DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 4, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced annual complaint and emergency preparedness survey was conducted at this facility from August 31, 2026, through September 4, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was seventy-four (74). The sample totaled twenty-two (22). Abbreviations/definitions used in this state report are as follows: ADHW – Assistant Director of Health and Wellness; BOD – Business Office Director; CM – Care Manager; DHW – Director of Health and Wellness; ED – Executive Director; LPN- Licensed Practical Nurse; MT – Medical Technician; MCPD – Memory Care Program Director; RN – Registered Nurse; RP – Responsible Party; Service plan/agreement - document developed with each resident that describes the services to be provided, who will provide the services, when the services will be provided, how the services will be provided, and, if applicable, the expected outcome. UAI – Uniform Assessment Instrument- an assessment to collect information on the physical condition, medical status, and psychosocial needs of an applicant/resident to determine eligibility for an assisted living.		
3225.0	**Assisted Living Facilities**		
3225.1.0	**Purpose**		

Provider's Signature Lisa MacKenzie Title Interim ED Date 10/21/26

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 4, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	The Department of Health and Social Services is issuing these regulations to promote and ensure the health, safety, and well-being of all residents of assisted living facilities. These regulations are also meant to ensure that service providers will be accountable to their residents and the Department, and to differentiate assisted living care from skilled nursing care. The essential nature of assisted living is to offer living arrangements to medically stable persons who do not require skilled nursing services and supervision. The regulations establish the minimal acceptable level of services for residents of assisted living facilities.	**3225.8.0 Medication Management** **1. Insulin identified improperly stored in the medication cart was disposed of by the DHW. A replacement insulin pen was ordered and sent by IPPC pharmacy.** **2. All residents who are prescribed insulin have the potential to be affected by this identified citation.** **3. In-service education on Proper storage of Insulin was initiated on 8/31/26 to all medication passers as well as nurses on the importance of following manufacturer instructions on how to store insulin. In addition, Discovery Management Group Policy MP12 Medication Storage-Centrally Stored Medications in-service will be provided to all med passers and nurses. All newly hired med passers and nurses will be given both educational in-services as a part of the new hire training by the ADHW.** **4. The DHW or designee will audit medication carts weekly x4, biweekly x2, and monthly x1. 100% compliance will be met by 10/30/2026.**	10/30/2026
3225.8.0	**Medication Management**		
3225.8.1	**An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:**		
3225.8.1.2	**Storing and controlling medication;**		
S/S – D	**These requirements were not met** Based on observation, record review and interview it was determined that the facility failed to adhere to written policies related to storing medication. Findings include: The facility policy on medication storage last updated, November 12,2024, indicated " All medications must be stored in accordance with the label instructions (refrigerate, room temperature, out of direct sunlight, etc.). 8/31/26 9:24 AM – During the medication storage observation with E5 (MT) an unopened insulin pen was discovered inside the		

Provider's Signature _____ Title INTERIM ED Date 10/21/26

NAME OF FACILITY: The Summit

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	third-floor medication cart a yellow sticker from the pharmacy read "refrigerate". 8/31/26 – 9:30 AM E2 (DHW) confirmed the finding and removed the insulin pen. 9/4/26 4:00 PM – These findings were reviewed during the exit conference with E1 (ED) and E2 (DHW).		
3225.9.0 **3225.9.9** **3225.9.9.3** **S/S – D**	**Infection Control** **Infection Prevention and Control Program** **All assisted living facility staff shall receive orientation at the time of employment and annual in-service education regarding the infection prevention and control program.** **These requirements were not met** Based on record review and interview it was determined that for two (E6 and E7) out of five staff reviewed for mandatory training the facility failed to ensure that staff received annual in-service education regarding the infection control program. Findings include: 9/2/26 10:30 AM – Review of the facilities employee training worksheet revealed the following employees did not complete annual in-service education training on infection control: 3/18/25 – E7 (server) completed infection control in-service education. 6/27/25 – E6 (care manager) completed infection control in-service education.	**3225.9.0 Infection Control** 1. **E7 no longer works at the community. E6 completed the Infection Control training on 9/7/2026.** 2. **All residents have the potential to be affected by this citation.** 3. **ED/designee and HR/Designee will audit all employee files to find an like team members who have not completed the training by 10/30/2026.** 4. **ED/designee and HR/designee will audit all team members biweeklyx1 month and monthly x1 month to ensure all team members are up to date with Infection Control education completion. 100% compliance will be met by 10/30/2026.**	10/30/2026

