DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and complaint survey, ACTS reference numbers 99830, 99843 and 99891, was conducted at Summit Commons Rehabilitation and Health Care Center on 3/10/2025 through 3/13/2025 to determine compliance with 42 C.F.R. Part 483, requirements for Long Term Care Facilities. A state licensure and emergency preparedness surveys were also conducted at this facility. Deficiencies were identified as a result of this survey.	F 000	Received APR 0 1 2025 F 000 Facilities Regulation This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583	F 583 1. The "Resident /Staff Roster" from dates 4/12/22, 6/14/2022, 7/27/2022, 8/11/2022, 8/30/2022, 10/24/2022, 1/18/2022, 1/25/2023, and 1/17/2025 were removed from the "Survey History Binder". 4/1/25 2. All residents identified on a "resident /staff roster" have the potential to be affected by the same alleged deficient practice. A facility wide audit of the "Survey History Binder" was completed to ensure there were no other "Resident /Staff Rosters" in the Survey History Binder". There were no others identified. 4/2/25 3. The Administrator received in-service education on not including the "Resident / Staff Rosters" in the Survey History Binder when updating the binder of any new survey results. The Administrator will visually audit the Survey History Binder when updating to ensure there is no resident/staff rosters included. 4. The results of the Survey History Binder Audits will be reviewed at the Quality Assurance Committee Meeting until ongoing compliance is obtained. 5. The Administrator is ultimately responsible to ensure ongoing compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 4/1/2025

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.

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F 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: 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	F 583		

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F 583	Continued From page 2 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.	F 583		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 693		

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F 693	Continued From page 3 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: 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.	F 693	F 693 1. Resident ID # 102 had the g-tube feeding orders changed back to the original order for the Jevity 1.5 with a flush of stated as it was on hold for less then the on hold for changed back to the original order for formula and flush on 2. All residents with g-tube feeding have the potential to be affected by the alleged deficient practice. A facility wide audit of residents receiving g-tube feedings were audited to ensure that the formula, rate and flush that is ordered was set on the pump. 3. The licensed nurses received in-service education on ensuring that the order for g-tube formula, rate and flush are being followed as ordered by the MD. The DNS or designee will complete a G-tube Order Audit randomly to ensure that the orders for formula, rate and flush are being followed as ordered. 4. The results of the G-tube Order Audits will be reviewed at the Quality Assurance Committee Meeting until ongoing compliance is obtained. 5. The Director of Nursing is ultimately responsible for ensuring ongoing compliance.	4/1/25

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F 693	Continued From page 4 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 milliliter) 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	F 693		

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F 693	Continued From page 5 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. 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.	F 693		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: 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	F 698		

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F 698	Continued From page 6 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	F 698	F 698 1. 1. A and B- Residents ID #'s 42 and 51 have had their orders enhanced to allow for supplemental documentation each shift of the fluid total received each shift. 2. All residents on fluid restrictions have the potential to be affected by the same alleged deficient practice. A facility wide audit of residents on fluid restrictions was completed to ensure that the order for fluid restriction had the additional supplemental documentation to document the amount of fluid consumed each shift. 3. The Licensed Nurses received in-service education on the Fluid Restriction Policy and a review of the expectation for the intakes to be monitored and documented on the order for fluid restriction from the intake sheets. The DNS or designee will complete a Fluid Restriction Audit to ensure that the orders for Formular, Rate and Flush are accurate on the g-tube pump if there are orders for any order changes. 4. The results of the Fluid Restriction Audits will be reviewed at the Quality Assurance Committee Meeting until ongoing compliance is obtained. 5. The Director of Nursing is ultimately responsible for ensuring ongoing compliance.	4/1/25

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F 698	Continued From page 7 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. 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	F 698	F 698 con't 2. 1. A and B. Resident ID #'s 42 and 79 will have any refusals of medications and falls communicated to the dialysis center. 2. All residents receiving dialysis have the potential to be affected by the alleged deficient practice. A facility wide audit of residents receiving dialysis was conducted and falls that have occurred within the last 3 months were reported to appropriate dialysis centers for each resident if they have had any falls. Those residents that receive dialysis had their medication administration record viewed since Marh 1st and any medication refusals were communicated to the dialysis center. 3. The Licensed Nurses received in-service education on the Hemodialysis Policy. This education included a review of notification on the COC / communication book to dialysis any falls or medication refusals for the resident since the last dialysis treatment. The DNS or designee will complete a Dialysis Notification Audit to ensure that falls and medication refusals are communicated to the dialysis center per policy. 4. The results of the Dialysis Notification Audits will be reviewed at the Quality Assurance Committee Meeting until ongoing compliance is obtained. 5. The Director of Nursing is ultimately responsible for ensuring ongoing compliance.	4/1/25

