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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 47939 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide residents with the right to personal privacy and confidentiality of his/her personal and medical records relative to the posting of past survey results. Findings are as follows: During a surveyor observation of the main lobby area on 3/12/2025 at 2:16 PM, revealed a Survey History Binder. Record review of the Survey History Binder revealed copies of previous surveys including the resident/staff rosters which contain identifying information of residents from the following survey dates: - Resident/Staff Roster form dated 4/12/2022 with one resident identified. - Resident/Staff Roster form dated 6/14/2022 with one resident identified. - Resident/Staff Roster form dated 7/18/2022 with four residents identified. - Resident/Staff Roster form dated 7/27/2022 with one resident identified. - Resident/Staff Roster form dated 8/11/2022 with three residents identified. - Resident/Staff Roster form dated 8/30/2022 with two residents identified. - Resident/Staff Roster form dated 10/24/2022 with three residents identified. - Resident/Staff Roster form dated 1/18/2023 with six residents identified. - Resident/Staff Roster form dated 1/25/2023 with two residents identified. - Resident/Staff Roster form dated 1/17/2025 with one resident identified. During a surveyor interview on 3/11/2025 at 3:46 PM with the Administrator, he was unable to provide evidence that the facility protected the identifying information of the 21 residents listed in the survey results binder.

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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46539 Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure residents who are fed through a feeding tube receive the appropriate treatment and services to prevent complications for 1 of 1 resident reviewed for a continuous feeding via a gastrostomy tube (G-tube, a surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine), Resident ID #102. Findings are as follows: Review of a facility policy titled Enteral Feeding [feeding provided via an alternative method via a G-tube] states in part, .Check physician order for formula, rate and water flushes . Record review revealed that Resident ID #102 was readmitted to the facility in January of 2025, with a diagnosis including, but not limited to, gastrostomy status. Record review revealed a progress note authored by the dietitian, dated 3/10/2025 at 3:38 PM, which revealed that the resident's weight has trended down since last review. It further revealed that the resident is currently on Jevity 1.2 cal (calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short-term tube feeding; provides 1.2 calories per milliliter) until Jevity 1.5 cal (provides 1.5 calories per millileter) is available. Additionally, due to weight loss, the residents current tube feed is changed to Jevity 1.2 cal at 75 milliliters (mL) /per hour (hr) and to flush the G-tube with 235 mL of water every shift until the Jevity 1.5 is available. Record review revealed a physician's order dated 3/10/2025 to administer Jevity 1.2 cal via feeding pump at 75 mL/hr continuously. Record review revealed a physician's order dated 3/10/2025 to flush the G-tube with 235 mL of water every shift. During a surveyor observation on 3/11/2025 at 11:50 AM, revealed the resident was receiving Jevity 1.2 cal at 60 mL/hr dated 3/11/2025, with a water flush rate of 350 mL per shift. Additionally, the observation revealed the water flush bag was empty, the tubing door to the feeding tube pump was open, and the screen was flashing a visible alarm. During a surveyor interview and simultaneous observation on 3/11/2025 at 11:54 AM with Registered Nurse, Staff A, she acknowledged that the resident's Jevity 1.2 should be running at 75 mL/hr with a water flush rate of 235 mL and not the 60 mL/hr with a water flush rate of 350 mL that the resident was currently receiving. Furthermore, she acknowledged that the water flush bag was empty, the tubing door to the feeding tube pump was open, and the screen was flashing a visible alarm. During a surveyor interview on 3/11/2025 at 12:05 PM, with the Director of Nursing Services, she revealed that she would expect that Resident ID #102's G-tube feeding and flush to be administered at the ordered rate. (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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 3/13/2025 at 2:22 PM with the Nurse Practitioner, he revealed that he would expect the G-tube feeding and flush to be administered at the ordered rate.

