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: August 16, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Complaint survey was conducted at this facility from August 7, 2024 through August 16, 2024. The deficiencies contained in this report are based on observations, interview and record review. The census on the day of the survey was forty-eight (48). The survey sample was eleven (11). Abbreviations/definitions used in this state report are as follows: CM - Care Manager; DON – Director of Nursing; MT – Med Tech; NHA – Nursing Home Administrator; DNI – Do not intubate; DNR – Do not resuscitate; Medications for Dementia - Namenda, Aricept and Lexapro; Pulmonary contusions – bruise on your lungs from chest injuries; Sternal fracture - break in the sternum, or breastbone, which is the long, flat bone in the center of the chest; Subdural hemorrhage – blood leaks between brain and skull; Subarachnoid hemorrhage – bleeding between the brain and surrounding membrane; Rib fractures – broken rib.	**Cross-Reference Plan of Correction for 1121. Resident's Rights** **3225 Staffing** **A. (Individual Impacted)** On 8/6/24, (R1) was placed on 1:1 supervision until 8/13/2024, when he was transported to the hospital, via ambulance. R1 was then discharged from the hospital to a skilled nursing facility. R1 has not returned since his 8/13 discharge to hospital. (R2) was transferred to the hospital on 8/6/2024. R2 has expired.	11/30/2024
3225 **3225.16.0** **3225.16.2** **S/S - E**	**Assisted Living Facilities** **Staffing** **A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.** Cross Refer: **§ 1121. Resident's rights**		

Provider's Signature Virginia A. Gray Title Executive Director Date December 13, 2024

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	Based on interview, record review and review of facility documents as indicated, it was determined that the facility failed to ensure sufficient staff to monitor residents, provide care and prevent abuse in the facility. Findings include: The facility's Safety Check Policy effective 1/2022 documented, "Resident care staff should make safety checks of the residents. A legally responsible party may choose not to have the staff perform night checks. The choice not to receive night checks should be documented in the Personal Service Plan. 1. Associates should perform periodic safety checks. 2. Note the resident's service plan should be consulted. 3. When performing a safety check, associates should open the door to the resident's apartment quietly and observe the resident from a reasonable distance. Assistance should be provided as necessary." A facility document undated and titled "3 - 11 Check List" was posted on the Garden level in the nursing station. The list included tasks that were to be completed by the 3:00 PM to 11:00 PM shift. The Check List included, "Get report from the shift before... Assignment sheet, Hourly checks..." 1. 8/5/24 3:00 PM to 11:00 PM – A facility document that details care that was provided for R1 was blank, including safety checks. 8/5/24 – A document titled "Every one-hour Safety Check" sheet for the 3:00 PM to 11:00 PM shift was blank for all residents the following hours 7:00 PM, 8:00 PM, 9:00 PM, 10:00 PM and 11:00 PM. The facility safety checks were blank for 7:00 PM to 11:00 PM on 8/5/24 despite R1's known aggression.	(R4) remains in the community with no known adverse effects from the event of 8/5/2024. **B. (Identification of other Residents)** All residents have the potential to be affected. 1. The Director of Health & Wellness (DHW) or designee, will re-educate the nursing staff on the End of Shift 24-Hour Report and Behavior Management policy, to identify any residents with aggressive behaviors. 2. The Memory Care Director and Assistant Director of Health & Wellness or designee, will re-educate all nursing staff on hourly check rounds, to verify	