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F 698	Continued From page 8 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.	F 698		

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F 698	Continued From page 9 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 - 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	F 698		

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F 698	Continued From page 10 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. 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	F 698		

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F 698	Continued From page 11 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.	F 698		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to	F 710		

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F 710	Continued From page 12 a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: 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	F 710	F 710 1. Resident ID # 28's weight loss was reported to the MD. The resident has orders for daily weights as [redacted] is being diuresised an weight loss was expected. 2. All residents have the potential to be affected by the alleged deficient practice. A facility wide audit was completed to determine if there were any other residents that have weight loss, and that the MD was notified of the weight loss. 3. The Licensed Nurses received in-service education on the Weight Loss Policy. There was a review of the need to notify the MD if the resident had lost weight loss and the need to document the notification. The DNS or designee will complete a Weight Loss Audit to determine if the MD was notified if weight loss was identified. 4. The results of the Weight Loss Audit will be reviewed at the Quality Assurance Committee Meeting until ongoing compliance is obtained. 5. The Director of Nursing is ultimately responsible for ensuring ongoing compliance.	4/1/25

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F 710	Continued From page 13 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.	F 710		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7)	F 730		

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F 730	Continued From page 14 §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: 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.	F 730	F 730 1. There were no residents identified in this deficiency. The evaluations on staff E, F, G, H, I and J were signed. 2. The facility completed an audit of the CNA evaluations that were due in March 2025 and ensured that the evaluations have been completed entirely. 3. The Director of Nursing received in-service education on completing the CNA's evaluations in their entirety. The DNS or designee will complete an Evaluation Audit monthly to ensure that all scheduled annual CNA evaluations that were scheduled for the month were completed. 4. The results from the Evaluation Audits will be reviewed at the Quality Assurance Committee Meeting until ongoing compliance is obtained. 5. The Director of Nursing is ultimately responsible for ensuring ongoing compliance.	4/1/25
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 15 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: 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	F 812	F 812 1. 1 and 2. The items identified in the kitchen and nourishment refrigerators were discarded. 2. All stored refrigerated opened food items have the potential to be affected by the same alleged deficient practice. A facility wide audit of the facilities walk-in refrigerators in the kitchen and the nourishment refrigerators on the units was completed to ensure all items were labeled and dated per the facilities policy. 3. The kitchen staff received in-service training on labelling and dating items in the walk-in refrigerators in the kitchen and labeling and dating items in the nourishment refrigerators on the units per policy. The Food Service Director or designee will audit the kitchen walk-in refrigerators and the nourishment refrigerators on the units for labeling and dating per policy. 4. The results of the Labeling/Dating of items in the kitchen walk-in and nourishment refrigerators will be reviewed at the Quality Assurance Committee Meeting until ongoing compliance is obtained. 5. The Food Service Director is ultimately responsible for ensuring ongoing compliance.	4/1/25

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F 812	Continued From page 16 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:	F 812		

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F 812	Continued From page 17 - 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 - 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:	F 812		

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F 812	Continued From page 18 - 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. 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.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)	F 842		

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F 842	Continued From page 19 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	F 842 1. 1. Resident ID # 13 had the order for Enhanced Barrier Precautions was discontinued. 2. All residents that were on Enhanced Barrier Precautions for wounds have the potential to be affected by the same alleged deficient practice. A facility wide audit of the orders for Enhanced Barrier Precautions was completed to determine if the residents on the order listing report continued to require the orders for Enhanced Barrier Precautions. 3. The Infection Control Nurse and the Licensed Nurses received in-service training on the Enhanced Barrier Precautions Policy with attention to discontinuing the order for the precautions if the resident was on the precautions related to a wound and the wound resolved. The infection control nurse or designee will complete Enhanced Barrier Precaution Discontinuation of Order Audit weekly to ensure if any resident that has had a wound healed and required the Enhanced Barrier Precautions to be discontinued that the order was discontinued in the EMR. 4. The results of the Enhanced Barrier Precautions Discontinuation of Orders Audits will be reviewed at the Quality Assurance Committee Meeting until ongoing compliance is obtained. 5. The Director of Nursing is ultimately responsible for ensuring ongoing compliance.	4/1/25

