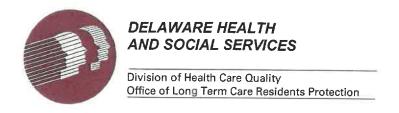


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NAME OF FACILITY: <u>AL-The Summit</u>

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Complaint survey was con-		
	ducted at this facility from February 25,	•	
	2025, through March 4, 2025. The deficien-		
	cies contained in this report are based on		
	observations, interview and record review.		=
	The census the first day of the survey was		
	ninety-one (91). The survey sample totaled		
	thirteen (13).		
	Abbreviations/definitions used in this State	·	
	report are as follows:		-4
	ADHW - Assistant Director of Health and		
	Wellness;		
	CM - Care Manager;		
	CSS - Culinary Services Supervisor;		
	DCS - Director of Culinary Services;		
	DHW - Director of Health and Wellness;		
	ED - Executive Director;		
	HCC - Health Care Coordinator;		
	LPN - Licensed Practical Nurse;		
	MT - Medication Technician;		
	MCD - Memory Care Director;		
	RN - Registered Nurse.		
	Congestive Heart Failure - (CHF) heart una-		
	ble to pump enough blood to meet the		
	body's needs;		
	Edema - retention of fluid into the tissue re-	*	
	sulting in swelling;		
	EMR - (Electronic Medical Record)) - a sys-		
	tematized collection of patient and popula-		
	tion electronically stored health information		
	in a digital format;		
	Fracture - broken bone;		
	Heart Failure - (congestive heart failure -		
	CHF) inability of heart muscle to pump		
	blood. Leads to fluid accumulation in the		
	lungs, which make breathing difficult and		
	causes swelling of the legs, feet, liver, and		
	other internal organs;		

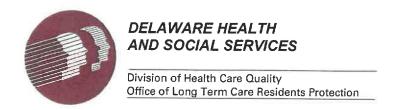


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NAME OF FACILITY: AL-The Summit

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completic Date
	Insulin - Medication to treat diabetes;		
	Laceration - cut/tear in skin;	3	
	Lymphedema - swelling in arm or leg most		
	commonly caused by blockage in a blood		
	vessel;		
	Medication Administration Record (MAR) -	3225.11.2	
	list of daily medications to be administered;	02E0.11.2	
	Rehabilitation (Rehab) - treatment for recov-	Criteria #1 - Individual Impacted	
	ery from an injury or disease, often after a	Resident R9 no longer resides at the facility.	
	hospitalization		
	Stroke - a medical condition in which poor	Criteria #2 – Identification of other	
	blood flow to the brain causes cell death:	residents	
	Subcutaneous - below the skin;	İ	
	Treatment Administration Record (TAR) - list	The Executive Director and/or his or her	
	of daily/weekly/monthly treatments to be	designee shall audit resident's records for	
	performed	those admitted from 3/4/2024 until	
		3/28/2025 for completion of the UAI within	
225.0	Regulations for Assisted Living Facilities.	30 days of admission, 30 days after	
		admission, annually, and after a significant	
3225.11.0	Resident Assessments	change.	
225.11.2	A resident seeking entrance shall have an	Criteria #3 – System Changes	
	initial UAI-based resident assessment com-	Ontoria no Oyotom Changes	
/S - D	pleted by a registered nurse (RN) acting on	Root cause analysis – There was a gap in	
	behalf of the assisted living facility no	coordination between sales and the clinical	
	more than 30 days prior to admission. In all	team.	
	cases, the assessment shall be completed		
	prior to admission. Such assessment shall	The Corporate Nurse and/or his or her	
	be reviewed by an RN within 30 days after	designee shall re-educate RNs on the	
	admission and, if appropriate, revised. If	completion of the UAI for admitting	
	the resident requires specialized medical,	residents, within 30 days prior to and after	
	therapeutic, nursing services, or assistive	30 days after admission, annually, and for	*
	technology, that component of the assess-	significant change. Created an admission	
	ment must be performed by personnel	review meeting including sales, operations,	
	qualified in that specialty area.	and clinical to validate timely completion of	
		UAI within 30 days prior to admission.	
	Based on record review and interview it was	Create a UAI tracking worksheet to	
	determined that for one (R9) out of thirteen	facilitate timely completion.	
			,
vider's Signa	ature kuy Hallinger Ti	tle secutive Director Date 4/14	1/25



