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RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01626	A. BUILDING: _____ B. WING _____	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMER VILLA	81 LAUREL AVENUE COVENTRY, RI 02816

(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) COMPLETE DATE
S 003	Initial Comments A biennial licensure survey and a complaint investigation (1H7Z11) was conducted at this residence on 3/3/2026 through 3/5/2026 to determine compliance with state laws and regulations. Deficiencies were identified relative to the licensure survey.	S 003		
S 255	Organization And Management 2.4.14.B Management Of Services 2.4.14 (B) Management Of Services B. The residence shall have a policy and procedure manual that is reviewed and updated by the administrator at intervals not to exceed twelve (12) months, and shall include, but not be limited to, the following items: 1. A written description of all services available to residents that shall be designed to promote the resident ' s efforts to maintain independence; 2. A written statement of admission criteria that shall include, at a minimum, the following information regarding the resident population: a. Nature and extent of disabling condition(s) served; and b. Restrictions (if any). (1) The statement of admission criteria shall include a statement that no otherwise qualified applicant shall be denied admission to the residence solely on the basis of age, sex, gender identity or expression, race, creed, color, religion, sexual orientation, marital status, familial status, disability, source of	S 255 3/3/26	① policy and procedure manual has been updated. ② we have added it to a Calendar so that it will not be missed. Received MAR 12 2026 Facilities Regulation	3/10/26 3/10/26
S890		S890 3/3/26	① all nurses have been spoken to about the importance of updating all required documents as changes occur and yearly.	3/6/26

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elo [illegible] TITLE: Administrato (X6) DATE: 3/11/26

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S 255	Continued From page 1 income, source of payment or profession, or national origin. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to have a policy and procedure manual that is reviewed and updated by the residence at intervals not to exceed twelve (12) months. Findings are as follows: Record review of the residence's policy and procedure binder failed to reveal evidence that residence's policies had been reviewed yearly. During a surveyor interview with the Administrator on 3/5/2026 at 10:16 AM, she could not provide evidence that the policy and procedure binder's contents had been updated at intervals not to exceed 12 months, as required.	S 255 S690 3/31/26	(2) all outside Service agencies were called 3/6/26 to send all appropriate documentation. (3) all care plans and assessments have been updated to reflect appropriate treatments.	3/6/26 3/6/26
S 390	Residency Requirements 2.4.17.D Resident Assessment/Service Plans 2.4.17 (D) Resident Assessments and Service Plans D. The assessment shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to review the residents' comprehensive assessment	S 390 S415 3/31/26	(1) nurses and administrator had a meeting and discussed what is expected of ~~those~~ this job description.	3/6/26

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S 390	Continued From page 2 at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly for 2 of 3 residents reviewed for outside services, Resident ID #s 1 and 2; the singular resident with behaviors, Resident ID #3; and the singular resident reviewed for self-administration of oxygen, Resident ID #4. Findings are as follows: Review of the list of residents receiving outside services revealed Resident ID #s 1 and 2. 1) Record review revealed Resident ID #1 moved into the residence in September of 2016 with a diagnosis of a history of bilateral lower extremities venous insufficiency (occurs when leg vein valves are damaged or weakened, preventing efficient blood return to the heart and causing blood to pool). Review of the outside agency notes revealed the resident started receiving skilled nursing (SN) on 11/7/2025 and was discharged on 1/19/2026. Review of the comprehensive assessment, dated 3/2/2026, failed to indicate the resident received skilled nursing services. Additionally, the start and end of service dates for SN services were not documented. During a surveyor interview with the Administrator on 3/5/2026 at approximately 2:15 PM, she could not provide evidence that Resident ID #1's comprehensive assessment was updated to include the start of care and end of care dates for skilled nursing services. 2) Record review revealed Resident ID #2 moved into the residence in September of 2020 with a	S 390 S415	(2) all Service plans have been updated to reflect appropriate Care and treatment. (3) nurses have a Calendar to go by from now on to ensure we do not miss any updates. (4) all nurses were retrained on importance of always making sure all documents reflect the on going Care and treatment	3/6/26 3/6/26 3/6/26