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F 842	Continued From page 20 §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: 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.	F 842	F 842 con't 2. 1. Resident ID # 217 had the signage and cart posted at the entrance to the room. 2. All residents on Enhanced Barrier Precautions have the potential to be affected by the same alleged deficient practice. A facility wide audit of residents on Enhanced Barrier Precautions was completed to ensure that the residents on the precautions had the appropriate precautions sign and cart posted at the entrance of their room. 3. The Infection Control Nurse and the Licensed Nurses received in-service training on the Enhanced Barrier Precautions Policy with attention to ensuring that when they are signing off the order for Enhanced Barrier Precautions, they must ensure the signage and cart are posted at the entrance to the resident's room. The infection control nurse or designee will complete Enhanced Barrier Precaution Signage and Cart Audit randomly to ensure the sign and cart are posted at the entrance to the resident's room 4. The results of the Enhanced Barrier Precautions Signage and Cart Audits will be reviewed at the Quality Assurance Committee Meeting until ongoing compliance is obtained. 5. The Director of Nursing is ultimately responsible for ensuring ongoing compliance.	4/1/25

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F 842	Continued From page 21 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	F 842		

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F 842	Continued From page 22 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. 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.	F 842		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting	F 868		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 23 at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: 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,	F 868	F 868 1. There were no residents identified in this deficiency. 2. All QAPI meetings have the potential to be affected by this alleged deficient practice as vacancies of positions and vacations occur. 3. The Administrator received in-service education on the Quality Assessment and Assurance Policy with a focus on the required attendance. The Administrator will ensure attendance of the Infection Control Nurse and the DNS quarterly. 4. The Administrator will take attendance and report on the attendance of the Infection Control Nurse and the DNS within the attendance sheet at the Quality Assurance Committee meeting quarterly to ensure ongoing compliance 5. The Administrator is ultimately responsible for ensuring ongoing compliance.	4/1/25

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 24 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	F 868		

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F 868	Continued From page 25 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.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880	F 880 1. Resident ID # 217 had the signage and cart posted at the entrance to the room. 2. All residents on Enhanced Barrier Precautions have the potential to be affected by the same alleged deficient practice. A facility wide audit of residents on Enhanced Barrier Precautions was completed to ensure that the residents on the precautions had the appropriate precautions sign and cart posted at the entrance of their room. 3. The Infection Control Nurse and the Licensed Nurses received in-service training on the Enhanced Barrier Precautions Policy with attention to ensuring that when they are signing off the order for Enhanced Barrier Precautions, they must ensure the signage and cart are posted at the entrance to the resident's room. The infection control nurse or designee will complete Enhanced Barrier Precaution Signage and Cart Audit randomly to ensure the sign and cart are posted at the entrance to the resident's room 4. The results of the Enhanced Barrier Precautions Signage and Cart Audits will be reviewed at the Quality Assurance Committee Meeting until ongoing compliance is obtained. 5. The Director of Nursing is ultimately responsible for ensuring ongoing compliance.	4/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 26 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 27 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..."	F 880		

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

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F 880	Continued From page 28 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. 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,	F 880		

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F 880	Continued From page 29 as ordered.	F 880		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LTC00769	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT COMMONS REHABILITATION AND HE	99 HILLSIDE AVENUE PROVIDENCE, RI 02906

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M 085	ORGANIZATION AND MANAGEMENT 1.13.2.B Quality Improvement Program 1.13.2.B. Each licensed nursing facility shall designate a qualified individual, who shall be determined by the nursing facility ' s administrator, to coordinate and manage the nursing facility ' s quality improvement program. 1. The nursing facility ' s quality improvement committee shall include at least the following members: 2. The nursing facility administrator; 3. The director of nursing; 4. The medical director; 5. A social worker; and 6. A representative of dietary services. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure QAPI/QAA (quality assurance performance improvement/quality assessment and assurance) committee included all required members. 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	M 085	M 085 1. There were no residents identified in this deficiency. 2. All QAPI meetings have the potential to be affected by this alleged deficient practice as vacancies of positions and vacations occur. 3. The Administrator received in-service education on the Quality Assessment and Assurance Policy with a focus on the required attendance. The Administrator will ensure attendance of the DNS, Social Worker and dietary staff quarterly. 4. The Administrator will take attendance and report on the attendance of the DNS, social worker, and dietary staff within the attendance sheet at the Quality Assurance Committee meeting quarterly to ensure ongoing compliance 5. The Administrator is ultimately responsible for ensuring ongoing compliance.	4/11/25

