

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

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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 07/02/2026
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.			
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F 0689 Level of Harm - Actual harm 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 resident and staff interviews, the facility failed to ensure that adequate supervision and assistive devices were provided to prevent an avoidable accident for 1 of 1 resident reviewed for accidents, Resident #77. Specifically, the facility failed to implement the resident's care-planned intervention requiring a two-person assist for bed mobility and turning/repositioning. As a result, a Nursing Assistant (NA) provided care to the resident without another staff member, resulting in the resident rolling from the bed onto the floor and sustaining an avoidable right tibia/fibula fracture that required emergency department evaluation, treatment, and pain management. Findings are as follows:Record review revealed the resident was admitted to the facility in August of 2022 with a diagnosis including, but not limited to, cerebral infarction (stroke).Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 of 15, indicating intact cognition. During a surveyor interview with the resident on 6/29/2026 at 9:40 AM, s/he revealed that s/he had fallen from bed recently and broke his/her leg. Additionally, s/he revealed one Nursing Assistant (NA) was providing care to him/her when the NA rolled him/her out of bed onto the floor.Review of the care plan revealed a focus area that the resident has an activity of daily living deficit from reduced endurance, obesity, and musculoskeletal weakness following a prior stroke. The care plan further revealed that the resident is unwilling to help with personal care, with an intervention that states, .2 persons assist for bed mobility and transfer utilizing Hoyer . Review of the progress notes revealed the following:6/3/2026 at 4:25 PM .the resident was on the floor. Staff notified writer they were in the room when it happened and was able to write a statement. Resident stated they fell of the bed during morning care.6/5/2026 at 6:30 PM .Resident noted to have undergone X-Ray of the right knee status post fall. Results revealed a positive tibia/fibula fracture (a breaks in both lower leg bones). Provider made aware of findings and gave order for resident to be sent to the emergency department (ED) for further evaluation and treatment.6/6/2026 at 6:26 AM .nurse reports had a fall in facility with pain reported in [right] leg. X ray performed resulted tibia/fibula [fracture]. Patient was sent out to ED for evaluation and was sent back same day.6/8/2026 at 1:57 PM revealed that the resident complained of pain following the fall, the Nurse Practitioner was notified, and an order was obtained for Oxycodone (pain medication) 5 milligrams every 6 hours as needed for 14 days.Review of the hospital emergency room paperwork dated 6/6/2026 states in part, .presented to our hospital for evaluation of witnessed fall 2 days ago while at a SNF (Skilled Nursing Facility) with subsequent imaging showing a right tibia/fib fracture. Patient requires full assist at baseline.Roughly 2 days ago, s/he was being moved by [his/her] CNA (Certified Nursing Assistant) and was getting turned on [his/her] bed when [s/he] was accidentally pushed off the bed, causing [him/her] to land over [his/her] hands and knees. The patient reports (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 0689 Level of Harm - Actual harm Residents Affected - Few	that [s/he] immediately started to experience right foot pain.right shin as well as right thigh pain.During a surveyor interview on 7/1/2026 at 8:24 AM with Licensed Practical Nurse, Staff C, she revealed that there was only one NA, Staff D, in the room at the time of the fall. Additionally, she acknowledged that the resident's care plan revealed that the resident was a two person assist with turning and repositioning at the time of the fall, and only one staff member was present.During a surveyor interview on 7/1/2026 at 1:35 PM with Staff D, she revealed that she believed the resident was a one person assist with care prior to his/her fall on 6/3/2026. She acknowledged that she independently provided care to this resident on 6/3/2026. She indicated that she positioned the resident on his/her side and when she turned her back to retrieve a facecloth that is when the resident fell off of the bed. During a surveyor interview with the Director of Nursing Services on 7/1/2026 at 9:05 AM, she acknowledged the resident's care plan was updated on 4/8/2026 to indicate that the resident requires two staff members for turning and repositioning. Additionally, she acknowledged the resident had only one staff member providing care when s/he fell from the bed and sustained a tibia/fibula fracture.The facility's failure to implement the required care plan intervention of a two-person assist for bed mobility resulted in actual harm for Resident ID #77. Due to a single staff member providing care to a resident with known one-sided weakness and obesity, the resident rolled out of bed and fell onto the floor. This failure resulted in severe physical injury, specifically a right tibia/fibula fracture requiring emergency department evaluation and treatment, as well as preventable pain and suffering.