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S 390	Continued From page 3	S 390		
	diagnosis including diabetic neuropathy (nerve damage caused by long-term high blood sugar, can cause numbness in the legs and feet). Review of the outside agency notes revealed the resident started receiving SN on 1/30/2026 and was discharged on 2/11/2026. Review of the comprehensive assessment, dated 1/30/2026, failed to indicate the end of service date for SN services. During a subsequent interview with the Administrator, she could not provide evidence that Resident ID #2's comprehensive assessment was updated to include an end of care date for SN services. 3) Record review revealed Resident ID #3 moved into the residence in November of 2024 with a diagnosis of HTN (hypertension). Review of the resident's progress notes for the past six months revealed the following: - 10/2/2025, "Resident has been exhibiting increased anger and threatening to hit other residents several times within the past several weeks. Psychiatric nurse practitioner met with (him/her) yesterday and prescribed Seroquel 25 mg (milligrams) TID (three times a day)..." - 12/23/2025, "10 pm This resident was accused of striking another resident in the face for having the TV on after 10 pm...rescue to transport this resident for change in mental status..." - 12/28/2025, The resident was saying angry words to another resident and the other resident walked away. This resident followed her/him out	S560 3/11/26	① We have purchased a new can opener and cutting boards all old ones were thrown away. 3/4/26 ② all kitchen staff have been retrained on what is expected and the proper cleaning requirments for the kitchen. 3/4/26 ③ AAA Restaurant helpys came and cleaned oven hood and fans. 3/10/26	

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S 390	Continued From page 4 the front door. When the other resident was on the top step, this resident took a swipe at her/him. Her/his probation officer and police were notified and took her/him out of the facility. Review of the comprehensive assessment, dated 11/25/2024, revealed that s/he is not assaultive or dangerous. During a subsequent interview with the Administrator, she could not provide evidence that the resident's assessment was updated to include s/he had behaviors. 4) Record review revealed Resident ID #4 moved into the residence in August of 2012 with a diagnosis of emphysema (a chronic, progressive obstructive lung disease caused primarily by smoking). During a surveyor observation of the resident in her/his room on 3/5/2026 at 11:15 AM, s/he was utilizing 6 liters of oxygen and indicated s/he did not know what the oxygen was supposed to be set on. Record review of the comprehensive assessment, last updated 1/28/2025, revealed the resident began utilizing oxygen on 7/28/2023. This assessment does not reflect a liter flow for oxygen or an annual update. Additionally, the comprehensive assessment indicates the resident "needs medication administration;" however, the resident is self-administering his/her oxygen. Review of the resident's record failed to reveal a self-administration of medication assessment was completed with each comprehensive assessment. Review of the physician's order, dated 9/27/2024,	S 390 S560 3/31/26 S640 3/31/26	① all Kitchen Staff were retrained on how to properly label and date all food, they also were retrained on how to properly wrap all food put in fridge. ① all med techs and RN's were retrained on checking dates and labels for all expirations. ② we have assigned one med tech to be in charge of overflow.	3/4/26 3/4/26 3/4/26

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S 415	Continued From page 6	S 415		
	Review of the outside agency notes revealed the resident started receiving skilled nursing (SN) on 11/7/2025 and was discharged on 1/19/2026. Review of the service plan, dated 10/12/2024, failed to reveal a start and end of care date for skilled nursing services. The plan further failed to reveal it was updated annually. During a surveyor interview on 3/5/2026 at approximately 2:15 PM with the Administrator, she could not provide evidence that the service plan was updated yearly. She further could not provide evidence that SN services were reflected on the service plan. 2) Record review revealed Resident ID #2 moved into the residence in September of 2020 with a diagnosis including diabetic neuropathy (nerve damage caused by long-term high blood sugar, can cause numbness in the legs and feet). Review of the outside agency notes revealed the resident started receiving SN on 1/30/2026 and was discharged on 2/11/2026. Review of the service plan, dated 12/3/2024, failed to reveal it was updated annually and failed to indicate the end of service date for SN. During a subsequent interview with the Administrator, she could not provide evidence that Resident ID #2's service plan was updated annually and to include an end of care date for SN services. 3) Record review revealed Resident ID #3 moved into the residence in November of 2024 with a diagnosis of HTN (hypertension).	S675 (Ann) 3/31/26	③ Going forward nurse will be Checking on all Self administes Residents to make sure they are in Compliance. We have made a Self administes assessment that will be completed upon admission and quarterly.	3/10/26