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 4/11/2025

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 085	Continued From page 1 composed of, at a minimum...The Director of Nursing or Assistant Director of Nursing..." 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 Social Worker or a dietary services representative attended the meeting. Review of the QAPI/QAA committee sign in sheet dated 7/24/2024 failed to reveal evidence that a dietary services representative attended the meeting. Review of the QAPI/QAA committee sign in sheet dated 10/15/2024 failed to reveal evidence that the Director of Nursing Services (DNS) or the Social Worker attended the meeting. Review of the QAPI/QAA committee sign in sheet dated 1/15/2025 failed to reveal evidence that the DNS or Social Worker 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 DNS, Social Worker, or a dietary services representative were in attendance for all of the above mentioned QAPI/QAA committee meetings.	M 085		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M1290	Continued From page 2	M1290	M 1290	
M1290	PHYSICAL PLANT 1.19.3.B Fire and Safety 1.19.3.B. Each nursing facility shall establish a monitoring program for the internal enforcement of all applicable fire and safety laws and Regulations. Such a program shall include written procedures for the implementation of said Rules and Regulations and logs shall be maintained. This Requirement is not met as evidenced by: Based on record review it has been determined the residence failed to have an annual State Fire Marshal inspection which indicates compliance with the Fire Safety Code. Findings are as follows: Record review failed to reveal an inspection report demonstrating compliance with the State Fire Marshal requirements. During a surveyor interview with the Regional Maintenance Director on 3/10/2025 at 2:00 PM, he acknowledged that the facility had not been inspected by the State Fire Marshal since 2019.	M1290	1. The were no residents identified in this deficiency statement. 2. The Fire Marshall was contacted and is scheduled to do an inspection on April 28, 2025. 3. The results of the annual fire marshal inspection will be reported to the Quality Assurance Committee to ensure ongoing compliance annually. 4. The Director of Maintenance is ultimately responsible to ensure ongoing compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation on 3/13/2025. The facility was found to be in compliance with 42 CFR §483.73 related to Emergency Preparedness. Capacity: 165 Census: 113	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 4/1/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415129	A. BUILDING 01 - MAIN BUIDLING B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency on 3/13/2025. Summit Commons Rehabilitation and Health Care Center was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) Physical Environment. Life Safety Code deficiencies were identified during the survey. The facility is NOT in compliance with all regulations surveyed. Capacity: 165 Census: 113	K 000	K 000 This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the	K 324		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

ADMINISTRATOR 4/1/2025

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.

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K 324	Continued From page 1 corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the kitchen hood suppression system was not being maintained in accordance with National Fire Protection Association (NFPA) 101 Life Safety Code 2012 Edition and NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2011 Edition. This deficient practice has the potential to impact 113 of 113 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: Record review of NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2011 Edition section 11.2 states in part, "...11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person (s) acceptable to the authority having jurisdiction at least every 6 months..." Record review of the facility's kitchen hood maintenance records failed to reveal it was serviced in 2024.	K 324	K 324 1. There were no residents identified in this deficiency statement. 2. The facility had the fire extinguishment system for the kitchen exhaust hood serviced by Eastern Fire Protection, LLC on 1/7/2025. 3. The Maintenance Director will report to the Quality Assurance Committee when the Kitchen hood is serviced to ensure ongoing compliance. 5. The Maintenance Director is ultimately responsible for ensuring ongoing compliance.	1/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 324	Continued From page 2 During a surveyor interview on 3/11/2025 at approximately 1:50 PM, with the Regional Maintenance Director and the facility Maintenance Director, they were unable to provide evidence that the kitchen hood was serviced by a certified person every six months, as required.	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that the fire alarm system was maintained in accordance with National Fire Protection Association (NFPA) 101 Life Safety Code, 2012 Edition, and NFPA 72 National Fire Alarm and Signaling Code, 2010 Edition. This deficient practice has the potential to impact 113 of 113 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: 1. Review of the NFPA 72 National Fire Alarm and Signaling Code, 2010 Edition, states in part,	K 345	K 345 1. There were no residents identified in this deficiency. 2. The facility has scheduled the battery discharge test on the fire alarm control panel on April 9th and 10th, 2025 by FSI (Fire Systems, Inc.) FSI has been scheduled to complete the fire alarm system maintenance on April 9th and 10th, 2025. 3. The Maintenance Director is responsible for maintaining compliance.	4/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415129	A. BUILDING 01 - MAIN BUIDLING 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