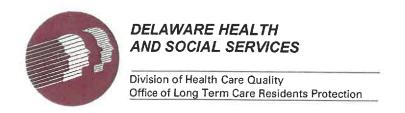
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	STATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR	Completion
SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Date
	residents reviewed the facility failed to ensure that an initial UAI assessment was completed. Findings include: Review of R9's clinical record revealed: 12/18/24 - R9 was admitted to the facility. 12/18/24 - An initial UAI assessment was initiated for R9. Review of the assessment lacked evidence of completion other than the date. 3/3/25 9:28 AM - During an interview E1 confirmed the findings and stated, "An initial assessment [facility internal form] by an RN was started but was not transferred to the UAI assessment and completed."	Criteria #4 – Success Evaluation The Executive Director and/or his or her designee shall audit new admissions weekly for one month and monthly for three months or until substantial compliance is achieved.	5/3/25
	3/4/25 12:15 PM - Findings were reviewed during the exit conference with E1 (ED) and E4 (ADHW).	3225.11.5	
3225.11.5 S/S - E	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 resident's condition.	Criteria #1 - Individuals Impacted Resident R1 and R11 – Review and update as appropriate the UAI to identify any changes that need to be assessed and updated. Residents R3 and R5 – no longer resides at	
	Based on record review and interview, it was determined that for four (R1, R3, R5 and R11) out of thirteen residents reviewed the facility failed to ensure that the residents' UAI assessments were updated when there were significant changes. Findings include: 1.Review of R1's clinical records revealed:	the facility. Criteria 2 – Identification of other residents The Executive Director and/or his or her designee shall audit resident records for those admitted from 3/4/2024 to 3/28/2025 for completion of the UAI within 30 days of admission, 30 days after admission, annually, and after a significant change.	

Provider's Signature way Hollings

Title Jecutive Director Date 4/14/25



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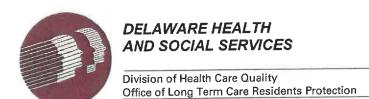
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NAME OF FACILITY: AL-The Summit

Provider's Signature

NAME OF FACILITY: AL-The Summit		DATE SURVEY COMPLETED: March 4, 2025		
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date	
	4/26/24 - R1's initial UAI health information revealed that R1 had congestive heart failure and did not receive home health rehab or hospice services from third party providers.	•		
	5/14/24 - R1 was admitted to the facility with diagnoses including diabetes, dementia, history of stroke and was noted with pitting edema to lower legs (swelling in the legs where pressing on the skin leaves a visible indention). 6/10/24 - R1's 30-day UAI assessment revealed no change from the initial assessment on 4/26/24. 6/20/24 12:24 PM - A nurse progress note documented " new bilateral tremor and UE (upper extremity) weakness. Swelling to bilateral (both) arms and legssent to ER (emergency room) to (sic) neuro changes/fluid overload symptoms" 7/27/24 11:47 AM - A nurse progress note documented, " Daughter came in and requested her mom to go to hospitalmom told her she's dizzy, extremely tired and nausea (sic), Daughterstatedshe (R1) is swollen all overtransported to (hospital)" 8/3/24 (approximately) 6:00 PM - A nurse progress note documented that R1 was discharged from the hospital and was going to a rehab facility.	reviewing or tracking residents for	5/3/25	
	documented that R1 was status post re-admitted to the facility.			

