DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint survey was conducted at this facility from September 16, 2024, through September 20, 2024. The deficiencies contained in this report are based on observation, interview and record review. The census on the day of the survey was ninety-eight (98). The survey sample was seven (7). Abbreviations/definitions used in this state report are as follows: CM – Care Manager; BOM – Business Office Manager; DHW – Director of Health and Wellness; ED – Executive Director; LPN – Licensed Practical Nurse; MT – Medication Tech; MCD – Memory Care Director; POA – Power of Attorney; Uniform Assessment Instrument (UAI) assessment tool used to evaluate resident function.		12/10/2024
3225.0 3225.13.0 3225.13.1 S/S-A	**Assisted Living Facilities** **Service Agreements** **A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement, and each shall receive a copy of the signed agreement.**	**3225.13.0 Service Agreements** **A. Individual/Resident impacted** R1 & R5's Service Agreement will be re-reviewed/updated with the resident/responsible party and signed by the resident/responsible party, Director of Health & Wellness (DHW) and Executive Director, with a copy provided to all parties. **B. Identification of other residents with the potential to be affected** 1. All residents have the potential to be affected by this deficient practice. 2. The DHW/designee will audit all resident Service Agreements to ensure resident/responsible party, DHW and Executive Director have signed the agreement. Copies will be provided to all parties.	

Provider's Signature [signature] Title EXECUTIVE DIRECTOR Date OCTOBER 25, 2024

NAME OF FACILITY: The Summit **DATE SURVEY COMPLETED:** September 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Based on record review and interview it was determined that for two (R1 and R5) out of seven residents reviewed the facility failed to ensure service agreements were signed by the resident/responsible party. Findings include: The undated facility policy on Service Agreement's indicated "The resident/responsible party, resident services director, and executive director shall sign the agreement with a copy provided to all parties." 1.Review of R5's clinical record revealed: 5/24/24 – A service agreement was completed for R5. The area for a signature from the resident or their responsible party was blank. 2.Review of R1's clinical record revealed: 6/7/24 - A service agreement was completed for R1. The area for a signature from the resident or their responsible party was blank. 9/20/24 11:00 AM – E2 (DHW) confirmed the findings and stated, "they are supposed to have signatures". Findings were reviewed with E1 (ED) and E2 (DHW) during the exit conference on 9/20/24 at 12:00 PM.	**C. System Changes** 1. The Regional Director of Health and Wellness will re-educate the DHW and Executive Director on the Service Agreement policy. 2. Upon completion of each Service Agreement, The DHW will ensure both the resident/responsible party and Executive Director sign the Service Agreement, then make copies for all parties. **D. Success Evaluation** 1. The DHW/designee will randomly select three (3) Service Agreements, daily, for three (3) consecutive weeks, until 100% compliance is achieved, then, three times, weekly, for three consecutive weeks, until 100% compliance is achieved. 2. Findings from random reviews will be reviewed during quarterly Quality Assurance Meetings.	
3225.12.0 **3225.12.1** **S/S-F**	**Services** **The assisted living facility shall ensure that:** **3225.12.1.3 Food service complies with the Delaware Food Code** **Delaware Food Code** **2-4 HYGIENIC PRACTICES 2-401.11 Eating, Drinking, or Using Tobacco. (A) Except as**	**3225.12.1 Delaware Food Code** **A. Individual/Resident Impacted** 1. On 9/16/2024, the Interim Director of Culinary Services educated E15, in addition to all servers on the importance of safe/sanitary food handling,	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit **DATE SURVEY COMPLETED:** September 20, 2024