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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46539 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 2 of 2 residents reviewed for fluid management, Resident ID #s 42 and 51, and for 2 of 3 residents reviewed for communication with the dialysis center, for Resident ID #s 42 and 79. Findings are as follows: 1. Review of a facility policy titled Hemodialysis, states in part, .Fluid Balance .If resident/patient is placed on fluid restriction, monitor intake . 1a. Record review revealed that Resident ID #42 was admitted to the facility in January of 2025, with a diagnosis including, but not limited to, end stage renal disease (ESRD). Record review for Resident ID #42 revealed that s/he receives dialysis three times a week. Record review revealed a physician's order with a start date of 2/11/2025 for a 1200 milliliter (mL) fluid restriction per day. Review of Resident ID #42's care plan dated 1/6/2025, revealed that the resident has a potential for impaired nutrition status due to a diagnosis of ESRD, with an intervention which includes, but is not limited to, document percent of fluids consumed. Record review for Resident ID #42, failed to reveal evidence of the amount of fluids the resident consumes in a day or the percent of fluids consumed per the physicians order and care plan. During a surveyor interview on 3/13/2025 at 9:05 AM, with Registered Nurse (RN), Staff B, she acknowledged that the resident has an order for a fluid restriction. Additionally, she revealed that the Nursing Assistants (NAs) would document that. She revealed that she was unable to find evidence under the NA's documentation and that the facility does not have a paper tracker for fluid intake. 1b. Record review revealed that Resident ID #51 was admitted to the facility in March of 2021, with a diagnosis including, but not limited to, dependence on renal dialysis. Record review revealed that Resident ID #51, receives dialysis three times a week. Record review revealed a physician's order with a start date of 12/23/2024, for a 1500 mL fluid restriction per day and to document the resident's intake on the intake and output sheet. Review of Resident ID #51's care plan dated 9/1/2023, revealed that the resident has a potential for impaired nutrition status due to a diagnosis of chronic kidney disease, with an intervention that includes, but is not limited to, document the percent of fluids consumed. (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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review for Resident ID #51 failed to reveal evidence of the amount of fluids the resident consumes in a day or the percent of fluids consumed per the physicians order and care plan. During a surveyor interview on 3/12/2025 at 11:34 AM, with Licensed Practical Nurse, Staff C, she acknowledged that Resident ID #51 has a physician's order for a 1500 mL fluid restriction per day and to document the resident's intake on the intake and output sheet. Additionally, she revealed that there is no paper documentation for intake and output for fluids. During a surveyor interview on 3/13/2025 at 9:11 AM, with the Assistant Director of Nursing (ADNS), she revealed that she is responsible for the over site of the dialysis residents. She revealed that there is no paper tracker for fluid documentation. Additionally, she revealed that the documentation completed by the NAs does not include fluid documentation. Furthermore, she revealed that the facility was not tracking the amount of fluid each resident consumes, and that the facility needs to put something in place. During surveyor interviews on 3/13/2025 at 9:37 AM and 10:41 AM, with the Director of Nursing Services (DNS), she acknowledged that Resident ID #42 and 51's records failed to reveal the amount of fluid or the percentage of fluid the residents are consuming in a day, per the facility policy or resident care plan. Furthermore, she was unable to provide evidence the facility is ensuring that Resident ID #'s 42 and 51's fluid restrictions are being followed as ordered. 2. 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 . 2a. Record review revealed that Resident ID #42 was admitted to the facility in January of 2025, with a diagnosis including, but not limited to, ESRD. Record review revealed that Resident ID #42, attends dialysis three times a week on Monday, Wednesday, and Friday. Review of the February 2025 Medication Administration Record (MAR), revealed that the resident refused his/her medications on the following dates: - 2/1 - 2/13 - 2/14 - 2/15 - 2/16 - 2/17 - 2/18 (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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2/20 - 2/22 - 2/23 - 2/25 - 2/27 Review of the March 2025 MAR, revealed that the resident refused his/her medications on the following dates: - 3/1 - 3/2 - 3/3 - 3/4 - 3/6 - 3/7 - 3/8 - 3/9 - 3/10 - 3/11 Review of the communication binder and communication sheets, for February and March of 2025, and record, failed to reveal evidence that the resident's refusal of medication was communicated to the dialysis center for the above-mentioned dates. Further record review revealed that Resident ID #42 had an unwitnessed fall on 1/23/2025. Review of the communication binder, communication sheets, and record failed to reveal evidence that the facility notified the dialysis center of the resident's fall. During a surveyor interview on 3/13/2025 at 8:59 AM, with RN, Staff B, she revealed that Resident ID #42 refuses his/her medication frequently and sustained a fall on 1/23/2025. Additionally, she revealed that it is the facility's practice to notify the physicians, the nurse practitioner and the resident's family. Furthermore, she was unaware that the facility policy states to notify the dialysis center with changes such as behaviors, medications, or falls. (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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b. Record review revealed that Resident ID #79 was admitted