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S 390	Continued From page 6 relative to oxygen revealed the resident is prescribed 2 liters of oxygen, not 8 liters. During a subsequent interview with the Administrator, she could not provide evidence of self-administration assessments for the resident's' ability to utilize oxygen independently.	S 390		
S 415	Residency Requirements 2.4.17.G.3 Resident Assessment/Service Plan 2.4.17 (G)(3) Service Plans 3. The service plan shall be reviewed by both parties at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly and all changes shall be acknowledged in writing by both parties. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to update the service plan for 6 of 6 residents reviewed relative to service provision and updates, Resident ID #s 1, 2, 3, 4, 5, and 6. Findings are as follows: Review of the list of residents receiving outside services revealed Resident ID #s 1 and 2. 1) Record review revealed Resident ID #1 moved into the residence in September of 2018 with a diagnosis of a history of bilateral lower extremities venous insufficiency (occurs when leg vein valves are damaged or weakened, preventing efficient blood return to the heart and causing blood to pool).	S 415 S675 3/31/26	① We have placed an O2 sign on the door of room w/ O2. ② Physician was notified about Residents non Compliance w/ O2 orders.	3/5/26 3/5/26

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S 415	Continued From page 7 Review of the service plan, dated 11/25/2024, failed to be updated annually. During a subsequent interview with the Administrator, she could not provide evidence that the resident's service plan was updated annually, as required. 4) Record review revealed Resident ID #4 moved into the residence in August of 2012 with a diagnosis of emphysema (a chronic, progressive obstructive lung disease caused primarily by smoking). Review of the service plan, dated 8/26/2024, failed to reveal it was updated annually. During a subsequent interview with the Administrator, she could not provide evidence that the resident's service plan was updated annually, as required. 5) Record review revealed Resident ID #5 moved into the residence in March of 2024 with a diagnosis of schizoaffective disorder. Review of the service plan, last updated on 12/18/2024, failed to reveal it was updated annually, as required. During a subsequent interview with the Administrator, she could not provide evidence that the resident's service plan was updated annually. 6) Record review revealed Resident ID #6 moved into the residence in August of 2021 with a diagnosis of diabetes. Review of the resident's physician's order, dated	S 415	S	

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S 415	Continued From page 8 6/30/2025, revealed an order for Insulin Lispro 100 units/milliliter. Review of the service plan, dated on 10/22/2024, failed to reveal it was updated annually. Additionally, the plan is inaccurate, as it indicates the resident does not self-administer her/his medications. The resident is prescribed insulin and self-administers her/his own insulin. During a subsequent interview with the Administrator, she could not provide evidence the service plan was updated annually, as required. She further could not provide evidence the service plan was accurate for self-administration of medication.	S 415		
S 660	Residential Care Services 2.4.23.C Dietetic Services 2.4.23 (C) Dietetic Services C. The food service in each residence shall comply with the appropriate requirements of R.I. Gen. Laws Chapters 21-27 and 21-31, Part 50-10-1 of this Title, Rhode Island Food Code, and such other applicable statutory or regulatory provisions. 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 comply with all appropriate standards of the Rhode Island Food Code relative to the main kitchen. Findings are as follows:	S 660		

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S 560	Continued From page 9 1) Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-601.11 (C) states in part, "...non-contact surfaces of equipment shall be free of an accumulation of...other debris..." 2) Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 6-501.113 Storing Maintenance Tools states in part, "...Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be: (A) Stored so they do not contaminate FOOD, EQUIPMENT, UTENSILS, LINENS..." 3) Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-501.12 states in part, "...Surfaces that are subject to scratching and scoring shall be...discarded if they can no longer be effectively cleaned and sanitized..." 4) Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 3-602.11 Food Labels states in part, "...(B) Label information shall include: (1) The common name of the food..." During a surveyor observation of the main kitchen on 3/3/2026 at approximately 8:10 AM the following was revealed: A. a can opener with black matter stuck to the blade. B. the hood slats with a heavy accumulation of dust and debris. C. a dustpan and 2 brooms were stored next to the handwashing sink and reach in refrigerator as	S 560		