Terry Hollinger Title Executive Director Date 4/14/25



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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
	9/19/24 5:26 PM - A nurse progress note documented that P1 (Cardiologist) was notified regarding R1's noncompliance with fluid restriction that the assisted living facility was "not able to monitor".		
	9/24/24 6:13 PM - A nurse progress note documented, "[R1] is on service with [home health agency] for leg edema.		
	10/10/24 4:02 PM - A nurse progress note documented, "antibiotic for LLE (left lower extremity) cellulitis [P2, home health] wound care nurse to see resident"		
	2/14/25 7:42 AM - A nurse progress note documented, "[R1] has orders to return to Lymphedema Clinic today. Lymphedema clinic will be attending to [R1]'s right leg going forward"		
	2/26/25 2:00 PM - Further review of R1's records revealed a lack of evidence that a significant change UAI was completed when R1 was re-admitted to the facility in September 2024 and that R1 was referred for treatments and therapies for edema management.		-
	3/4/25 11:00 AM - Findings were confirmed and discussed with E4 (ADHW).		
	2. Review of R3's clinical record revealed:		
	11/29/23 - R3's initial UAI assessment revealed that R3 required supervision with mobility using a walker and needed standby		



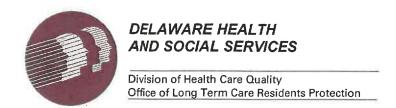
Division of Health Care Quality Office of Long Term Care Residents Protection

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- 37 1111144 🔾 5	FACILITY: <u>AL-The Summit</u>	DATE SURVEY COMPLETED: M	arch 4, 2025
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	assistance during transfers. R3's Fall Risk As-		
	sessment indicated that she fell in the last		
	30 days. During the review period, R3 was		
	receiving rehab services and was not receiv-		
	ing hospice services.		
	12/15/23 - R3 was admitted to the facility.		
	12/29/23 - R3 30-day UAI assessment re-		
	vealed no change from the initial assess-	0 0	
	ment on 11/29/23.		
	6/18/24 - R3's significant change UAI assess-		10
	ment revealed that R3 required supervision		
	with mobility using a wheelchair and		
	needed one-person physical assistance dur-		
	ing transfers. R3's Fall Risk Assessment indi-		
	cated impaired balance, confusion, balance		
	problems when standing and had limited ac-		
	tivities due to fear of falling. R3 fell in the		
	last 30 -180 days. During the review period,		
	R3 was receiving rehab services and was not		
	on hospice care.		
	8/29/24 - R3's hospice [P3] start of care		
	date.		
	8/30/24 - R3's physician order documented		
	that R3 was serviced by P4 (hospice).		
	2/27/25 2:10 PM - Further review of R's rec-		:
	ords revealed a lack of evidence that a signif-		
	icant change UAI was completed when R3		
	was admitted to hospice services on	1	
	8/29/24.		
	3/4/25 11:02 AM - Findings were confirmed		
	and discussed with E4 (ADHW).		
ider's Signa	sture lesses Hollinger Titl	e jecutive DirectorDate 4/1	4/25
Suite	7	Tree Date 4/16	4/25
			5



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NAME OF FACILITY: AL-The Summit

NAME OF FACILITY: <u>AL-The Summit</u>		DATE SURVEY COMPLETED: March 4, 2025		
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completior Date	
	3. Review of R5's clinical records revealed:			
	2/22/23 - R5's initial UAI assessment re-			
	vealed that R5 was independent with mobil-			
	ity. Fall Risk Assessment revealed that R5's			
	confusion and history of stroke increased			
	R5's risk of falling.			
	2/23/23 - R5 was admitted to the facility.			
	There was a lack of evidence that R5's 30-			
	day UAI was completed on 3/23/23.			
	9/6/23 12:10 PM - A facility incident report			
	documented, " [R5] observed with pants			
	at her ankles, no shoes and sitting on the			
	floorattempted ROM (range of motion),			
	[R5] displays discomfort bottom and			
	hipshospital for eval"			
	11/1/23 - R5 was readmitted to the facility			
	with diagnoses including high fall risk and			
	multiple pelvic and sacral fractures.			
	11/2/23 1:56 PM - A nurse progress note			
	documented, " s/p (status post) readmis-			
	sion [R5] assisted with ADLs. Alert and			
	oriented to self only. Needs constant redi-			
	rection. Seen by therapy today. Therapy			
	gave resident a walker. [R5] remains a fall			
	risk Caregivers to closely monitor."			
	11/23/23 4:20 PM - A facility incident report			
	documented, " [R5] found on the			
	floorleaning on her left armdisplays dis-			
	comfort of her left armgrunt in painhad			
	facial grimace sent out to hospital"	<u> </u>		