to the facility in December of 2024, with a diagnosis including, but not limited to, dependence on renal dialysis. Record review revealed that Resident ID #79 attends dialysis on Tuesday, Thursday, and Saturday. Record review revealed that Resident ID #79 had a fall on 2/27/2025. Review of the communication binder, communication sheets, and record failed to reveal evidence that the facility notified the dialysis center of the resident's fall. During a surveyor interview on 3/13/2025 at 10:26 AM, with RN, Staff D, she acknowledged that Resident ID #79 had a fall on 2/27/2025. Additionally, she revealed that it was not the facility's practice to notify outside providers of a resident fall. Furthermore, she acknowledged that the dialysis center was not notified that Resident ID #79 fell . During a surveyor interview on 3/13/2025 at 9:11 AM, with the ADNS, she revealed that the facility does not notify the dialysis center when a resident falls. Furthermore, she revealed that she was unaware if the staff notified the dialysis center of medication refusals for Resident ID #42. During surveyor interviews on 3/13/2025 at 9:37 AM and 10:41 AM, with the DNS, she acknowledged that Resident ID #42 and 51's, communication binder, communication sheets, and records failed to reveal evidence that the facility notified the dialysis center of the resident's fall. Additionally, she acknowledged that the communication binder, communication sheets, and medical record failed to reveal evidence that the facility notified the dialysis center of Resident ID #42's medication refusals. Furthermore, she revealed that she was unaware that the facility had to notify the dialysis center of a fall, although the facility policy states to do so. 47939 50004

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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 50004 Based on record review and staff interview, it has been determined that the facility failed to ensure the medical care of each resident is supervised by a physician for 1 of 1 resident reviewed for significant weight loss, Resident ID #28. Findings are as follows: 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 . Record review revealed that Resident ID #28 was readmitted to the facility in September of 2024, with diagnoses including, but not limited to, dementia and dysphagia (difficulty swallowing). Review of a care plan last revised on 1/30/2025 revealed, the resident is at risk for malnutrition due to dementia and a history of dysphagia. Record review for the resident revealed a weight of 166.9 pounds (lbs.) on 2/1/2025 and a weight of 152.1 lbs. on 3/1/2025, indicating that the resident had an 8.87% weight loss (-14.8 lbs.) in 30 days. Further record review revealed a weight of 175.1 lbs. on 9/3/2024 indicating that the resident had an 13.14% weight loss (-23 lbs.) in six months. Record review failed to reveal evidence that the physician or nurse practitioner (NP) was notified of the significant weight loss. During a surveyor interview on 3/13/2025 at 11:58 AM with the Director of Nursing Services, she revealed that when a resident experiences a significant weight loss her expectation would be for the dietician to notify the physician or NP. She was unable to provide evidence that the physician was notified about the above-mentioned resident's weight loss. During a telephone interview on 3/13/2025 at 12:23 PM with the resident's NP, he revealed that he was not aware of the above resident's weight loss. He further revealed that if a resident experiences a significant weight loss, he would expect the facility dietitian to notify him.

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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47939 Based on record review and staff interview, it has been determined that the facility failed to complete an annual performance review for every nurse aide (NA), at least once every 12 months, for 6 of 6 NA personnel records reviewed, Staff E, F, G, H, I and J. 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 E, hired in March of 2015 -Staff F, hired in November of 2011 -Staff G, hired in August of 2022 -Staff H, hired in February of 2020 -Staff I, hired in August of 2023 -Staff J, hired in October of 2023 During a surveyor interview with the Director of Nursing Services on 3/13/2025 at 12:41 PM, she was unable to provide evidence that performance evaluations were completed to their entirety for Staff E, F, G, H, I and J 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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48928 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that food is stored and distributed in accordance with professional standards for food service safety, relative to the main kitchen and 3 of 3 kitchenettes observed. Findings are as follows: 1. Record review of Rhode Island Food Code, 2018 Edition, Section 3-501.17 states in part, .READY -TO-EAT-TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees Celsius or 41 degrees Fahrenheit or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 . During the initial tour of the main kitchen's walk in coolers in the presence of a Cook, Staff K on 3/10/2025 at 8:15 AM, revealed the following: - eight turkey and cheese sandwiches on white bread without a label or date - three sheet pans approximately 15 inches () x 21 full of cooked sausage links without a label or date - three baking pans approximately 12 x 10, containing white cakes without a label or date - one 4 deep, stainless steel steam table pan filled with unidentified gelatinous yellow liquid without a label or date - a pack of American cheese wrapped in plastic wrap approximately 1 thick without a label or date During a surveyor interview following the above observations with Staff K, he acknowledged that the above mentioned items should have been labeled and dated per regulations. 