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S 660	Continued From page 10 well as a bottle of heavy-duty oven and grill cleaner and 2 bottles of comet were stored directly under the sink. D. 5 cutting boards: cream color, green, red, yellow, and blue are scratched and scored. E. In the reach-in refrigerator were five plastic bags of chicken breast, seven wrapped packages of pizza, and a plate of macaroni and cheese, not dated. Additionally, there was a strawberry/bread dessert in a dish not covered, labeled, or dated and a half-pan of unidentifiable yellow cake, not labeled or dated. Following the above observations, Cook, Staff A acknowledged the can opener had black matter stuck to the blade; the hood slats with a heavy accumulation of dust and debris; the brooms and chemicals stored near the food prep area and next to the refrigerator; the cutting boards were scored; and the bags of chicken breast, pizza, macaroni and cheese were not dated, the strawberry dessert (not covered, labeled, or dated), and the yellow cake was not labeled or dated. During a surveyor interview with the Kitchen Manager on 3/4/2026 at approximately 8:00 AM, she was made aware of the above findings and acknowledged the can opener still had black matter stuck to the blade.	S 660		
S 640	Residential Care Services 2.4.26.B.1 Medication Services 2.4.26 (B) (1) Administration of Medications 1. Residences licensed at the M1 level may	S 640		

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S 640	Continued From page 11 administer medications to residents including, but not limited to, removing medication containers from storage, assisting with the removal of a medication from a container for residents with disability which prevents independence in this act, and/or administering the medication directly to the resident. a. The resident or guardian must provide written authorization for the residence to provide administration of medications. b. Medications shall be administered in accordance with written orders of a physician. The residence must provide in writing, a description of services provided by the residence to each physician, including limitations on service. c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist. d. The resident must be identified prior to administration of any medication. e. The medication must be in the original pharmacy-dispensed container with proper label and directions attached and be administered in accordance with such label. f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse. g. There shall be written a policy/procedure for the disposal of hypodermic needles, syringes and other such instruments that is in compliance with Part 20-15-6 of this Title, Hypodermic	S 640		

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S 640	Continued From page 12 Needles, Syringes, and Other Such Instruments. (1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor. (AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use. (BB) Excess and undesired needles, syringes and other such instruments shall be stored in impervious, rigid, puncture-resistant container for disposal. Intact needles shall be placed directly into the collection containers. (CC) Personnel handling disposal waste materials such as needles, syringes, and other such instruments may treat and destroy such waste by a DEM-approved alternative treatment/destruction technology or prepare the regulated medical waste for off-site transport by a DEM-permitted medical waste transporter. h. Individual medication records must be retained for each resident to whom medications are being administered and each dose administered to the resident must be properly recorded. i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate. j. Medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access. Provisions for safe storage may include	S 640		

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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) COMPLETE DATE
S 640	Continued From page 15 date of 2/12/2026, one with an expiration date of 2/13/2026, one with an expiration date of 2/14/2026, and one with an expiration date of 2/21/2026. -Addipak unit dose vials 3 ml sterile 0.9 % sodium chloride solution for inhalation with a use by date of 8/31/2024. -betamethasone valerate cream, no date and no cap. During a surveyor interview with the Administrator following the above observations, she was unable to provide evidence the above-mentioned medications were stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access, as required.	S 640		
S 675	Physical Plant 2.4.29.A.1(a,b,c,d) General Provisions 2.4.29 (A) (1) (a,b,c,d) General Provisions A. Fire Code and Structural Requirements 1. Existing facilities shall be constructed, equipped and maintained to protect the safety and well-being of residents, and shall provide a comfortable, sanitary environment, and shall furthermore comply with the applicable requirements of the Fire Safety Code - General Provisions (R.I. Gen. Laws Chapter 23-28.1), as determined by the State Fire Marshal and the Regulations. a. Pursuant to R.I. Gen. Laws § 23-17.4-6, a residence with Fire Code deficiencies may be	S 675		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01528	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMER VILLA	51 LAUREL AVENUE COVENTRY, RI 02816

(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) COMPLETE DATE
S 675	Continued From page 16 granted a license which may be renewed subject to the submission of a plan of correction acceptable to the State Fire Marshal and provided the nature of the deficiencies are such that they do not jeopardize the health, safety, and welfare of the residents. b. A residence with residents who are blind, deaf, and physically disabled shall be subject to the applicable requirements of ANSI A117.1 - 2009 Accessible and Usable Buildings and Facilities (incorporated above at § 2.2(B) of this Part), and any other provisions that may be required by these Regulations. c. Resident occupancy shall be permitted only in those areas where building design or structural limitations do not prevent, delay or reduce a resident from exercising self-preservation in an emergency. d. A residence that elects to comply with a higher Life Safety Code (F1) and is so approved by the State Fire Marshal and meets the Department's requirements for the appropriate level of licensure may admit residents not capable of self-preservation. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined the residence failed to have a posting on the door of the resident's room which indicates "oxygen in use" or "oxygen-no smoking" for the singular resident reviewed for oxygen, Resident ID #4. Findings are as follows:	S 675		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01625	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMER VILLA	51 LAUREL AVENUE COVENTRY, RI 02816