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on record review, surveyor observations, and staff interviews, the facility failed to ensure that bed side rails were safely installed, assessed, and managed in accordance with manufacturer recommendations, the CMS Resident Assessment Instrument (RAI) Manual, and the facility's own policy. Specifically, the facility failed to: ensure bed side rails were compatible with the bed frame and installed according to manufacturer specifications for four of four units, affecting one of one resident reviewed for bed system compatibility, Resident ID #6. Additionally, the facility failed to complete required quarterly bed side rail assessments for five of five residents reviewed for quarterly reassessments, Resident ID #'s 6, 16, 77, 99, and 11 and the facility failed to develop and maintain individualized care plans addressing the use of bed side rails for four of five residents reviewed for care planning, Resident ID #'s 10, 16, 77, and 99. These deficient practices had the potential to affect all residents utilizing bed side rails within the facility and placed residents at risk for foreseeable harm, including entrapment, falls, injury, and the continued use of restrictive devices without ongoing evaluation of their medical necessity, safety, or effectiveness. Findings are as follows:Record review of the Centers for Medicare & Medicaid Services' Resident Assessment Instrument (RAI) 3.0 Manual, dated October 2025, revealed that the use of bed siderails must be assessed prior to implementation and reassessed at least quarterly (every three months), and with any significant change in condition, to determine whether the continued use of the device remains appropriate and safe for the resident.Review of a facility policy titled, Side Rails/Bed Rails dated 10/24/2022 states in part, Purpose: To ensure the appropriate, safe and correct installation, use, and maintenance of bedrails.The facility shall ensure that prior to the installation of bed rails, the facility has attempted to use alternatives.The facility shall ensure the bed is appropriate for the resident and that bed rails are properly installed and maintained.After alternatives have been attempted and prior to installation, the facility shall obtain informed consent from the resident or if applicable, the resident representative for the use of bed rails.The care plan shall be developed on an individual basis, and may include but is not limited to the following related to use of bed rails: which medical need would be met through the use of bed rails.What the resident's functional ability is, such as bed mobility and ability to transfer between positions, to and from bed or chair, and to stand and toilet and staff required for each function that requires assistance.Before bed rails are installed, the facility should: Check with the manufacturer (s) to make sure the bed rails, mattress, and bed frame are compatible, since most bed rails and mattresses are purchased separately from the bed frame.Review of a facility provided, QI Project/Plan: Side Rails dated 2/26/2026 states in part, .Action Steps.ensure physician orders are obtained, ensure care plans are updated, ensure consents are obtained.A. During a surveyor observation conducted on 7/2/2026 at 8:56 AM, Resident ID #6's bed was observed to have two different bed side rails of dissimilar design attached to the bed.During a surveyor interview on 7/2/2026 at 9:13 AM with the Maintenance Director, he acknowledged that the bed side rails attached to Resident ID #6's bed did not match. When asked how the facility determines whether a bed rail is appropriate and compatible with a particular bed frame, he stated, As long as the holes line up.The Maintenance Director further revealed that the facility maintains an inventory of beds and bed side rails obtained from multiple sister facilities and various manufacturers. He acknowledged that the facility does not verify manufacturer compatibility before installing bed side rails and was unable to provide manufacturer specifications, compatibility guidance, or installation instructions demonstrating (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that the bed side rails attached to Resident ID #6's bed were approved for use with that bed frame. As a result, the facility could not demonstrate that the bed and bed side rail system had been assembled in accordance with manufacturer recommendations or that it was safe for resident use. This practice was not limited to Resident ID #6 and had the potential to affect any resident using a bed with side rails assembled under the same process, placing residents at risk for hazards associated with incompatible bed systems, including entrapment, falls, or equipment failure. B1. Record review revealed that Resident ID #6 was admitted to the facility in January of 2026 with a diagnosis including, but