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	8/5/24 - A Staffing Sheet originally documented that for 3:00 PM to 11:00 PM shift E11 (CM), E15 (CM), E20 (CM), and E21 (MT) were working on the Garden Unit. The schedule was updated to remove E20 and E21 at 7:00 PM. E10 (MT) was pulled from another unit to work on the Garden Unit. This dropped the staff coverage from three CM's to two CM's covering three assignments and one MT that was giving medications. 8/5/24 at 10:50 PM – A report to the State agency documented R1 was observed by staff in R4's room striking R4 in the stomach and legs. 8/6/24 8:20 AM – A report to the State agency documented "Around 12:15 AM, [E13] received a call to the nursing station that during rounds a caregiver found resident [R2] laying on the floor with blood coming from [R2] head with a forehead laceration, I went to call 911 & resident was sent out to ER for evaluation." 8/6/24 11:00 AM – The state agency was notified that the Delaware State Police had initiated an investigation into the R2's injuries. 8/9/24 8:14 AM - In an interview with E7 (CM) it was revealed that one-hour safety checks should involve checking all residents every hour to make sure they are not on the floor and make sure they are safe. When asked when the last time that R2 was checked, E7 stated according to the hourly check sheet the last check was at 6:00 PM. 8/9/24 9:43 AM - During an interview with E8 (CM), who worked the 11:00 PM to 7:00 AM shift, it was revealed that originally four staff were scheduled for 3:00 PM to 11:00 PM but that two staff were sent home early because of an argument. E8 stated that E7 and E8 had more resident care to provide than normal.	all staff check on residents every hour and document their findings on the Safety Hourly Check Log. 3. Due to the large environmental space of the memory care neighborhood, the facility has increased staffing in memory care for expanded visibility and monitoring. 4. The Director of Facilities Operations, or designee, will verify all resident room doors close and latch independently, upon exiting resident rooms. **C. (Systemic Changes)** 1. The nurse supervisor/designee, will review the hourly safety checklist for all shifts regarding completion and compliance, three (3) times, weekly. 2. The DHW/designee, will review the 24-hour report and any narrative notes that identify behaviors for memory care residents at least three (3) times, weekly. The DHW/designee, will work with the community team to implement specific interventions. **D. (Success Evaluation)** The Director of Health & Wellness or designee, will complete a review of scheduled staff in the community	

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	E8 stated that for shift report it was only reported that two residents refused care and nothing else. 8/16/24 3:30 PM – During exit conference findings were reviewed with E1 (NHA) and E2 (DON). **Per the State of Delaware Board of Nursing's Scope of Practice document entitled "RN, LPN and NA/UAP Duties 2024", last revised 4/10/24, only a Registered Nurse (RN) can perform admission assessments and admission history review.** Based on interview, record review and review of other documentation as indicated, it was determined that for two (R5 and R6) out of eight residents reviewed for resident-to-resident abuse, the facility failed to ensure that an RN was available to complete required assessments (Resident Review Tool Admission Readmission Assessment) and instead allowed an LPN to sign the assessments despite this being outside the LPN's scope of practice. Findings include: 1. R5's clinical record revealed: 3/12/24 – R5 was admitted to the facility. 3/25/24 – R5's Resident Review Tool Admission Readmission Assessment was completed by E9 (LPN). 2. R6's clinical record revealed: 7/29/24 – R6 was admitted to the facility. 8/1/24 – R6's Resident Review Tool Admission Readmission Assessment was completed by E18 (LPN).	weekly, for three (3) weeks, then monthly, for three (3) months, until the community consistently reaches 100% success. The DHW/designee will audit five (5) residents (across three (3) daily shifts), for verification of hourly safety checks weekly, for four (4) weeks, then monthly, for three (3) months, until the community consistently reaches 100% success. The DHW will review findings during the community's Quarterly Quality Assurance meetings. **A. (Individual Impacted)** (R5) and (R6) had their Resident Review Tool Admission/Re-Admission signed by an LPN upon their return from the hospital. **B. (Identification of Other Residents)** All residents have the potential to be affected. **C. (Systemic Changes)** The facility has identified that (R5) and (R6) had their re-admission review tool signed by an LPN, upon their return from the hospital. Henceforth, RNs will complete all admissions and re-admission assessments upon residents' return from the hospital. The DHW/designee will educate all licensed professionals on the State of Delaware Board of Nursing's Scope of Practice document entitled "RN, LPN and NA/UAP Duties 2024", last revised	