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	specified in ¶ (B) of this section, an EMPLOYEE shall eat, drink, or use any form of tobacco and/or devices that people use to inhale an aerosol, only in designated areas where the contamination of exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES; or other items needing protection cannot result. **3-3 PROTECTION FROM CONTAMINATION AFTER RECEIVING 3-304.12 In-Use Utensils, Between-Use Storage. During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (E) In a clean, protected location if the UTENSILS, such as ice scoops, are used only with a FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD.** **3-305.11 Food Storage. (A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (2) Where it is not exposed to splash, dust, or other contamination.** **3-5 LIMITATION OF GROWTH OF ORGANISMS OF PUBLIC HEALTH CONCERN 3-501 Temperature and Time Control 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above.**	eating/drinking in resident food service areas and the importance of wearing clean gloves and changing gloves between service, when handling food. 2. On 9/16/2024, the Interim Director of Culinary educated all staff on the importance of leaving food and personal items out of all resident dining and kitchen areas. 3. On 9/25/2024, the Interim Director of Culinary Services educated all cooks and food prep staff on the importance of recording time & temperature logs, safe food handling and understanding the proper protocols on food storage, labeling and dating food items. 4. On 9/16/2024, the Interim Director of Culinary Services and Sous Chef discarded all expired food items, in addition to foods not properly stored. 5. On 9/26/2024, the Assistant Director of Culinary Services installed a new container for the ice scoop. 6. On 9/18/2024, the Interim Director of Culinary Services replenished the soap and paper towels in both dispensers at the hand sink, located in the kitchen.	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit **DATE SURVEY COMPLETED:** September 20, 2024

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	3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (E) and (F) of this section, refrigerated, READY-TOEAT, 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 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. **6-3 NUMBERS AND CAPACITIES 6-301.11 Handwashing Cleanser, Availability. Each HANDWASHING SINK or group of 2 adjacent HANDWASHING SINKS shall be provided with a supply of hand cleaning liquid, powder, or bar soap.** **6-301.12 Hand Drying Provision. Each HANDWASHING SINK or group of adjacent HANDWASHING SINKS shall be provided with: (A) Individual, disposable towels.** Based on observations, interview, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include: 9/16/24 10:56 AM – During random observation of food preparation E15 (server) was observed touching a turkey burger with an ungloved hand. E15 had used a tong in the right hand to pick up the turkey burger from a large metal pan and place it on a bun, then took two bare fingers of the left hand and repositioned the patty. E15 immediately confirmed the findings, performed hand hygiene and donned rubber gloves before resuming.	**B. Identification of other Residents with the potential of being affected.** 1. All residents have the potential to be affected by this deficient practice. 2. On 9/25/2024, the Interim Director of Culinary Services educated all staff on food safety and the importance of recording time & temperature logs, safe food handling and understanding the proper protocols on food storage, labeling and dating food items. **C. System Changes** 1. The Director of Culinary Services/designee will educate all staff on the following kitchen/sanitation standards: use of temperature logs, proper handwashing techniques, the importance of replenishing soap and paper towel dispensers, safe food handling, first in, first out procedures for proper food storage, proper use of gloves when handling food, keeping drinks/food and personal items away from kitchen and service areas. 2. The Director of Culinary Services/designee will implement a daily cleaning schedule to ensure all identified deficiencies are monitored and adhered to.	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	9/16/24 12:01 PM – During a random dining observation E15 (server) was observed drinking from paper cup while plating food for residents. E15 immediately confirmed the findings. 9/17/24- During the survey of the facility at approximately 10:45AM, the service area for the AL dining contained two unidentified drink items on the counter and one in the refrigerator that were not a part of the food service. 9/17/24 - During an interview with E16 (Director of Culinary Services), at approximately 10:45 AM, E16 confirmed the drink items. 9/17/24 – During the survey of the facility at approximately 10:45 AM, temperature logs for May – August were not maintained apart from July 3-9 of 2024 in the memory care units. 9/17/24 – During an interview with E16 (Director of Culinary Services), at approximately 10:45 AM, E16 confirmed the unavailable temperature logs. 9/17/24 – During the survey of the facility at approximately 11:15 AM, three expired food items were found in a kitchen refrigerator. Two containers of lime juice were dated 9/8/24 and a container of 2% milk was dated 9/4/24. 9/17/24 – During the survey of the facility at approximately 11:30 AM, two (25lbs) bags of rice were left open exposing the contents. 9/17/24 – During the survey of the facility at approximately 12:15PM, the ice scoop in the kitchen was stored on top of the ice machine and a protected location was not available for storage.	3. The Director of Culinary Services/designee will implement a daily cleaning schedule log to ensure the Culinary Services team is adhering to the identified deficiencies. **D. Success Evaluation** 1. The Director of Culinary Services will randomly audit three (3) temperature and cleaning logs, daily, for three (3) consecutive weeks, until 100% compliance is achieved, then, three times, weekly, for three consecutive weeks, until 100% compliance is achieved. 2. Findings from random audits will be reviewed during quarterly Quality Assurance Meetings.	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit **DATE SURVEY COMPLETED:** September 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	9/17/24 – During the survey of the facility at approximately 12:45 PM, the AL service area handwashing sink did not contain soap. 9/17/24 – During the survey of the facility at approximately 12:45 PM, the AL service area and the memory care #2 did not have paper towels available at the hand washing sinks. 9/17/24 – During an interview with E16 (Director of Culinary Services), at approximately 1:45PM, E16 confirmed the open packages. 9/20/24 – Findings were reviewed with E1 (Executive Director) and E16 (Director of Culinary Services) at approximately 2:45 PM.		
3225.18.0 **3225.18.3** **S/S-F**	**Fire Safety and Other Emergency Plans** **Each facility shall develop and maintain all-hazard emergency plans for evacuation and sheltering in place. The plan must be submitted to the Division and DEMA in a digital format and it must conform to the template prescribed by the Division. The all-hazard emergency plan must include plans to address staffing shortages and facility demands.** 9/20/24 – During the survey of the facility, the Emergency Operations Plan was reviewed and supporting documents referenced in the plan to address each hazard identified as a risk for the facility were not received. The Incident management resources were also not available.	**3225.18.0 Fire Safety and Other Emergency Plans** **A. Individual Impacted** No residents were affected by this deficient practice. **B. Identification of other Residents** All residents have the potential to be affected by this deficient practice. **C. System Changes** The facility will submit the supporting documents referenced in the plan to address each hazard identified as a risk and Incident Management Resources. **D. Success Evaluation** The facility will review any/all EOP changes during each Quarterly Quality Assurance meetings.	
16 Del. Code, Ch. 11, Sub-Chapter III **§1131** **S/S-J**	**Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients** **Definitions**		