2. Record review of facility policy titled Use & Storage of Food Brought in By Family or Visitors states in part, . the facility may refrigerate, label and date prepared items in the nourishment refrigerator .If not consumed within 3 days, food will be thrown away by facility staff . During a surveyor observation of the 2nd floor kitchenette on 3/10/2025 at approximately 8:50 AM in the presence of Certified Medication Technician, Staff L, the following was revealed: - one large round covered plastic container, approximately 2 quarts in size filled with chili, without a label or date - one large square covered plastic container, filled with an unidentified food, without a label or date (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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- one rectangular covered plastic container, filled with an unidentified food, without a label or date - one black plastic bag without a label, dated 3/1/2025, containing a covered plastic container approximately 2 quarts in size. During a surveyor interview immediately following observations of the 2nd floor kitchenette with Staff L, she acknowledged the above-mentioned items should have been labeled, dated or discarded as indicated per the facility policy. During a surveyor observation of the 4th floor kitchenette on 3/10/2025 at approximately 9:05 AM in the presence of Nursing Assistant, Staff E, the following was revealed: - one 12-ounce (oz) container of crab salad, without a label or date - one round container approximately 32 oz containing cut watermelon, without a label or date - one square container approximately 4 oz containing cut fruit, without a label or date During a surveyor interview immediately following the observations of the 4th floor kitchenette with Staff E, she acknowledged the above-mentioned items should have been labeled, dated or discarded as indicated per the facility policy. During a surveyor observation of the 5th floor kitchenette on 3/10/2025 at approximately 9:20 AM in the presence of the Administrator, the following was revealed: - one black covered, multi compartment rectangular to go container containing taco meat, shredded cheese, and a hard taco shell, without a label or date - one small plastic bag of lettuce and diced, partially liquefied, without a label and date - one container with a yellow lid, approximately 4 oz containing sour cream, without a label and date - one round container with a red lid, approximately 32 oz with cut up cucumbers, without a label or date - one 12 oz container labeled cod fish salad, without a date - one black to-go container approximately 6 x 9 containing an unidentified food, without a label or date - one black to-go container approximately 6 x 9 containing cooked rice, without a label or date During a surveyor interview immediately following the observation of the 5th floor kitchenette with the Administrator, he acknowledged the above-mentioned items should have been labeled, dated or discarded as indicated per the facility policy. (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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview on 3/10/2025 with the Food Service Director at 2:25 PM, he acknowledged that all of the items listed above in the main kitchen, 2nd floor kitchenette, 4th floor kitchenette, and the 5th floor kitchenette, should have been labeled, dated or discarded as indicated per regulations and the facility policy.

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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46539 47939 46241 Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that medical records are accurately documented for 2 of 3 residents reviewed for enhanced barrier precautions (EBP - refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities), Resident ID #s 13 and 217. Findings are as follows: 1. Record review revealed Resident ID #13 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, congestive heart failure. Record review revealed a physician's order dated 2/3/2025 for EBP, related to his/her wounds. Review of the February 2025 Medication Administration Record (MAR) revealed the EBP order was signed off as completed from 2/3 - 2/28/2025. Review of the March 2025 MAR revealed the EBP order was signed off as completed from 3/1 - 3/12/2025. Record review revealed the resident had a wound which was resolved on 2/13/2025. Surveyor observations on 3/10, 3/11 and 3/12/2025, failed to reveal signage posted outside of the resident's room indicating that s/he was on EBP. During a surveyor interview on 3/12/2025 at 12:32 PM with the Director of Nursing Services (DNS), she revealed that she would have expected the EBP order to have been discontinued when his/her wound was resolved, or that staff would document not applicable, as the resident was no longer on EBP. 2. Record review revealed Resident ID #217 was admitted to the facility in February of 2025 with a diagnosis including, but not limited to, personal history of Methicillin Resistant Staphylococcus Aureus (MRSA - a multi drug resistant organism). Record review revealed two physician's orders with a start dates of 2/26/2025 and 2/27/2025, for EBP, related to his/her history of MRSA. Review of the March 2025 MAR revealed the EBP orders were signed off as completed from 3/1 - 3/12/2025. (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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor observations on 3/10, 3/11 and 3/12/2025, failed to reveal signage posted outside of the resident's room indicating that s/he was on EBP. During a surveyor interview on 3/12/2025 at 11:07 AM with Registered Nurse, Staff A, she acknowledged that the resident was not on EBP. She further acknowledged that there was a physician's order for EBP, and it was not being followed. During a surveyor interview on 3/12/2025 at 12:30 PM, with the DNS, she revealed that she would expect for there to be EBP signage and a bin containing personal protective equipment (PPE) located outside of the resident's room. She further revealed that she would expect nurses to verify that there is EBP signage, and a PPE bin, located outside of the resident's room before signing off the order in the MAR.