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	8/16/24 12:00 PM – In an interview with E3 (ADON) it was revealed that the Resident Review Tool Admission Readmission Assessment document was a Global type of Assessment completed on Admission or Readmission of a resident to the facility. E3 verified that the signature was an LPN. 8/16/24 3:30 PM – During exit conference findings were reviewed with E1 (NHA) and E2 (DON)	4/10/24, only a Registered Nurse (RN) can perform admission assessments and admission history review. **D. (Success Evaluation)** The DHW/designee or Executive Director will complete a review of all new and re-admission assessments, to verify RN signature, weekly, for four (4) weeks, then monthly, for three (3) months, until the community consistently reaches 100% success.	
16 Del. Code, Chapter 11, Subchapter II **§ 1121.** **S/S - K**	**Rights of Residents** **Resident's rights.** **(30) Each resident shall be free from verbal, physical or mental abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food, and deprivation of sleep.** Based on observation, interview, record review and review of other documentation as indicated it was determined that for four (R1, R2, R3 and R4) out of eight residents reviewed for abuse the facility failed to ensure that residents on the Memory Care Unit were free from physical abuse. For R3 and R4 physical abuse was inflicted by R1. R2 sustained lethal injuries consistent with an attack resulting in a severe adverse outcome to the resident. Additionally, R1, a resident ordered on 1:1 supervision for the physical attack of another resident, was not consistently supervised. Despite having a known aggressive resident (R1) who had physically assaulted other residents, the facility failed to ensure that an effective supervision plan was identified and implemented. On 8/8/24 the surveyor observed lack of 1:1 supervision. Immediate jeopardy was identified for the failure to protect from abuse by	**Resident's Rights** **A. (Individual Impacted)** On 8/6/24, (R1) was placed on 1:1 supervision until 8/13/2024, when he was transported to the hospital, via ambulance. R1 was then discharged from the hospital to a skilled nursing facility. R1 has not returned since his 8/13 discharge to hospital. (R2) was transferred to the hospital on 8/6/2024. (R2) has expired.	

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	not maintaining the 1:1 supervision putting residents at risk for a severe adverse outcome. The IJ was abated on 8/12/24. Findings include: Abuse is defined "16 Delaware Code, Chapter 11, Subchapter III: (1) "Abuse" means the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish and includes all of the following: a. Physical abuse. – "Physical abuse" means the unnecessary infliction of pain or injury to a patient or resident. "Physical abuse" includes hitting, kicking, punching, slapping, or pulling hair. If any act constituting physical abuse has been proven, the infliction of pain is presumed. The Facility's Safety Check Policy effective 1/2022 stated, "Resident care staff should make safety checks of the residents. A legally responsible party may choose not to have the staff perform night checks. The choice not to receive night checks should be documented in the Personal Service Plan. 1. Associates should perform periodic safety checks. 2. Note the resident's service plan should be consulted. 3. When performing a safety check, associates should open the door to the resident's apartment quietly and observe the resident from a reasonable distance. Assistance should be provided as necessary." A facility document undated and titled "3 - 11 Check List" was posted on the Garden level in the nursing station. The list included tasks that were to be completed by the 3:00 PM to 11:00 PM shift. The Check List included, "Get report from the shift before... Assignment sheet, Hourly checks..."	(R2) was transferred to the hospital on 8/6/2024. (R2) has expired. (R3) remains in the community with no known adverse effects from the event of 7/15/2024. (R4) remains in the community with no known adverse effects from the event of 8/5/2024. **B. (Identification of other Residents)** All residents have the potential to be affected. **C. (Systemic Changes)** The facility has identified that the facility's one-to-one supervision policy was not effectively followed to minimize or re-direct a resident from the potential of engaging in a harmful act. Henceforth, the Executive Director and DHW/designee will re-educate all staff on the requirements of the Delaware Code Title 16, Chapter 11, Sub-chapter III. on Abuse, Neglect, Mistreatment and Financial Exploitation. The facility has identified that the safety check policy of staff conducting hourly checks on the memory care neighborhood, was not consistently followed. Henceforth, the Executive Director and DHW/designee will re-educate all clinical staff on the facility's Safety Check and Monitoring Residents policy. The DHW/designee will review all resident behavior records, to identify any residents with aggressive behaviors.	