not limited to, abnormalities of gait and mobility. During surveyor observations on 6/29, 6/30, 7/1, and 7/2/2026 revealed the resident has bilateral bed side rails. Record review revealed that the last bed side rail assessment was completed on 2/20/2026. Record review failed to reveal evidence that a bed side rail assessment was completed quarterly as required per the RAI manual. B2. Record review revealed that Resident ID #10 was admitted to the facility in August of 2023 with diagnoses including, but not limited to, brain damage and muscle weakness. During surveyor observations on 6/30, 7/1 and 7/2/2026 revealed the resident has bilateral bed side rails. Review of a Quarterly Evaluation dated 5/3/2026 revealed that the resident requires bed side rails. Record review failed to reveal evidence of a care plan for the use of bed side rails as required per the facility's policy. During a surveyor interview on 7/2/2026 at 9:35 AM with Licensed Practical Nurse (LPN), Staff E, she acknowledged that Resident ID #10 does not have a care plan in place for bed side rails. B3. Record review revealed that Resident ID #16 was admitted to the facility in January of 2025 with diagnoses including, but not limited to, stroke and altered mental status. During surveyor observations on 6/29, 6/30, 7/1, and 7/2/2026 revealed the resident has bilateral bed side rails. Record review revealed that the last bed side rail assessment was completed on 2/12/2026. Record review failed to reveal evidence that a bed side rail assessment was completed quarterly as required per the RAI manual. Record review failed to reveal evidence of a care plan for the use of bed side rails as required per the facility's policy. B4. Record review revealed that Resident ID #77 was admitted to the facility in August of 2022 with diagnoses including, but not limited to, stroke and dementia. During surveyor observations on 6/29, 6/30, 7/1, and 7/2/2026 revealed the resident has bilateral bed side rails. Record review revealed that the last bed side rail assessment was completed on 2/18/2026. Record review failed to reveal evidence that a side rail assessment was completed quarterly as required per the RAI manual. Record review failed to reveal evidence of a care plan for the use of bed side rails as required per the facility's policy. B5. Record review revealed Resident ID #99 was admitted to the facility in December of 2023 with diagnoses including, but not limited to, Alzheimer's disease and dementia. During surveyor observations on 6/29, 6/30, 7/1, and 7/2/2026 revealed the resident has bilateral bed side rails. Record review revealed that the last bed side rail assessment was completed on 2/26/2026. Record review failed to reveal evidence that a bed side rail assessment was completed quarterly as required per the RAI manual. Record review failed to reveal evidence of a care plan for the use of bed side rails as required per the facility's policy. B6. Record review revealed that Resident ID #111 was admitted to the facility in May of 2025 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease. During surveyor observations on 6/29, 6/30, 7/1, and 7/2/2026 revealed the resident has bilateral bed side rails. Record review revealed that the last bed side rail assessment was completed on 2/26/2026. Record review failed to reveal evidence that a bed side rail assessment was completed quarterly as required per the RAI manual. During a surveyor interview on 7/2/2026 at 10:28 AM, the Director of Nursing Services (DNS) revealed that all residents with bed side rails should have care plans in place as required in the facility policy. Additionally, she acknowledged that bed side rail assessments should be completed quarterly.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, surveyor observation, and resident and staff interviews, the facility failed to follow the weekly menu relative to providing soup daily as stated on the menu for 4 of 4 units. Additionally, the facility failed to ensure that the residents' meal tickets matched the meal served to each resident, affecting Resident ID #s 12, 20, 45, 56, 58, 76, 93, and 115. Findings are as follows: Record review revealed that Resident ID #93 was admitted to the facility on [DATE] with diagnoses including, but not limited to, type 2 diabetes mellitus and heart failure. Record review of the Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 of 15, indicating intact cognition. During a surveyor interview during the initial tour on 6/29/2026 at 11:49 AM, Resident ID #93 stated that his/her meal ticket does not always match what is served. S/he stated, we do not have soup even though the slips indicate that we receive soup every day. 1. During surveyor observations of the lunch meal service on 6/30/2026, the facility failed to serve the specific food items listed on the meal tickets for the following residents: a. Resident ID #12's meal ticket indicated that s/he is supposed to receive a bowl of soup and chocolate pudding. Surveyor observation revealed the resident failed to receive a bowl of soup and was served Jello, instead of chocolate pudding. During a surveyor interview with Resident ID #12 following the above observation, s/he revealed that s/he wishes to have soup as listed on the meal ticket. b. Resident ID #45's meal ticket indicated that s/he is supposed to receive a side salad. Surveyor observation revealed the resident failed to receive a side salad. During a surveyor interview following the above observation, s/he revealed that s/he has not been served the salad. c. Resident ID #s 12, 20, 56, and 76's meal tickets indicated that they are supposed to have pineapple with their meals. Surveyor observation revealed the above residents failed to receive pineapple with their meals. 