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NAME OF FACILITY: AL-The Summit

NAME OF FACILITY: AL-The Summit		DATE SURVEY COMPLETED: March 4, 2025		
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date	
	11/24/23 1:01 PM - A nurse progress notes			
	documented, " S/P (status post) Left (sic)			
	arm fracture. Sling applied to left arm"			
	The facility failed to review R5's UAI assess-			
	ments when R5 obtained multiple pelvic			
	and sacral fractures on 9/6/23 and when R5			
	had a left arm fracture on 11/23/23.			
	3/4/25 11:08 AM - Findings were confirmed			
	and discussed with E4 (ADHW).			
	4. Review of R11's clinical record revealed:			
	12/19/22 - R11's initial UAI assessment re-			
	vealed that R11 was independent with mo-			
	bility and was able to transfer self. R11's Fall			
	Risk Assessment indicated risk of falling due			
	to gait problem and impaired balance. Dur-			
	ing the review period, R11 was not on hos-			
	pice service.			
	1/16/23 - R11 was admitted to the facility			
	with diagnoses including dementia with no			
	disruptive behaviors.			
	2/16/23 - R11's 30-day UAI assessment indi-			
	cated no change from the initial UAI on			
	12/19/22.			
	12/19/23 - R11's annual UAI assessment re-			
	vealed that R11 required occasional physical			
	assistance with mobility and required one-			
	person physical assistance with transfers.			
	R11's Fall Risk Assessment indicated risk of			
	falling due to gait problem and impaired			
	balance. R11 was not on hospice service but			
	was combative and agitated with care dur-			
	ing the review period.			
vider's Signa	ature Kiny Hollinger Ti	itle Tracutive Directore 4	14/25	



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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
	2/20/24 6:48 AM - A nurse progress note		
	documented, " Caregiver reported resi-		
	dent fell on floor in sitting position skin		
	tear on his right elbow and right knee along		
	with knot on his forehead from fall. Unable		
	to obtain V/S (vital signs) and full ROM		
	(range of motion) due to resident being		
	combative. 911 called. [R11] combative to-		
	wards male paramedic while trying to put		
	his neck brace on, paramedics hit wall then		
	fell down on floor due to resident combat-		
	iveness"	a	
	2/22/24 4:54 PM - A nurse progress note		
	documented, " [P3, hospice] to eval (eval-		
	uate) and treat."	-	
	2/24/24 12:32 - A nurse progress note docu-		
	mented, " [P6 hospice nurse] came in vis-		
	ited with resident."		
	2/28/24 6:32 PM - A nurse progress note		
	documented, " [R11] assisted to stand.		
	Combative to staff"		
	2/20/24 4 50 224		
	2/29/24 4:50 PM - A nurse progress note documented, " [R11] ambulating, up and		
	down from chair. Unable to redirect. Heard		
	and observed loud crash. [R11] fell down to		
	floor on right side. Combative with assisting		
	up.		
	The facility failed to review R11's UAI as-	я —	
	sessments when R11 exhibited increasing falls with disruptive behaviors and his ad-		
	mission to hospice care on 2/24/24.		
	3/4/25 11:12 AM - Findings were confirmed		
	and discussed with E4 (ADHW).		
vider's Sign	11.00	Executive Director Date 4/1	7



