STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415129	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUMMIT COMMONS REHABILITATION AND HEALTH CARE CNT	**99 HILLSIDE AVENUE PROVIDENCE, RI 02906**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** Based on record review and staff interview it has been determined that the facility failed to implement a system for surveillance of tracking fever, respiratory illness and other signs/symptoms of COVID-19 for all residents in the facility. According to the CDC, Preparing for COVID-19 in Nursing Homes .Evaluate and Manage Residents with Symptoms of COVID-19 .The health department should be notified about .(equal to or greater than) 3 residents or HCP (Health Care Providers) with new-onset respiratory symptoms within 72 hours of each other . Review of the facility policy and procedure titled, Section C-Novel Coronavirus Covid-19 states in part, .Line listing will be conducted each shift for any resident exhibiting respiratory symptoms . Record review failed to reveal evidence of a system for surveillance of tracking fever, respiratory illness and other signs/symptoms of COVID-19. Additionally, the facility could not provide a line list for each resident that may had been exhibiting respiratory symptoms. During a surveyor interview with the Infection Control Nurse, on 8/20/2020 at approximately 2:30 PM, she could not provide evidence of a system for surveillance of tracking fever, respiratory illness and other signs/symptoms of COVID-19 or a line list for each resident that may had been exhibiting respiratory symptoms.

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

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.