Provider's Signature _____ Title Interim ED Date 10/24/26

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 4, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	9/2/26 11:00 AM – During an interview, E8 (Human Resource Specialist) confirmed that E6 and E7 had not completed required training for infection control. 9/4/26 4:00 PM – These findings were reviewed during the exit conference with E1 (ED) and E2 (DHW).		
3225.10	**Contracts**	**3225.10 Contracts**	
3225.10.6	**The contract or service agreement shall include, at a minimum, the following non-financial provisions:**	**1. R16 no longer resides in the community.** **2. All residents have the potential to be affected by the cited practice.**	
3225.10.6.5	**Discharge/temporary absence policies and procedures, including**	**3. ED/designee and DHW/designee will review the residents through assessment are unable to return to the community from SNF/Hospital; a 30-day notice will be provided to the Resident/POA in accordance with the regulations.**	9/25/2026
3225.10.6.5.2 **S/S – D**	**The procedures which the assisted living facility shall follow if it intends to discharge a resident and thereby terminate the contract, including a provision under which the assisted living facility shall give at least 30 days' notice to the resident before the effective date of the discharge and termination of the contract, except in the case of a health emergency or substantial risk to the health and safety of the other residents or facility staff;** **These requirements were not met** Based on interview and record review it was determined that for one (R16) out of three residents reviewed for the discharge the facility failed to provide at least thirty days' notice to resident [or responsible party] before the effective date of the discharge and termination of the contract. Findings include:	**4. ED/designee and DHW/designee will review each resident prior to their return to the community. 100% compliance will be met by 10/30/26.**	

Provider's Signature _____ Title INTERIM ED Date 10/24/26

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 4, 2026

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	The facility policy on discharge related to non-emergency status last updated November 12, 2024, indicated, "Discharge out of the community is carried out in a manner that will limit trauma for the resident and enhance communication". 4/17/23 – R16's responsible party, RP1 signed an admission contract that indicated, "Termination with thirty days' notice. Except as otherwise provided in Section IV.C.2 below, we may transfer or discharge you and terminate this agreement for one or more of the following reasons by giving thirty days' written notice. (a) The transfer is for your welfare, and your needs cannot be met by the facility;" 1/12/26 2:00 PM – A progress note in R16's clinical record documented, "RN assessment performed today. Open blister noted to residents left heel...[homecare agency] wound care evaluation requested." 1/14/26 – A home care visit report documented that R16 had an unstageable pressure ulcer of the left heel. 1/19/26 2:00 PM - A progress note in R16's clinical record documented, "NP and this nurse assessed resident today. Left heel wound increased in size...NP recommended for the resident to go to the ER for further evaluation." R16 never returned to the facility. 3/20/26 – An email was sent from E11 (former ED) to RP1 that indicated, "I am afraid that your mom would not benefit from the assisted living level of care [the facility] is able to provide at this time, even with the		

Provider's Signature _____ Title Interim ED Date 10/21/26

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	wound healing...The Assisted Living regulations are very clear about the types of skin injury which can be managed in the AL setting. Any decline would again put us in a situation where we would not be able to provide the care your mom needs...I am not sure if [E9 (BOD)] ever had an official move out date for your mom. We could work on that. Again we are all very glad to hear your mom is on the road to recovery." 3/30/26 – A move out form was completed for R16 by E9 (BOD) that documented that R16/RP1 room charges would end on 3/26/26 move out reason higher level of care. 9/4/26 2:06 PM – The surveyor sent an email to E1 (ED) and E2 (DHW) that requested a copy of the discharge notice provided to R16/RP1. 9/4/26 3:05 PM – During an interview, E2 (DHW) confirmed the facility was aware that R16 had a pressure ulcer that was being managed by the homecare agency prior to being sent to the hospital. 9/4/26 3:32 PM – During an interview, E9 (BOD) confirmed that RP1 was not provided a written thirty-day discharge notice. E9 stated, "I think it was a verbal conversation. From what I understand it was she possibly had a pressure ulcer and she was at rehab [rehabilitation facility] and couldn't return because of the pressure ulcer according to [E11 (former ED)." 9/4/26 4:00 PM – During the estimated sixty days of R16's absence from the facility for treatment of the pressure ulcer, RP1 was not provided a written discharge notice. At		