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit **DATE SURVEY COMPLETED:** September 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	(12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following: **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** **This requirement was not met as evidenced by:** Based on record review, interview and review of facility policies and procedures, it was determined that for one (R1) out of three sampled residents reviewed for wandering and elopement, the facility failed to provide the needed supervision and services to prevent elopements. R1 eloped from the facility on 9/12/24. The facility was made aware on 9/17/24 at 1:30 PM of immediate jeopardy. R1 was a risk for severe adverse outcome related to being found outside of the facility unattended, around the corner on a busy roadway. Due to the facility's corrective measures following the incident, this is being cited as immediate jeopardy past non-compliance with an abatement date of 9/13/24. Findings include: The undated facility policies on safety checks indicated, "Direct care staff assigned to the secured dementia unit will be responsible for accounting for resident hourly." The facility policy on Wandering and Elopement last updated, 9/1/18 indicated, "If a resident is determined to be at risk for Wandering and Elopement, educational material will be available concerning the risk for elopements. Specific interventions will be provided to the resident and family and will be documented in the resident's record."	**Cross-refer to PoC Abatement on 9/13**	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit **DATE SURVEY COMPLETED:** September 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Review of R1's clinical record revealed: 6/7/24 – An initial UAI assessment was completed for R1 and documented memory problems and a history of wandering warranting placement on a secured unit. 6/7/24 – A resident service agreement completed for R1 lacked evidence that safety needs related to elopement risk were included. The elopement risk area and interventions were blank. The service agreement was unsigned by R1's responsible party. Undated – A mental status assessment stapled to R1's 6/7/24 service agreement scored the resident as a "10" with scores of 8-10 indicative of severe intellectual impairment. 6/10/24 - R1 was admitted to the facility with multiple diagnoses including Alzheimer's dementia, general anxiety and major depression. 6/10/24 – An admission resident review was completed for R1 that documented the resident was anxious and required safety checks. 6/10/24- A wandering/elopement risk evaluation documented R1 as a score of "15", scores greater than 8 indicate high risk for wandering/elopement. 9/12/24 7:00 AM – 3:00 PM – Hourly safety checks for R1 were left blank. 9/12/24 – The facility reported R1's elopement to the State Agency. 9/12/24 4:23 PM – A progress note in R1's clinical record written by E7 (LPN) documented, "At 2:15 PM this nurse was on the phone with a MD office when informed by	**Cross-refer to PoC Abatement on 9/13**	