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	1. Review of R1's clinical record revealed: 9/18/23 – R1 was admitted to the facility with diagnoses including but not limited to dementia. 5/3/24 – R1 was seen by a psychiatrist for medication management for "increased aggression, yelling at the staff, getting [sic] on staff faces. The patient is currently on Namenda, Aricept and Lexapro." R1 is "...alert and ambulating orienting to self and surrounding. He moves around freely, confused about time and place. Memory is impaired. Insight and judgement are poor. Sleep and appetite is fair. The patient is compliant with care and medication." 7/15/24 2:08 PM - The facility reported to the State Agency that R1 was in R3's room hitting R3 in the stomach and legs. A bruise was noted on R3's left arm. In response the facility ordered a psychiatric consult for R1. 7/15/24 – According to facility documents, the facility responded to the incident by documenting R1's behaviors for nine shifts. There were no additional behaviors observed or reported in those nine shifts. R1 was seen by the physician, sent for a dementia evaluation and medication was increased. 7/15/24 – A physicians progress note documented, "Today, was asked to evaluate patient after staff reported that he went into another resident's room and punched him in his belly and leg area. Staff reports intermittent agitation. During exam [R1] is in no acute distress. [R1] is calm and due to advanced dementia, he does not recall recent incident. The plan of care discussed with nursing staff who will continue to monitor the patient closely for any acute changes."	Individualized Service Plans will be updated, as appropriate. **D. (Success Evaluation)** The DHW/designee, will conduct a weekly audit of five (5) one-to-one resident observation/monitor logs (as appropriate), for four (4) weeks, then monthly, for three (3) months, until the community consistently reaches 100% success. The DHW/designee will conduct five (5) hourly safety check logs, weekly, for four (4) weeks, then monthly, for three (3) months, until the community consistently reaches 100% success. The DHW/designee will conduct five (5) audits, weekly, for four (4) weeks, then monthly, for three (3) months, until the community reaches 100% success. Findings will be reviewed during the community's Quarterly Quality Assurance meetings.	

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	7/31/24 – R1 was seen by a psychiatrist for "aggression and agitation and needs something for breakthrough aggression." "[R1] is still acting out at times. [R1] is showing some irritability and aggression." Seroquel 25 mg as needed was added to the current medication: Seroquel 25 mg twice a day along with trazodone, Lexapro and melatonin and follow up for mood and medication. 8/5/24 3:00 PM to 11:00 PM - A facility document that details care that was provided for R1 was blank including safety checks. 8/5/24 – A document titled "Every one-hour Safety Check" sheet for the 3:00 PM to 11:00 PM shift was blank for all residents during the following hours 7:00 PM, 8:00 PM, 9:00 PM, 10:00 PM and 11:00 PM. 8/5/24 8:18 PM – The exit door camera at the south end of the facility on the Garden level captured R1 on video, R1 stops for seconds and looks out at the exit door near R2's room and then continues. It is unclear by the video where R1 goes after out of view of the camera. 8/5/24 9:49 PM – The exit door camera at the south end of the facility on the Garden level captured R1 on video walking in the other direction. It is unclear by the video where R1 was coming from before entering the view of the exit door camera. 8/5/24 10:50 PM – A report to the State agency documented R1 was observed by staff in R4's room striking R4 in the stomach and legs. 8/5/24 11:27 PM –A progress note documented, "It was reported to this nurse that [R1] was displaying some behaviors. [R1] went		

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	to the MedTech on duty and said that a lady was attempting to commit suicide in her apartment. Staff walked to [R1's] room and saw nobody there. They then called this nurse to ask if [R1] could be administered his PRN for agitation. While preparing the medication, [R1] went into [R4's] room and started punching [R4] in the stomach. A call was placed to the nurses on duty. Upon arrival [R1] was escorted out of the [R4's] room and taken to [R1's] own room/ Where [R1] began to become combative with [staff] members. Once a moment of calmness happened, [R1] was given his PRN Seroquel. [R1] was monitored and helped into pajamas until [R1] calmed down. This nurse notified [E3] (ADON)... on call provider notified." 8/5/24 - A document for R1, from facility's behavior book for "Actual Falls" with a list of interventions was updated with an added intervention "8/5 1:1 private aid." 8/6/24 3:00 PM to 11:00 PM – An unnamed facility document used to document care tasks included in comments that R1 was on 1:1. 8/6/24 11:27 AM – A progress note documented, R1 was sent out to the hospital for lethargy. 8/6/24 6:00 PM – A progress note documented, R1 returned from the hospital. 8/6/24 - A Care Plan for R1 provided by E2 (DON) documented "1:1 observation at all times." 8/7/24 5:17 AM – A progress note documented, R1 was on 1:1 care by staff this shift. 8/7/24 - An observation by surveyor of R1 in a chair alone and unattended by staff.		