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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
	3/4/25 12:15 PM - Findings were reviewed during the exit conference with E1(ED) and	3225.12.3	
	E4 (ADHW).	Criteria #1 - Individuals Impacted	
3225.12.0	Services	Resident R3 – No longer resides at the	
3223.12.U	Scrivices	facility.	
3225.12.3	The assisted living shall ensure that the		
	resident's service agreement is being	Criteria 2 - Identification of other residents	
	properly implemented.		
		The Executive Director and/or his or her	
	Based on record review and interview, it	designee shall audit the resident service	
	was determined that for one (R3) out of	agreement for those residents admitted	
	thirteen total residents reviewed the facility	from 1/1/2025 until 3/28/2025 to ensure	
	failed to ensure that R3's service agreement	adequate completion of the service	
	was properly implemented. Findings in-	agreement.	
	clude:		
	Stage.	Criteria #3 – System Changes	
	Review of R3's clinical record revealed the		
	following:	Root cause analysis – No defined process	
	, and the same of	for care staff to review service agreement	
	A. 6/19/24 - R3's significant change service	interventions document task completed.	
	agreement revealed that R3's safety inter-	_	
	ventions included fall risk assessment quar-	The corporate nurse and/or his or her	
	terly or when necessary and every two-hour	designee shall re-train nursing staff on the	
	safety checks. R3 had actual falls on	implementation of the service agreement	
	5/24/24, 5/27/24 and 6/8/24 with updated	and documentation requirements including	
	falls interventions including, "LOC (level of	but not limited to falls and toileting	
	care) change to 1-person transfer. Reminder	interventions. Create a resident care plan	
	to call for assistance. Continue PT (Physical	profile for care giver staff to review service	
	Therapy) and OT (Occupational Therapy)	agreement interventions. A document will be created for care staff to document	
	Wear nonslip shoes or socks."	interventions completed.	
	mirrous normally shoes of socks.	mervendens completed.	
	2/27/25 11:40 AM - A review of R3's fall in-	Criteria #4 – Success Evaluation	
	cident reports from December 2024		
	through February 26, 2025, revealed the fol-	The Executive Director and/or his or her	-121-
	lowing unwitnessed falls:	designee shall audit new resident's service	5/3/25
	•	agreements weekly for one month and	
		monthly for three months or until	
		substantial compliance is achieved.	



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NAME OF FACILITY: <u>AL-The Summit</u>		DATE SURVEY COMPLETED: March 4, 2025		
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completio Date	
	December 2024 - two falls, 1 injury " small			
	abrasion on left side of face near the fore-			
	headdried blood was noted around the			
	area"			
	January 2025 - four falls, no injury			
	February 1 - 26, 2025 - three falls, no injury			
	2/27/25 2:00 PM - A review of R3's ADL doc-			
	umentation completed by care managers			
	lacked documentation to attest completion			
	of R3's safety checks when she fell on the			
	following dates:			
	- 12/10/24 6:00 PM			
	- 12/25/24 4:00 PM			
	- 1/22/25 6:50 AM	z.		
	- 2/7/25 10:45 AM			
	- 2/17/25 2:45 PM			
	- 2/18/25 12:30 AM			
	The facility failed to ensure that R3's service			
	agreement was properly implemented			
	when her safety risk interventions of every			
	two-hour safety checks lacked evidence that	1 1 1 1 1 1 1 1		
	they were completed and R3 experienced			
	multiple unwitnessed fall.			
	3/4/25 11:00 AM - Findings were confirmed			
	and discussed with E4 (ADHW).			
	B. 6/19/24 - R3's significant change service			
	agreement revealed that R3 required daily			
	or as needed, cues or reminders and clean-			
1	ing assistance for toileting services. R3 also			
	required stand by or one person assist with			
	transfer.			