Provider's Signature _____ Title _____ Date _____

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	staff nurse that a call was received from Caregiver that resident was outside the building located off the premises unescorted. This nurse and another nurse as well as other staff members went outside the building to search for resident. Resident located on Papermill Road and was walking with a caregiver who noticed her. Staff had difficulty redirecting resident to facility vehicle. Resident resistant, argumentative and combative. 911 was notified by manager present. After calling son and resident daughter and much conversing resident did get in police car and assisted back to her residence. Daughter came while resident was being assessed by paramedics. Resident observed back on Memory Care Unit ambulating with daughter. Wander guard applied to left wrist with some resistance. Daughter present and gave verbal permission to apply. (medical group) NP notified." The facility provided the following corrective measures: 9/12/24 – Wander guard placed on R1. 9/12/24 5:44 PM – Service orders documented pin codes for doors connecting the locked memory care unit were changed and request for parts to add additional pin security to unalarmed door. 9/12/24 – Warning signs posted at entrance to secured memory care unit that indicated, "Please see concierge for entry into Memory Care. When leaving please be mindful of your group size as you exit memory care units due to the safety of our residents." 9/13/24 – All residents on memory care units with risk of wandering/elopement were reassessed for the need of additional interventions.	**Cross-refer to PoC Abatement on 9/13**	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	9/13/24 – A staff meeting was conducted that reviewed the following: - Review of 9/12/24 elopement. - Implementation of changes to locked unit to change pin code and install keypad to alarm glass doors. - Reassessment of wander guards. - Reminder to immediately report to nurse changes in resident behavior. - Review of techniques to ensure methods of engagement to distract residents when appropriate. 9/13/24 – Education on elopement was completed. 9/16/24 at 12:06 PM - During an interview, E1 (NHA) reported, "[E11 (CM)] saw [R1] I believe on limestone road at first. [R1] was pacing at the entrance of the doorway. She sat, then exited through the [alarmed] doors." E1 confirmed the first set of doors [glass] are not alarmed and lead to a vestibule with a loveseat, secured elevators and an alarmed door that leads to the facility main lobby. "We changed the second door alarm, now staff only to allow entry. The person exiting did not know the resident was behind her. We educated staff about that." E1 reported additional interventions included, "We notified staff and visitors of need for escort to enter the locked unit, and we ordered a lock to secure first set of [glass] doors. We provided education to staff, placed signs." E1 provided the surveyor with a copy of the signs that indicated the following: "Please see the concierge for entry into memory care. Be mindful of your group as you enter and exit".	**Cross-refer to PoC Abatement on 9/13**	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	9/16/24 -1:57 PM - During an interview, E12 (MT) on R1'S unit on 9/12/24 stated, "From what they said from looking at the camera. [R1] sat here on the couches, waited for someone to leave and got to the door before it closed." 9/16/24 2:00 PM - During an interview, E7 (LPN) stated, "I was on the phone with the doctor, and I got a text from an employee that a resident was off the premises they alerted another nurse and stayed with the resident to keep her safe." 9/16/24 2:11 PM – During an interview E5 (LPN) stated, "[E11 (CM)] called because she couldn't get [E7 (LPN)] on the phone and said she saw [R1] outside. I went over to the Unit to check, and we couldn't find [R1] so then we went out and looked for her. [R1] was on Papermill road [E11] had her she was very agitated at that point." 9/17/24 10:59 AM – Surveyor reported to E1 (ED) that an immediate jeopardy in the area of neglect had been identified regarding the facility's failure to provide adequate supervision to prevent elopements. 9/17/24 1:30 PM – E1 (ED) was presented with the IJ template. 9/17/24 2:42 PM – Surveyor, E1 (ED) and E14 (BOM) viewed security footage from R1's elopement on 9/12/24. The footage showed R1 passing through the unsecured glass doors of the memory care unit and sitting on the loveseat. E7 (LPN) passes by with no interaction with R1. A facility visitor was seen exiting the glass doors and R1 followed behind the visitor before the secured door leading to the facility lobby could closed and lock. R1 then followed closely behind the visitor and exited	**Cross-refer to PoC Abatement on 9/13**	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
S/S-D	the facility through the assisted living main entrance. 9/17/24 4:10 PM – E1 (ED) provided a copy of the facilities abatement plan that documented the immediate jeopardy was abated on 9/13/24 at 8:10 PM. 9/18/24 1:55 PM During an interview E11 (CM) stated, "I was at the light to turn to go home in the far lane and I saw [R1] outside the gate. I didn't see her caregiver. I called [E7 (LPN)] then [E5 (LPN)] to let them know and tried to make a U-turn. When I got where I saw R1 she wasn't there, I made the turn and check a neighborhood and didn't see her. I came out and kept going until I saw her on papermill mill road. I pulled over got out and tried to get her to get into my car. I stayed with her, but she wouldn't get in the car, I kept her from going into the street, she kept trying to take my keys from me. I sent [E5 (LPN)] my location three times. Finally they saw us and came over with the facility van." Findings were reviewed with E1 (ED) and E2 (DHW) during the exit conference on 9/20/24 at 12:00 PM. **Title 19** **Labor** **Part I General Provisions** **Chapter 7** **Employment Practices** **Subchapter I** **708. Special employment practices relating to health care and childcare facilities.**	**Cross-refer to PoC Abatement on 9/13**	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	(b) Service letter. — (1) No employer who operates a health care facility and/or childcare facility, or provides health, nutritional or personal care in such a facility, shall hire any person seeking employment without obtaining 1 or more service letters regarding that person, provided such person has been previously employed. The service letter(s) obtained must include a service letter from the person's current or most recent previous employer. In addition, if a person seeking employment was employed in a health care facility and/or childcare facility within the past 5 years, the employer shall also obtain a service letter from such employer(s). If the person seeking employment has not been previously employed, or was self-employed, then the employer must require the person to provide letters of reference from 2 adults who are familiar with the person, but who are not relatives of the person. **7) An employer covered under paragraph (b)(1) of this section shall make a good faith attempt to locate the previous employer(s) identified in the employment application of the person seeking employment and to obtain the service letter(s) from each such employer. The burden of proof to demonstrate a good faith attempt shall rest with the employer. Any such employer who hires a person seeking employment without obtaining the required service letter(s) and/or who has not made a good faith attempt to obtain such service letter(s)shall be subject to a civil penalty of not less than $1,000 nor more than $5,000 for each violation.** Based on record review and interview it was determined that for two (E6 and E8) out of five employees sampled for the personnel audit review the facility failed to ensure service letters were received prior to hiring. Findings include:	**708. Special employment practices relating to health care and childcare facilities.** **A. Individual/Resident Impacted** The facility is unable to correct the action for E8 and E6. **B. Identification of Other Residents** The Human Resource Director will ensure all future new hires include a service letter, prior to hiring. **C. System Changes** 1. On 9/20/2024, the Human Resource Director developed an Authorization letter on company letterhead, that is sent	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit **DATE SURVEY COMPLETED:** September 20, 2024