Provider's Signature _____ Title INTERIM CO Date 10/21/26

NAME OF FACILITY: The Summit

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	conclusion of the survey the facility failed to provided evidence of a written discharge notice to RP1 on R16's behalf. R16 was sent to the hospital on January 19, 2026, with a pressure ulcer and denied return to the facility March 20, 2026, via email due to a pressure ulcer treated by home care while at the facility. 9/9/26 11:45 AM – During an interview, RP1 confirmed the facility did not provide a written notice of discharge and that the facility initiated the discharge during a telephone conversation followed by the email from E11 (former ED) on 3/20/26. 9/4/26 4:00 PM – These findings were reviewed during the exit conference with E1 (ED) and E2 (DHW).	**322.11.0 Resident Assessments** 1. **R21's Significant Change UAI was completed on 9/3/2026 to reflect the changes in her behaviors under section Four-Psychological/Social/Cognitive. R22's Significant Change UAI completed on 9/9/2026 to reflect the changes in her behaviors under Section Four-Psychological/Social/Cognitive.** 2. **All residents have the potential to be affected by the cited practice.** 3. **Divisional VP of Resident Care inserviced the DHW on incident reports, UAI & Service Agreement/Care Plan updates on 9/8/26. The DHW/designee will audit the last 30 days of incident reports to review for possible UAI and service agreement updates by 10/30/2026.** 4. **DHW/designee will audit the incident reports weekly x4, biweekly x2 and monthly x1. 100%compliance will be met by 10/30/2026.**	10/30/2026
3225.11.0 **3225.11.5** **S/S – D**	**Resident Assessments** **The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the residents' condition.** **These requirements were not met** Based on record review and interview it was determined that for two (R21 and R22) the facility failed to update the resident assessment to reflect significant changes in the residents' condition. Findings include: 1. Review of R21's clinical record revealed: 2/21/26 – An initial UAI assessment was completed for R21 that documented the		

Provider's Signature _____ Title INTERIM ED Date 10/21/26

NAME OF FACILITY: The Summit

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	resident had no history of disruptive, assaultive, destructive, demanding behaviors or wandering. 3/7/26 4:15 AM – A note in R21's clinical record documented, "Resident requires being redirected from entering other resident rooms." 3/19/26 – A thirty-day UAI assessment was completed for R21 that documented no change in the assessment. 4/5/26 7:45 PM - A note in R21's clinical record documented, "Resident noted with physical aggression towards staff. Nurse was informed that the resident was irate, aggressive, uncooperative with care and had scratched her assigned care giver in the eye." 4/21/26 1:00 PM - A note in R21's clinical record documented, "On 4/20/26, [E12 (MCPD)], reported to this nurse that she was informed/made aware that [R21] exhibited aggressive behavior towards another resident, sometime over the past weekend, (4/18-4/19)... [R21] grabbed at resident's arm to refrain her from leaving." 2. Review of R22's clinical record revealed: 4/10/26 4:00 AM – A note in R22's clinical record documented, "Nurse was called to the Memory Care Compass Unit by a care manager due to a resident attempting to elope. When staff attempted to redirect the resident, she became increasingly aggressive and combative." 4/21/26 1:45 PM– A note in R22's clinical record documented, "This nurse informed		

Provider's Signature _____ Title INTERIM ED Date 10-21-26

NAME OF FACILITY: The Summit

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	by overnight nurse that she was just informed of an incident regarding resident striking another resident." 6/2/26 – An annual UAI assessment completed for R22 documented R21 that documented the resident had no history of disruptive, assaultive, destructive, demanding behaviors or wandering. 9/4/26 9:39 AM – During an interview, E2 (DHW) confirmed that both residents' UAI assessments were not updated to include the significant changes in R21 and R22's behaviors. 9/4/26 4:00 PM – These findings were reviewed during the exit conference with E1 (ED) and E2 (DHW).	**3225.12.0 Services** 1. **Community acknowledges the incomplete temperature logs cited by the survey.** 2. **All residents have the potential to be affected by the cited practice.** 3. **The Regional Director of Culinary will in-service the Director of Culinary as well as the Culinary Supervisor (E10) on Thermometer Calibration, Time and Temperature Control and Cleaning Checklist and Temperature Logs on 9/22/2026. All dining culinary staff responsible for temperatures will be in-serviced by 10/30/2026.** 4. **Director of Culinary/designee will audit temperature logs weekly x4, biweekly x2 and monthly x1. 100% compliance will be met by 10/30/2026.**	
3225.12.0 **3225.12.1** **3225.12.1.3** **S/S- E**	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **4458 State of Delaware Food Code Regulations** **2.0 Adoption of United States Public Health Service 2022 Food Code** **2.1 The State of Delaware Food Code adopts, as if fully set forth in this regulation, the United States Public Health Service 2022 Food Code** **2022 Food Code U.S Food and Drug Administration** **Chapter 3. Food** **3-401 Cooking 3-401.11 Raw Animal Foods.**		10/30/2026

Provider's Signature _____ Title INTERIM ED Date 10/21/26

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	(A) Except as specified under ¶ (B) and in ¶¶ (C) and (D) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature and for a time that complies. **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 75 FDA Food Code 2022 Chapter 3. Food under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except 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 54°C (130°F) or above; P or (2) At 5°C (41°F) or less.** **These requirements were not met** Based on document review it was determined that the facility failed to comply with the Delaware Food Code. Findings include: 9/2/26 – During the survey of the facility, at approximately 1:00 PM, the surveyor requested the food temperature logs from E10 (Culinary Supervisor). A review of food temperature documentation revealed missing food temperature logs in the month of June and July. The Month of June revealed 13 meals out of 60 reviewed that did not have food temperature documentation. The month of July revealed 18 meals out of 63 reviewed that did not have food temperature documentation. Additionally, cold		