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	8/8/24 6:44 AM – A progress note documented, R1 had 1:1 staff in the room. 8/8/24 – The Garden Assignment sheet last updated (revised) 7/23/24, by the facility documented that E5 (CM) was assigned to R1 for 1:1 supervision for the 7:00 AM to 3:00 PM shift. 8/8/24 – The following observations by surveyors were made: Approximately 8:30 AM – R1 was alone and unattended by staff in a chair on the Garden level dementia unit. The assigned 1:1 was in the dining room at a table separated by more than 25 to 30 feet from R1. A small living room area and residents separated R1 from E5 (CM). 9:41 AM – R1 was left alone and unattended by staff in a chair on the Garden level dementia unit. E5 CM was not near the patient. 9:46 AM – E5 was observed in the kitchen/dining area having personal conversation by the coffee pots more than 25 feet away from R1. 9:48 AM – E3 observed R1 sitting alone and unattended stops to sit and provide the 1:1 with R1. 9:53 AM – E5 returns to provide 1:1 with R1. 10:06 AM – E5 was observed helping residents in the dining room, leaving R1 alone in a chair by the entrance door. 10:08 AM - An observation of E5 walking another resident to activities leaving R1 unattended. Another employee (unknown name) takes the other resident and E5 returns to provide 1:1 with R1.		

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	10:30 AM – An observation of R1 in activities, E5 gets up to assist another resident with a walker. E5 was not within reach to provide 1:1 or redirection of R1 during this time. 8/8/24 9:30 AM – In an interview with E6 (CM), it was revealed that the assignment sheet had R1 on a 1:1. When asked what that meant it was explained that a staff person would always remain with them. It was further confirmed that E5 (CM) was the assigned 1:1 for R1. After repeated observations of R1 failing to receive 1:1 supervision an Immediate Jeopardy was called on 8/8/24 at 3:45 PM. All residents were at risk of serious injury, serious harm, serious impairment, or death due to the facility's failure to protect residents from resident-to-resident abuse by R1, a known aggressive resident, who had assaulted at least two residents. While R1 was on a 1:1, staff left R1 alone and unattended. 8/8/24 Approximately 2:45 PM – In an interview with E2 (DON) it was stated that 1:1 was eyes on the resident. 8/8/24 Approximately 3:00 PM – In an interview with E1 (NHA) it was stated that E1 would consider 1:1 to be within reach or arm's length. The facility removal plan included taking immediate action with an in-service that educated on 1:1 resident observation. The facility completed 70% of the staff training by 8/11/24 and 100% by 8/12/24 at 10:18 AM. The IJ was abated on 8/12/24. This was verified by review of education, staff interview and observation. 2. Review of R2's record revealed:		

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	R2 admitted to the facility with diagnoses including but not limited to dementia. 8/5/24 – A document titled "Every one-hour Safety Check" for the 3:00 PM to 11:00 PM shift was blank for the following hours 7:00 PM, 8:00 PM, 9:00 PM, 10:00 PM and 11:00 PM. 8/5/24 - A Staffing Sheet originally documented that for 3:00 PM to 11:00 PM shift E11 (CM), E15 (CM), E20 (CM), and E21 (MT) were working on the Garden Unit. The schedule was updated to remove E20 and E21 at 7:00 PM. E10 (MT) was pulled from another unit to work on the Garden Unit. This dropped the staff coverage from three CM's to two CM's covering three assignments and one MT that was giving medications. 8/5/24 8:13 PM – A visitors log documented that E16 (Hospice Nurse) logged out of the building. 8/5/24 9:53 PM and 9:56 PM – In a review of video footage of the south exit door camera near R2's room, E15 (CM) was seen passing near R2's room and then coming back within view of the exit door camera. E15 was looking down at a cell phone that E15 was carrying. 8/6/24 at 12:12 AM – R2 was found lying on the (bedroom) floor gasping for air and bleeding from the head. R2 was emergently transported to the hospital. 8/6/24 8:20 AM – A report to the State agency documented "Around 12:15 AM, [E13] received a call to the nursing station that during rounds a caregiver found resident (R2) laying on the floor with blood coming from [R2] head with a forehead laceration, I went to call 911 & resident was sent out to ER for evaluation."		