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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46241 Based on record review and surveyor interview, it has been determined that the facility failed to ensure the QAPI/QAA (quality assurance performance improvement/quality assessment and assurance) committee includes the required committee members consisting at a minimum of, the Director of Nursing Services (DNS), the Medical Director, Infection Preventionist and at least three other members of the facility staff. Findings are as follows: Review of a policy titled Policy & Procedure Manual Quality Assessment and Assurance Committee states in part, .The Committee will be composed of staff who understand the characteristics and complexities of the care and services delivered in each unit and/or department. The QAA committee will be composed of, at a minimum .The Director of Nursing or Assistant Director of Nursing .The Infection Preventionist .The infection preventionist must be a member of the QAA committee and report to the committee on the infection prevention and control program . Record review revealed the QAPI/QAA committee met on the following dates in 2024/2025: - 4/11/2024 - 7/24/2024 - 10/16/2024 - 1/15/2025 Review of the QAPI/QAA committee sign in sheet dated 4/11/2024 failed to reveal evidence that the Infection Preventionist attended the meeting. Review of the QAPI/QAA committee sign in sheet dated 10/15/2024 failed to reveal evidence that the Infection Preventionist or the DNS attended the meeting. Review of the QAPI/QAA committee sign in sheet dated 1/15/2025 failed to reveal evidence that the Infection Preventionist or the DNS attended the meeting. During a surveyor interview on 3/13/2025 at approximately 10:00 AM, with the Administrator, he was unable to provide evidence that the Infection Preventionist and DNS were in attendance for all of the above mentioned QAPI/QAA committee meetings.

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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46539 50004 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, relative to enhanced barrier precautions (EBP- refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact resident care activities), for 1 of 3 residents reviewed with a history of Methicillin-Resistant Staphylococcus Aureus (MRSA), Resident ID #217. Findings are as follows: Review of a facility policy titled, Enhanced Barrier Precautions Policy states in part, .It is the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms .important MDROs may include, but are not limited to: Methicillin-resistant Staphylococcus aureus (MRSA) .Enhanced barrier precautions require the use of a gown and gloves for certain residents during specific high-contact resident care activities in which there is an increased risk of transmission for multidrug-resistant organisms. High-contact resident care activities include bathing/showering, providing hygiene, dressing, transferring, linen changes, toileting .Signage will be posted on the door or the wall outside of the resident's room indicating the need for enhanced barrier precautions, the required personal protective equipment (PPE) .Carts with appropriate PPE will be placed outside the resident's room . Record review revealed Resident ID #217 was admitted to the facility in February of 2025 with a diagnosis including, but not limited to, personal history of MRSA. Record review of a hospital document titled, Continuity of Care- Post-Acute Facility, dated 2/26/2025, revealed that the resident tested positive for MRSA with an onset date of 10/15/2022. Record review of a physician's order dated 2/27/2025, revealed an order for EBP related to a history of MRSA. Record review of the March 2025 Medication Administration Record revealed the above order was signed off as completed from 3/1 - 3/12/2025, during all three shifts. Surveyor observations on 3/10, 3/11 and 3/12/2025, failed to reveal signage posted outside of the resident's room indicating that s/he was on EBP. During a surveyor interview on 3/12/2025 at 11:07 AM with Registered Nurse, Staff A, she acknowledged that the resident was not on EBP. She further acknowledged that there was a physician's order for EBP, and it was not being followed. (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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Commons Rehabilitation and Health Care Cnt	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor observation and interview on 3/12/2025 at 12:13 PM, with the Infection Preventionist, she acknowledged that there was no signage posted for EBP on the resident's door or a bin containing PPE outside of the resident's room. She further revealed that the resident should be on EBP related to a history of MRSA, as ordered.