2. During the breakfast service on 7/1/2026, surveyor observations confirmed the facility failed to serve English muffins to Resident ID #s 12, 20, 56, and 76, as indicated by their individual meal tickets. During a surveyor interview on 7/1/2026 at 1:41 PM, the Food Service Director revealed that the facility does not offer soup during the summer months, per the company's policy. He further stated that the facility's Dietitian, Staff F, should have updated the residents' meal tickets for accuracy. During a surveyor interview on 7/1/2026 at 1:52 PM, Staff F acknowledged that the residents' meal tickets and the food served on the nursing units failed to match. During a surveyor interview on 7/1/2026 at 2:51 PM, the Director of Nursing Services stated that she expects residents to receive the items listed on the menu. She acknowledged that discrepancies between menu listings and meal tickets have been an ongoing concern.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that a resident was treated with dignity and in a manner that maintained his/her quality of life for 1 of 3 residents reviewed related to gastrostomy tube (G-tube - a medical device inserted directly through the abdomen into the stomach prescribed to provide nutrition), Resident ID #16. Findings are as follows: Record review revealed the resident was admitted to the facility in May of 2026 with diagnoses including, but not limited to, cerebral infarction (stroke) and dysphagia (difficulty swallowing). Record review revealed a physician's order dated 4/13/2026 to administer Jevity 1.5 calorie nutrition (a balanced nutrition administered through a feeding tube) at 65 milliliters per hour via G-tube. Record review revealed a care plan intervention dated 4/8/2026 to provide privacy and promote dignity during care. During a surveyor observation on 6/30/2026 at 11:33 AM, the resident was seated in the common dining room with other residents when Registered Nurse, Staff A, removed the resident's abdominal binder, exposed his/her abdomen, placed a towel under the G-tube, attached the nutrition formula, and started the infusion. Additionally, Staff A failed to request permission from the resident or ensure privacy before exposing and accessing the G-tube site in a public area with other residents present. During a surveyor interview on 6/30/2026 at 1:39 PM, Staff A acknowledged reconnecting the resident's Jevity nutrition to his/her G-tube in the common area without providing privacy before exposing the resident's abdomen. During a surveyor interview on 6/30/2026 at 2:04 PM with the Director of Nursing Services, she revealed that she would expect staff to ask for permission prior to accessing the resident's G-tube site when in a common area. Additionally, she was unable to provide evidence that staff ensured the resident was provided with privacy and was treated with dignity.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff, resident and resident representative interviews, the facility failed to provide reasonable accommodations for resident needs and preferences by not individualizing the physical environment. Specifically, affecting 1 of 1 resident who requested a bariatric bed Resident ID #45 and for 1 of 1 resident who required the correct placement of a Foot Buddy positioning device, Resident ID #101. Findings are as follows:Review of a facility document titled ADL - SUPPORT last revised 5/2026 states in part, .Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).a. Record review revealed Resident ID #45 was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, morbid obesity (a chronic disease with a body mass index of 40 or higher).Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating intact cognition.Further record review revealed that the resident's last recorded weight was 318 pounds on 6/2/2026.During a surveyor observation on 6/29/2026 at 11:49 AM, Resident ID #45 was sitting on the edge of a standard bed, which appeared to be too small to accommodate him/her comfortably.During a surveyor interview on 6/29/2026, following the above observation, Resident ID #45 stated, .as you can see, I need a bigger bed because this bed is so uncomfortable. The resident reported previously notifying maintenance staff, who instructed the resident to inform nursing. The resident stated s/he made this request to a nurse approximately one month prior but received no follow-up.During a surveyor interview on 6/30/2026 at 12:59 PM with Registered Nurse, Staff G, she revealed that she was made aware that the resident requested a larger bed approximately 