(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) COMPLETE DATE
S 675	Continued From page 17 Review of NFPA 99, 2012 Edition, states in part, "11.3.4.1 A precautionary sign, readable from a distance of 1.5 meters (5 feet), shall be displayed on each door..." where combustible gas is stored. Surveyor observation of the building on 3/3/2026 at approximately 8:30 AM, did not reveal any oxygen signs on any resident doors. During a surveyor interview with the Administrator on 3/3/2026 at approximately 9:30 AM, she revealed Resident ID #4 has oxygen in use. Record review revealed Resident ID #4 moved into the residence in August of 2012 with a diagnosis of emphysema (a chronic, progressive obstructive lung disease caused primarily by smoking). During a surveyor observation of the resident in her/his room on 3/5/2026 at 11:15 AM, s/he was utilizing 8 liters of oxygen from a portable oxygen tank. During a surveyor interview with the resident following the observation, s/he revealed that s/he smokes. During a surveyor interview with the Administrator on 3/5/2026 at 1:00 PM, she could not provide evidence the resident had an oxygen posting on her/his door, as required.	S 675		

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	ALR01625	A. BUILDING: _____ B. WING _____	C 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMER VILLA	51 LAUREL AVENUE COVENTRY, RI 02816

(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) COMPLETE DATE
S 003	Initial Comments A complaint investigation, ACTS references numbers 102731 and 103268, and a biennial licensure survey (3IW611), were conducted at this residence on 3/3/2026 through 3/5/2026 to determine compliance with state laws and regulations. No deficiencies were identified relative to the complaint survey.	S 003		

Facilities Regulation

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01525	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMER VILLA	61 LAUREL AVENUE COVENTRY, RI 02816

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S 640	Continued From page 13 lockable containers, secure spaces, or lockable units, as appropriate to the residence and the resident population. k. All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely as stated in § 2.4.25(A)(3)(a)(8) of this Part. l. All centrally stored medications shall be maintained in accordance with manufacturer ' s labeling and administered by authorized personnel. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the residence failed to ensure that medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for the singular medication storage closet. Findings are as follows: During a surveyor observation of the medication closet on 3/4/2026 at 11:25 AM, the following medications had the following expired or discard dates: -a bottle of acetaminophen gel capsules 500 mg (milligrams) with an expiration date of 2/2026. - two bottles of docusate sodium 100 mg. One bottle with a discard after date of 4/14/2025 and the other one with a discard after date of 3/22/2025.	S 640		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01626	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMER VILLA	61 LAUREL AVENUE COVENTRY, RI 02816

(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) COMPLETE DATE
S 640	Continued From page 14 -albuterol sulfate inhalation solution 2.5 mg/3 ml (milliliters). One with an expiration date of 2/11/2025, three with an expiration date of 4/9/2025, and one with an expiration date of 10/3/2025, one with an expiration date of 1/31/2026, and four with an expiration date of 2/19/2026. -two boxes of ipratropium bromide 0.5mg and albuterol sulfate 3 mg inhalation solution with a discard after date of 1/12/2023 and one with an expiration date of 11/2023. -a box of True Plus lancets 30 gauge with an expiration date of 4/22/2025. -a bottle of Baqsimi 3 mg spray with an expiration date of 8/19/2023. -triamcinolone 0.025% cream with an expiration date of 3/16/2025. -a Suprep bowel preparation kit with an expiration date of 9/11/2024. -two bottles of ketoconazole shampoo 2%. One with a discard after date of 2/8/2025 and one with a discard after date of 5/22/2025. -ondansetron 8 mg tablets with an expiration date of 1/7/2026. -Free Style Precision Neo blood glucose test strips with an expiration date of 4/30/2025. -Pilot Covid-19 at home test with an issue date of May 2023. -permethrin cream 5%. Two with an expiration	S 640		