impairment. Additionally, the MDS indicates that s/he has a behavior of wandering the unit.Record review of the care plan dated 3/9/2026, revealed the resident is at a high risk for elopement and that prior to his/her admission to this facility s/he has a history of eloping, recent attempts to leave the premises/unit, and s/he has verbalized statements relative to leaving. Additionally, the care plan also indicates that the resident exhibits a wandering behavior pattern, and s/he wears a wander guard.Record review of an undated written statement, authored by Licensed Practical Nurse, Staff C, indicated that at approximately 9:30 AM on 3/16/2026 the resident was observed attempting to open the unit exit door. The resident was redirected and escorted back to the dining room by the facility staff. Record review of a nursing progress note, dated 3/16/2026 at 1:13 PM, revealed that the resident had eloped from the unit via the stairway through an undisclosed exit after last being seen in his/her room at approximately 10:00 AM that morning. The note further revealed that at approximately 11:20 AM a Code Orange was called and the elopement protocol was initiated. The resident was located on a main road by staff members who then transported the resident back to the facility safely without injury. During a surveyor interview on 3/23/2026 at 9:06 AM, with the Director of Nursing Services (DNS) and the Administrator, they indicated that the resident is an elopement risk, wanders the unit, and wears a wander guard, but that the wander guard is not detected at the exit doors of the unit. They further revealed that the wander sensors are located only at the elevators. They revealed that on 3/16/2026, the resident left the secured unit by a stairwell door that alarms when opened, walked down several flights of stairs to the basement level, and then exited the facility through the basement exterior door. Additionally, they indicated that they believed Resident ID #1 eloped from a door that initially alarmed but then stopped when the door closed. Lastly, they revealed that the door stops alarming after a period of time. During a surveyor interview on 3/24/2026 at 10:27 AM, with Physical Therapist, Staff A, he stated that on 3/16/2026 at approximately 11:20 AM, he observed the resident walking along the main road and crossing a four-lane street. Staff A noted that at the time of the observation, he did not recognize the individual as a resident of the facility. Upon arriving to the facility, Staff A learned that a resident was missing. He then informed the facility of his observation. Staff A and two other staff members drove to the location where he saw the resident, they located him/her and drove him/her back to the facility.The facility failed to provide adequate supervision and elopement (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	03/26/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	protection for Resident ID #1, who was a known high elopement risk. This failure enabled the resident to exit a secured unit undetected and travel approximately two miles off premises, for an approximate time frame of last being seen at 10:00 AM until his/her return at 11:45 AM. This resident was able to traverse a heavily trafficked roadway and cross four lanes of active traffic unattended. This lapse of supervision placed Resident ID #1 at risk for more than minimal harm, serious injury, or death.