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	2/9/22 – E8 (CM) began employment with the facility. 7/21/22 - E6 (LPN) began employment with the facility. 9/19/24 12:09 PM – A personnel audit sheet was sent to E1 (ED) that requested evidence that the five sampled employee's had service letters provided to the facility upon employment. 9/20/24 9:15 AM – Review of the facility's submitted personnel audit sheet lacked evidence of service letters received for two, E8 (CM) and E6 (LPN) employees. 9/20/24 10:45 AM - E1 (ED) confirmed the findings. Findings were reviewed with E1 (ED) and E2 (DHW) during the exit conference on 9/20/24 at 12:00 PM.	with the Service Letter authorizing the former employer to complete the Service Letter. 2. During the pre-hire paper signing, the Human Resource Director/designee will mail Service Letters to former employers of the applicant to complete. 3. If Service Letters are not received within 10 days of the mailing date, the Human Resource Director/designee will send another letter. 4. For all non-healthcare professional applicants, the Human Resource Director will ensure the hiring manager verifies employment through telephone reference checks or letters of reference. **D. Success Evaluation** 1. The Human Resource Director will audit all new hires, weekly, until 100% compliance is achieved. 2. All findings will be reviewed during Quarterly Quality Assurance Meetings.	

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Provider's Signature _____ Title _____ Date _____