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	8/7/24 – The hospital record documented the following injuries: "Subarachnoid hemorrhage Multiple extensive traumatic injuries: In the brain, face, lung, and ribs... police investigation as the severity of the injuries is not explained by simple fall...Discussed with... As of right now we will make sure the pain is controlled... and the patient's family would like to keep the patient [sic] is a DNR/DNI and awaiting for inpatient hospice services." The record further revealed that the "injuries were inconsistent with a fall." 8/7/24 4:13 PM – In an interview, E17 (Hospice Manager) revealed R2 was visited from 7:31 PM to 8:12 PM on 8/5. During the visit R2 was lethargic but arousable. 8/9/24 8:14 AM - In an interview with E7 (CM) it was confirmed that R2 was found on the floor on 8/6/24 and R2 had some blood coming from the head. E7 called for help right away and 911 was called. E7 revealed that he had arrived to work at 11:12 PM. During rounds, E7 stated he could hear sounds and went to several rooms checking residents before he found R2. E7 described R2 as gasping for air and laying on the floor and bleeding from the head. E7 further revealed that every one-hour safety checks should involve checking the residents to make sure they are not on the floor and make sure they are safe. When asked when the last time that R2 was checked, E7 stated according to the hourly check sheet the last check was at 6:00 PM. 8/9/24 9:43 AM - During an interview with E8 (CM), who worked the 11:00 PM to 7:00 AM shift, it was revealed that on 8/6/24, R2 was laying in the floor, gasping for air, mouth and face were bloody and busted up. E8 stated it looked like R2 "was attacked". E8 further stated four staff were originally scheduled for		

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	3:00 PM to 11:00 PM but that two staff were sent home early because of an argument. E8 stated that E7 and E8 had more resident care to provide than normal. E8 stated that for shift report it was only reported that two residents refused care and nothing else. 8/9/24 – During an interview with E21 it was revealed during the 3:00 PM to 11:00 PM shift on 8/5/24, E21 and E20 had a verbal altercation and the facility's response was to send them home despite this resulting in decreased staffing. 8/9/24 - During a phone interview E13 (LPN) revealed that she saw R2 at approximately 7:00 PM or 7:30 PM and R2 was lethargic and did not want to eat. 8/9/24 - Review of the death certificate documented an autopsy that identified R2's cause of death to be the result of a homicide, blunt force injuries to the head and torso caused by an assault. The injuries include the following: subdural hemorrhage, subarachnoid hemorrhage, bilateral rib fractures and pulmonary contusions. 8/9/24 12:43 PM – In an interview with E15 (CM), it was revealed that staff do the hourly rounding to monitor and check the residents. The rounding is supposed to be every hour but it was stated that "sometimes you get to it when you are able." On the night of 8/5/24, two CM's were sent home leaving only E15 and E11 to split the rounds. E11 did the 9:00 PM, E15 did the 10:00 PM (10:30 PM), and E10 (MT) came to finish passing medications. E15 further revealed that she had not completed the Hourly Check sheet, but her last check was at about 10:30 PM. E15 further revealed that she had checked on R2 that last round. R2 was not feeling well and E20 had passed along to E15 to keep a check on R2.		