2 weeks ago. She further revealed that the Maintenance staff were notified of the request. Additionally, Staff G revealed that the Maintenance staff indicated that they were looking into getting the resident a larger bed.During a surveyor interview on 6/30/2026 at 1:13 PM, Maintenance Assistant, Staff H, acknowledged being aware of the resident's request for a larger bed. However, she revealed that there were no functional bariatric beds available in the building at that time.During a surveyor interview on 6/30/2026 at 1:22 PM with the Director of Nursing Services (DNS), she revealed that she was not made aware of the resident's request for a bariatric bed. During a surveyor observation and subsequent interview on 7/1/2026 at 9:44 AM, the resident was noted to be in a new bed that was appropriate for his/her size. Additionally, Resident ID #45 expressed satisfaction, stating that s/he was happy and had slept well the previous night.b. Record review revealed Resident ID #101 was admitted to the facility in January of 2026 with diagnoses including, but not limited to, dementia and stiffness of joints.Review of the Quarterly MDS assessment dated [DATE] revealed that Resident ID #101 is noninterviewable. Additional review of the MDS revealed the resident depends on staff for all activities of daily living.Review of the care plan last revised on 5/19/2026 states the resident is at risk for falls, decrease in mobility and poor safety awareness related to cognitive impairment with an intervention to apply appropriate footwear when ambulating or when in the wheelchair. Additional review of the care plan dated 6/24/2026 states the resident is dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits and physical limitations. Further review of the care plan failed to identify the need for a foot buddy to be applied to the resident's wheelchair.During a surveyor observation on 6/29/2026 at 12:04 PM, Resident ID #101 was observed moaning in the main dining room. The resident's legs were improperly positioned behind the wheelchair leg rests, and the foot buddy support was only covering the lower footing of the rest. The facility staff were immediately notified of (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review and resident and staff interviews, the facility failed to ensure services provided meet professional standards of practice for 1 of 1 resident reviewed for wound care, Resident ID #111. Specifically, nursing staff improperly applied an Unna boot (a specialized compression dressing) to Resident ID #111's right lower extremity (RLE), omitting the foot and ankle. Findings are as follows: Review of the manufacturer's instruction for the Unna boot application revealed the following: 1. Position the foot at a right angle, so the foot is perpendicular to the leg. Begin wrapping without pressure just above the toes and continue upwards using a spiral technique with a 50% overlap. 2. Mold wrap to the contours of the leg. Finish wrapping 1-2 [inches] below the knee. Smooth out wrinkles as needed. 3. Secure by covering with a secondary dressing such as a self-adherent wrap, elastic bandage, or gauze roll. Record review revealed that Resident ID #111 was admitted to the facility in May of 2025 with a diagnosis including, but not limited to, fluid overload. Record review revealed a physician order with a start date 5/6/2026 to cleanse the right lower extremity with normal saline, pat the extremity dry, and apply an Unna boot every Tuesday and Friday. During a surveyor interview with Resident ID #111 on 6/29/2026 at 9:27 AM, the resident revealed that a nurse applied the Unna boot wrapping his/her leg incorrectly. The resident revealed that s/he had increased pain from the application. Review of a skin/wound note dated 6/12/2026 revealed a skin assessment was completed, and the resident's leg was not weeping. Review of a progress note authored by Nurse Practitioner, Staff J, dated 6/21/2026, revealed a video consultation was conducted with Resident ID #111 and the facility nurse, regarding Resident ID #111 as s/he was experiencing acute pain. The resident was complaining of right ankle pain and the nurse reports ankle edema (swelling caused by excess fluid in tissues, often due to inflammation, injury, or underlying conditions), with serous drainage (clear to pale yellow, thin, watery fluid that leaks from an area affected by edema). On the video the resident was observed to have an Unna boot covered with an ACE bandage to the lower leg; however, the dressing was applied in a fashion that stopped abruptly above the ankle. During the consultation, Resident ID #111 stated that the dressing had been applied correctly by staff in the past but not this time. During a surveyor interview on 6/30/2026 at 11:32 AM with Registered Nurse (RN), Staff A, she revealed that the nurse wrapped the resident's leg inappropriately. She revealed that the Unna boot wrapping should have been applied from the base of the toes to below the knee. During a surveyor interviews on 6/30/2026 at 2:07 PM and 7/1/2026 at 10:07 AM, with the Director of Nursing Services, she acknowledged that the nurse didn't apply the Unna boot correctly.		

