

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/22/2026
NAME OF PROVIDER OR SUPPLIER Adviniacare Summit Commons, LLC		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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on clinical record review and staff and resident interviews, it has been determined that the facility failed to protect a resident's right to be free from resident to resident abuse for 2 of 4 residents reviewed, Resident ID#s 1 and 3. Findings are as follows: Record review the facility policy titled Clinical Operations states in part, The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of residents/patients property by anyone including staff, family, friends, etc .1. Record review of facility reported incident submitted to the Rhode Island Department of Health on 7/10/2026 revealed that Resident ID #1 and Resident ID #2 were witnessed by staff having a verbal argument. Resident ID #2 was overheard by several staff members telling Resident ID #1 I will make sure you die overnight. Record review revealed that Resident ID #1, the alleged victim, was originally admitted to the facility in May of 2025 and readmitted in December of 2025 with diagnoses including, but not limited to, major depressive disorder, cognitive communication deficit and opioid dependence. Review of a Minimum Data Set (MDS) assessment conducted on 6/18/2026 revealed a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating intact cognition. Record review of Resident ID #2, the alleged perpetrator, revealed s/he was originally admitted to the facility in October of 2025 and readmitted in July of 2026 with diagnoses including, but not limited to, bipolar II disorder, hemiplegia (weakness of one side of the body) and hemiparesis (paralysis of one side of the body) following a stroke and migraines. Review of a MDS assessment conducted on 6/8/2026 revealed a BIMS score of 15 of 15, indicating intact cognition. Record review of documentation from the facility's internal investigation revealed several written statements from staff that were present at the time of the verbal altercation. These statements indicated that Resident ID #2 had made threatening comments to Resident ID #1. Additionally, Resident ID #2 had also become aggressive with staff while trying to get physically closer to Resident ID #1. During a surveyor interview with Resident ID #1 on 7/15/2026 at approximately 11:25 AM, s/he revealed that Resident ID #2 attempted to physically attack him/her after verbally threatening to kill him/her. During a surveyor interview with the Administrator and the Director of Nursing Services (DNS) on 7/16/2026 at approximately 9:30 AM, they revealed that they were present at the time of the incident. Additionally, they confirmed that they overheard Resident ID #2 say I will make sure you die overnight to Resident ID #1. 2. Record review of a facility reported incident submitted to the Rhode Island Department of Health on 7/17/2026 revealed that Resident ID #4 was observed in the room of Resident ID #3 with his/her hand under the bed sheet. Record review revealed that Resident ID #3, the alleged victim, was originally admitted to the facility in May of 2026 with diagnoses including, but not limited to, acquired absence of the eye, purulent endophthalmitis (an infection of the eye), schizoaffective disorder, muscle weakness, and opioid use. Review of a MDS assessment conducted on 6/2/2026 revealed a BIMS score of 14 of 15, indicating intact cognition. Record 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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	that Resident ID #4, the alleged perpetrator, was originally admitted to the facility in October of 2025 and readmitted in July of 2026 with diagnoses including, but not limited to, the acquired absence of the right and left legs below the knees and anxiety. Review of a MDS assessment conducted on 6/18/2026 revealed a BIMS score of 14 of 15, indicating intact cognition. Record review of a written statement authored by Nursing Assistant (NA), Staff A, revealed that she observed the alleged perpetrator, Resident ID #4, pass by Resident ID #3's room several times during the shift the incident occurred on. Staff A further stated that whenever Resident ID #4 noticed her watching him/her, s/he would try to make small talk but would immediately cut short and move along. Further the written statement revealed that when Staff A was assisting another resident in their room at approximately 4:00 AM, she saw Resident ID #4's reflection in a window and noticed him/her passing by in the hall. Staff A indicated she quickly finished up with the resident she was assisting and went to Resident ID #3's room and observed Resident ID #4 with his/her hand underneath Resident ID #3's bed sheets touching him/her inappropriately. Lastly the statement revealed that Resident ID #3 was wearing a hospital gown without any underwear or brief on when Resident ID #4 had his/her hand under the bed sheets of Resident ID #3. During a surveyor interview with the Administrator on 7/17/2026 at approximately 1:10 PM, she acknowledged that Staff A had observed Resident ID #4 pass by the room of Resident ID #3 repeatedly just before 4:00 AM on 7/17/2026. She then revealed that Staff A observed Resident ID #3 to be sleeping in bed and Resident ID #4 was observed with his/her hand underneath Resident ID #3's bed sheets. Lastly, she revealed that Resident ID #3 customarily sleeps with a light top on and no bottoms.		