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	E15 did not observe anything suspicious, and all residents were accounted for. 8/15/24 - In an interview with E16 (Hospice) it was revealed the R2 was seen by the Hospice Nurse on 8/5/24 from the hours of 7:31 PM to 8:12 PM. 8/16/24 3:30 PM – During exit conference findings were reviewed with E1 (NHA) and E2 (DON).	**Inspections and Monitoring** **A. (Individual impacted)** The Summit's Regional Support team understands the importance of the inspection and monitoring process outlined in the Delaware Code Title 16, Chapter 11, Subchapter I. 1107. Inspections and Monitoring.	
16 Del. Code, Chapter 11, Subchapter I. **§ 1107** **S/S - B**	**Health and Safety** **Regulatory Provisions Concerning Public Health** **Long Term Care Facilities and Services Licensing By The State** **Inspections and monitoring.** **(a) The Department shall inspect each long-term care facility on a regular basis to ensure compliance with this chapter and the regulations adopted pursuant to it.** **(b) The Department shall have the authority to assess additional fees to recover the actual costs and expenses of the Department for any monitoring or inspections needed beyond the standard inspection in those cases in which substantiated violations are found.** **(c) Any duly authorized employee or agent of the Department may enter and inspect any facility licensed under this chapter without notice at any time. All licensees are required to provide immediate access to Department personnel to conduct inspections. Such inspections may include any of the following:** **(1) Interviewing residents.** **(2) Interviewing family members or staff.**	**B. (Identification of other Residents)** All residents have the potential to be affected. **C. (Systemic Changes)** The Summit's Regional Support Team was not familiar with the State of Delaware's requirement regarding their request for any/all records. The Summit is the company's only Delaware community in its portfolio. Henceforth, the regional and community leadership team will provide any/all records requested by the State in a timely manner. **D. (Success Evaluation)** The Executive Director and DHW/ designee will provide the Department requested information in advance of any annual or complaint inspections. State entrance required documents and investigations will be reviewed during the community's quarterly Quality Assurance meetings.	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Summit **DATE SURVEY COMPLETED:** August 16, 2024

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	(3) Reviewing and photocopying any records and documents maintained by the licensee. (4) Inspecting any portion of the physical plant of the facility. (5) Enforcing any provision of this chapter and the regulations pursuant to it, as well as applicable federal law and regulations. (d) Advance notice may not be given to any facility of any inspection conducted under this chapter unless specifically authorized by the Secretary of the Department or the Secretary's designee or as otherwise required by federal law or regulation. Failure to comply with this subsection results in the imposition by the Department of a civil penalty not to exceed $5,000 per violation. (e) At the conclusion of each inspection, the Department shall promptly notify the facility of any violations of this chapter and its regulations as well as of federal law and regulations. It shall provide a comprehensive exit interview at the conclusion of each inspection whereby the facility is made aware of any problems found, including violations of applicable law or regulations. Representatives from the Long-Term Care Ombudsperson's Office shall be invited to attend each exit interview. (f) [Repealed.] (g) Any person who is a former employee of a long-term care facility is disqualified from participating for 2 years in any manner in any inspection of that facility. (h) Any person who has a relative residing or working in a long-term care facility is disqualified from participating in any manner in any inspection of that facility.		

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	Based on interview and records not produced immediately when requested, it was determined that the facility failed to provide investigation documents pertinent to the complaint survey. Findings include: 8/7/24 Approximately 10:00 AM - An Entrance Conference Worksheet was presented to the facility requesting incidents and investigations for the last 60 days be provided immediately. The facility provided the incident reports but failed to provide the investigations. 8/8/24 – The request for the investigations was made again to E1 (NHA) and E2 (DON). 8/9/24 12:44 PM – An email communication was sent from the state agency was sent to E1 requesting the missing documents that were requested on 8/7 & 8/8. The email documented the State agency "provided a list of items that are needed for the investigation. It included the hourly rounding sheets, the no name sheet and assignment sheet for several dates. I also provided original copies of certain dates that the [state agency] requested copies made." 8/10/24 4:09 PM – The surveyor received an email from the facility providing the remaining documents requested for the state agency investigation. That was three days after documents were requested. 8/16/24 3:30 PM – During exit conference findings were reviewed with E1 (NHA) and E2 (DON).		

Provider's Signature _____ Title _____ Date _____