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 07/02/2026
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 0559 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on clinical record review and resident, resident representative, and staff interviews, the facility failed to provide written notification, including the reason for the room change, before the resident's room or roommate in the facility is changed, for 6 of 6 residents reviewed, Resident ID #s, 45, 66, 93, 99, 101, and 147. Findings are as follows: Record review of a facility policy titled Room Change last revised in October of 2022, states in part, .The resident has the right to refuse transfer to another room in the facility if the purpose of the transfer is. Solely for the convenience of staff. When a resident room change is occurring, the resident being moved. will be informed of the room change. The resident receiving a new roommate will also be notified. The notice of a change in room or roommate assignment will be both verbal and in writing including the reason(s) for the change. Staff should complete a room change notice and provide to the resident. placed in the resident's medical record. 1. Record review revealed Resident ID #45 was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, type two diabetes. Record review of a Brief Interview for Mental Status (BIMS) score dated 5/8/2026, revealed a score of 15 of 15, indicating intact cognition. Record review of the facility census revealed that the resident was moved from his/her room on 4/1/2026. Review failed to reveal evidence that Resident ID #45 received written notification of the room change, including the reason for the change, per the facility policy. 2. Record review revealed Resident ID #147 was admitted to the facility in May of 2026 with a diagnosis including, but not limited to, pneumonia. Record review of a BIMS score dated 5/29/2026, revealed a score of 8 of 15, indicating a moderate cognitive impairment. Record review of the facility census revealed that the resident was moved from his/her room on 6/9/2026. Record review failed to reveal evidence that Resident ID# 147 received written notification of the room change, including the reason for the change, per the facility policy. During a surveyor interview on 6/30/2026 at approximately 3:00 PM with Resident ID #147, s/he revealed that s/he was not initially happy with the transfer to another floor because s/he made friends on the second floor. 3. Record review revealed Resident ID #66 was admitted to the facility in January of 2024 with diagnoses including, but not limited to, anxiety and depression. Record review of a BIMS score dated 5/28/2026, revealed a score of 15 of 15, indicating intact cognition. During a surveyor interview on 6/30/2026 at approximately 1:20 PM the resident revealed that one morning s/he was awoken by staff telling him/her that his/her room will be changed. The resident further revealed that s/he didn't not have a choice and did not want to move as s/he had been in that room for several years. The resident denied receiving written notification of the room change. Record review of the facility census revealed that the resident was moved from his/her room on 5/27/2026. Record review failed to reveal evidence that Resident ID #66 received written notification of the room change, including the reason for the change, per the facility policy. 4. Record review revealed Resident ID #93 was admitted to the facility in October of 2021 with a diagnosis including, but not limited to, heart failure. Record review of a BIMS score dated 4/10/2026, revealed a score of 15 of 15, indicating intact cognition. During a surveyor interview on 7/1/2026 at 12:57 PM with Resident ID #93, s/he revealed that s/he was not notified about receiving a roommate prior to the transfer. Record review failed to reveal evidence of written notification to the resident that s/he was to receive a roommate. 5. Record review revealed Resident ID #99 was admitted to the facility in December of 2023 with diagnoses including, but not limited to, dementia and obsessive-compulsive disorder. Record review of a BIMS score dated 6/25/2026, revealed a score of 0 of 15, indicating severe cognitive impairment. Record review of the facility census revealed that the resident was moved from his/her room three times (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Adviniacare Summit Commons, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 99 Hillside Avenue Providence, RI 02906	
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F 0559 Level of Harm - Potential for minimal harm Residents Affected - Many	from December 2024 to June of 2026. During a surveyor interview on 6/30/2026 at 1:06 PM with Resident ID #99's representative, s/he revealed that there were no written notifications provided for room changes within the facility. Record review failed to reveal evidence that Resident ID #99's resident representative received written notification of the room change, including the reason for the change, per the facility policy. 6. Record review revealed Resident ID #101 was admitted to the facility in January of 2026 with a diagnosis including, but not limited to, dementia. Record review of a BIMS score dated 5/7/2026, revealed a score of 0 of 15, indicating severe cognitive impairment. Record review of the facility census revealed that the resident was moved from his/her room three times from January 2026 to June of 2026. During a surveyor interview on 6/30/2026 at 1:06 PM with Resident ID #101's representative, s/he revealed that there were no written notifications provided for room changes within the facility. Record review failed to reveal evidence that Resident ID #101's representative received written notification of the room change, including the reason for the change, per the facility policy. During a surveyor interview on 7/2/2026 at 11:17 AM, with the Social Worker, she revealed that when a room change or roommate change occurs the facility will complete an assessment in the record but does not give any written notification to the resident and/or resident representative. During a surveyor interview on 7/1/2026 at 10:36 AM and 7/2/2026 at 2:17 PM, with the Director of Nursing Services, she acknowledged that the facility failed to provide written notification, including the reason for the room change, before the resident's room or roommate in the facility is changed, for Resident ID #s, 45, 66, 93, 99, and 101, and 147.		