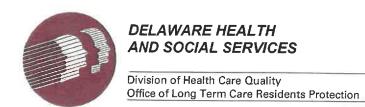
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	6/19/24 (reviewed 1/2/25) - R3's full-service description revealed that R3's bathroom assistance status required regular employee's assistance in managing bowel and/or bladder care. To include: - assist to bathroom and ensure privacy. - assist resident with removing cloth and/or incontinence products. - assist onto toilet and with personal cleaning tasks as needed. - assist with redressing and use of fresh incontinence products. - report increasing difficulty with toileting tasks or safety concerns.		
	2/27/25 11:40 AM - A review of R3's fall incident reports from December 2024 through February 26, 2025, revealed the following multiple unwitnessed falls related to R3's need for toileting assistance: 11/10/24 10:08 PM - " noted resident on		
	the bathroom floor" 12/25/24 4:00 PM - " sitting on the floor next to the recliner chairattempting to transfer to chair to use the bathroom"		
	1/5/25 1:01 PM - " had a fall in the bath- room near dining room" 1/13/25 6:15 PM - " sitting on the floor next to bed in bedroom trying to get into her wheelchair to go into the bathroom in- dependently"		
100	The facility failed to ensure that R3's service agreement was properly implemented		is w



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NAME OF FACILITY: AL-The Summit

	when her toileting services lacked evidence		
	that they were completed and R3 experienced multiple unwitnessed falls related to her need for toileting assistance.	*	
	3/4/25 11:02 AM - Findings were confirmed and discussed with E4 (ADHW).		
	3/4/25 12:15 PM - Findings were reviewed during the exit conference with E1(ED) and E4 (ADHW).		
3225.13.0	Service Agreements	000 5 40 4	
225.13.1	A service agreement based on the needs identified in the UAI shall be completed	322.5.13.1 Criteria #1 - Individual Impacted	
/S - D	prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resi-	Resident R9 is no longer resides at the facility.	
	dent and the facility shall sign the agree- ment, and each shall receive a copy of the	Criteria 2 – Identification of other residents	
	signed agreement. All persons who sign the agreement must be able to compre- hend and perform their obligations under the agreement.	The Executive Director and/or his or her designee shall audit the resident service agreements for those residents admitted from 1/1/2025 to 3/28/2025 to ensure that there was a signature from the resident	
	Based on record review and interview it was determined that for one (R9) out of thirteen residents reviewed the facility failed to ensure that service agreements contained a signature from resident/responsible party. Findings include:	and/or their responsible party. Current residents that were admitted prior to 1/1/25 shall have their service agreements updated upon annual review and/or significant change.	
	Review of R9's clinical record revealed:		
	12/17/24 - An initial service agreement was completed for R9. Review of this service agreement lacked evidence of a signature from R9 or R9's responsible party.		

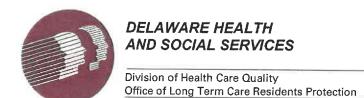


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		DATE CONVET COMPLETED. MAICH 4, 202	
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	2/4/24 - A significant change service agreement was completed for R9. Review of this service agreement lacked evidence of a signature from R9 or R9's responsible party.	Criteria #3 – System Changes Root cause analysis - No process to review signature of service agreements.	
	2/27/25 1:27 PM - During an interview E4 (ADHW) confirmed the finding. 2/28/25 1:38 PM - E1 (ED) provided the surveyor with a revised service agreement that contained the signature of R9's responsible party.	The Corporate Nurse and/or his or her designee will re-educate nursing staff to ensure that the service agreement is signed by the resident and/or responsible party and ensure that a copy is provided to the resident or responsible party. Executive Director will review and approve execution	
	3/4/25 12:15 PM - Findings were reviewed during the exit conference with E1 (ED) and E4 (ADHW.	of the service agreement and validate appropriate signatures. Criteria #4 – Success Evaluation	
3225.13.2	The service agreement or contract shall address the physical, medical, and psychosocial services that the resident requires as follows:	The Executive Director and/or his or her designee shall audit new resident's service agreements, weekly for one month and monthly for three months or until substantial compliance is achieved.	5/3/25
3225.13.2.3	Food, nutrition, and hydration services;		
S/S - D	Based on record review and interview it was determined that for one (R9) out of thirteen residents reviewed the facility failed to ensure that the service agreements contained food and nutrition information for a specified diet. Findings include: Review of R9's clinical record revealed:	3225.13.2.3 Criteria #1 - Individual Impacted Resident R9 no longer resides at the facility.	
	12/18/24 - A diet notification form documented that R9 was to receive a mechanical soft textured diet. 2/4/25 - A significant change service agreement was completed for R9. Review of this service agreement lacked evidence of R9's	Criteria 2 – Identification of other residents The Executive Director and/or his or her designee shall audit existing resident service agreements as of 3/28/25 to ensure that the service agreement contains the food and nutrition information for a specified diet.	
	2 1/11	/	