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K 345	Continued From page 3 "14.4 Testing. 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction." Further review of the NFPA 72 National Fire Alarm and Signaling Code, 2010 Edition revealed, the fire alarm control panel battery discharge test is required to be completed annually. Record review of the facility's fire alarm system maintenance records failed to reveal evidence that the fire alarm control panel battery discharge test was completed in the last year. During a surveyor interview on 3/11/2025 at approximately 1:30 PM, with the Regional Maintenance Director and the facility Maintenance Director, they could not provide evidence that the fire alarm control panel battery discharge test had been completed annually, as required. 2. Review of the NFPA 72 National Fire Alarm and Signaling Code, 2010 Edition, states in part, "...9.6 Fire Detection, Alarm, and Communications Systems. 9.6.1* General. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use..."	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415129	A. BUILDING 01 - MAIN BUIDLING B. WING _____	03/13/2025

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SUMMIT COMMONS REHABILITATION AND HEALTH CARE CNT	99 HILLSIDE AVENUE PROVIDENCE, RI 02906

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K 345	Continued From page 4 Record review of NFPA 72 National Fire Alarm and Signaling Code 2010 Edition states in part, "...14.4 Testing. 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction..." Record review of the last four quarterly (every three months) fire alarm system maintenance reports on 3/11/2025, failed to reveal evidence that the facility completed the quarterly maintenance testing between 7/16/2024 and 1/16/2025, as required. During a surveyor interview on 3/11/2025 at approximately 1:40 PM, with the Regional Maintenance Director and the facility Maintenance Director, they could not provide evidence that the fire alarm system received quarterly testing maintenance, as required.	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353	K 353 1. There were no residents identified in this deficiency. 2. The facility has scheduled the sprinkler system maintenance by FSI on April 9th and 10th 2025. 3. The Maintenance Director is responsible for maintaining compliance. 4/2/25 4/10/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415129	A. BUILDING 01 - MAIN BUIDLING B. WING _____	03/13/2025

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SUMMIT COMMONS REHABILITATION AND HEALTH CARE CNT	99 HILLSIDE AVENUE PROVIDENCE, RI 02906

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K 353	Continued From page 5 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on surveyor observations, record review, and staff interview it has been determined that the facility failed to ensure that the automatic sprinkler system was being maintained in accordance with National Fire Protection Association (NFPA) 101 Life Safety Code 2012 Edition sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011 edition. This deficient practice has the potential to impact 113 of 113 residents as well as an indeterminable number of staff and visitors. Findings are as follows: Record review of NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011 Edition states in part, "...4.5 Testing. 4.5.1 All components and systems shall be tested to verify that they function as intended. 4.5.2 The frequency of tests shall be in accordance with this Standard. 4.7* Maintenance. Maintenance shall be performed to keep the system equipment operable or to make repairs..." NFPA 25 Standard for the Inspection, Testing,	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415129	A. BUILDING 01 - MAIN BUIDLING B. WING _____	03/13/2025

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K 353	Continued From page 6 and Maintenance of Water-Based Fire Protection Systems 2011 edition states in part, "...5.1.1.2 Table 5.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. 5.3.2* Gauges. 5.3.2.1 Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. 5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly..." Record review of the sprinkler system quarterly reports revealed that maintenance of the sprinkler system was last completed on 7/16/2024, approximately eight months ago. Further record review failed to reveal that the sprinkler system maintenance was completed quarterly (every three months), as required. During a surveyor interview on 3/11/2025 at approximately 1:45 PM, with the Regional Maintenance Director and the facility Maintenance Director, they could not provide evidence that the sprinkler system received quarterly maintenance, as required.	K 353		