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	food items did not have food temperature documentation on 36 out of 61 days reviewed. 9/2/26 - Findings were reviewed with E1 (ED) and E 10 (Culinary Supervisor) at approximately 3:30 PM.		
3225.19.0 **3225.19.6** **S/S – D**	**Records and reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **These requirements were not met** Based on record review and interview it was determined that for two (R1 and R10) out of four residents reviewed for abuse the facility failed to ensure that reportable incidents were reported immediately to the State Agency. Findings include: The facility policy on abuse last updated November 11, 2024 indicated, "Reporting of any suspected, alleged, or witnessed abuse will be completed according to state requirements." 1.Review of R1's clinical record revealed: 4/21/26 1:00 PM – A note in R1's clinical record documented, "On 4/20/26, [E12 (MCPD)] reported to this nurse that she was informed/made aware that [R21] exhibited aggressive behavior towards another resident [R1], sometime over the past weekend, (4/18-4/19). According to what was reported TO [E12] [R21] was following the [R1] and their family member around the common area and attempted to also leave the common area door/exit with the resident and their family member. [R1] made claims	**3225.19.0 Records and Reports** 1. **R1, R10, R21, R22 remain in the community. The reportable events identified were submitted on 4/21/2026.**	

Provider's Signature _____ Title INTERIM ED Date 10/21/26

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	to family member such as "you can't leave with my mother!" and grabbed at [R1's] arm to refrain her from leaving. 4/21/26 – The facility reported a resident-to-resident abuse incident that alleged [R1] was allegedly struck in the face by on 4/18/26 [R21]. 9/3/26 2:06 PM – During an interview RP2 confirmed that on 4/18/26 she observed [R21] grab [R1] and after separating the two immediately reported it to a staff member. RP2 stated, "I reported it to (E12 [MCPD]) that Monday. [R1] thought my mom was her relative and grabbed her arm. An aide came and she had already stopped but I told her what happened". 9/4/26 10:15 AM – During an interview, E17 (CP) confirmed that the resident-to-resident incident between [R1] and [R22] was not reported to the nurse. E17 stated, "I didn't see but [RP2] did report it to me and another care partner. I had so much to do so the other care partner said she would tell the nurse." 2. Review of R10's clinical record revealed: 4/21/26 5:45 AM – A note in R10's clinical record written by E13 (LPN) documented, "At approximately 5:45 a.m. while administering residents scheduled 6:00 a.m. medication, nurse observed light discoloration and puffiness around the resident's left eye. Nurse inquired with the assigned care manager regarding the observation and possible cause. [E16 (CP)] stated she had also noticed the resident's eye and reported that the injury may have resulted from an incident last week when another resident displayed behavioral aggression and struck resident Judy in the eye. Nurse reviewed the resident's	**2. All residents have the potential to be affected.** **3. DHW/designee will submit reportable events according to the regulation. In addition, the ED/designee will provide additional education to all team members monthly via town hall meetings on reporting events timely as well as posting in team member areas starting 9/26/2026.** **4. ED/designee will have team members in-serviced on reporting and reportable events. 100% compliance will be met by 10/30/2026.**	10/30/2026

Provider's Signature _____ Title Interim ED Date 10/26/26

NAME OF FACILITY: The Summit

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	chart and found no documentation or incident report related to this alleged event." 4/21/26 – The facility reported a resident-to-resident abuse incident that alleged [R10] was allegedly grabbed on the arm by [R22] at night of 4/16/26. 9/4/26 11:19 AM – During an interview, E16 (CP) stated, "I was working overnight me and two other people. I was sitting with [R10] and [R22] walks around and that night [R10] having an episode with screaming and when she does we watch her. R22 sat on the other side of her and I overhead a smack. I look and see [R10] saying she slapped me I got [R22] to let her go. We wrote the statements a few days later." E16 confirmed that she did not report the incident to a nurses. E16 stated, "I kept them apart so it wouldn't happen again." 9/4/26 1:52 PM – During an interview, E13 (LPN) confirmed that on 4/16/26 a resident to resident incident in which R10 was slapped was not reported to her. E13 stated, "I reported her eye was red and discolored a couple nights later. [E16 (CP)] said it's probably when [R22] slapped her the other night. They said it happened on my shift. They have radios and they didn't tell me. The care partners were talking about it but they are not telling the nurses!" 9/3/26 12:31 PM During an interview, E2 (DHW) confirmed that the incidents of resident-to-resident abuse were not reported to the State Agency. 9/4/26 4:00 PM – These findings were reviewed during the exit conference with E1 (ED) and E2 (DHW).		

Provider's Signature _____ Title Interim ED Date 10/24/26

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Provider's Signature _____ Title INTERIM ED Date 10/22/26