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	diet order. The space for diet order was left blank	Criteria #3 – System Changes	
	2/27/25 1:27 PM - During an interview E4 (ADHW) confirmed the finding. 2/28/25 1:38 PM - E1 (ED) provided the	Root cause analysis – No process for interdisciplinary review of diet changes existed.	
	surveyor with a revised service agreement that now identified R9's diet order.	The Corporate Nurse and/or his or her designee shall complete an in-service with	
Ķ	3/4/25 12:15 PM - Findings were reviewed during the exit conference with E1 (ED) and E4 (ADHW).	nursing staff to ensure that the service agreement includes the nutrition information for a specified diet. Resident diet changes will be reviewed daily during	
3225.13.2.9 S/S - D	Notification procedures when an incident occurs or there is a change in the health status of the resident;	stand-up meeting and will update service agreements as appropriate.	
	Based on record review and interview, it was determined that for two (R1 and R4) out of thirteen residents reviewed the facility failed to ensure that the Service Agreements contained heart failure and edema management information when the resident experienced a change in condition. For R4, the facility failed to ensure that the R4's Service Agreements contained fall precautions when she had actual falls. Findings include:	Criteria #4 – Success Evaluation The Executive Director and/or his or her designee shall audit existing resident diet changes weekly for one month and monthly for three months or until substantial compliance is achieved.	5/3/25
	1.Review of R1's clinical record revealed:	3225.13.2.9	
110	10/30/24 - A cardiology visit summary note documented, "General Heart Failure Management: -Weigh yourself every day and callif you gain more than 3 pounds in a day or more than 5 pounds -Monitor your fluid and sodium intake closely. Limit your sodium intake to less than	Criteria #1 - Individual Impacted Resident R1 – The resident's service agreement was reviewed and updated to include heart failure and edema management. Resident R4 – The resident no longer resides in the facility.	

_ Title Juntive Director Date 4/14/25



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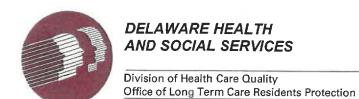
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	2000 mg daily and limit your fluid to less than		
	2 Liters (about 64 ounces daily."	3	
		Criteria 2 – Identification of other residents	
	2/27/25 - A review of R1's initial service		
	agreement lacked evidence of the heart fail-	The Executive Director and/or his or her	
	ure and edema management information.	designee shall audit existing resident	
		service agreements as of 3/28/2025 to	
	The facility failed to ensure that the Service	ensure that it includes information for when	
	Agreements contained heart failure and	there is a change of condition.	
	edema management information for R1		
	when she had a change in condition	Criteria #3 – System Changes	
	3/4/25 11:00 AM - Findings were confirmed	Root cause analysis – No process was in	
	and discussed with E4 (ADHW).	place for interdisciplinary review of	
		changes in resident condition.	
	2. Review of R4's clinical records revealed:	The Corporate Nurse and/or his or her	
	7/26/23 - R4's initial service agreement doc-	designee will re-train nursing staff to ensure	
	umented that R4 was dependent with trans-	that the service agreement includes	
	fers and toileting services. R4 received	updates related to a resident's change of	
	home health rehab services.	condition. Resident changes in condition	
	0/24/22 D4	will be reviewed during the daily stand-up	
	8/21/23 - R4 was admitted to the facility.	meeting and service plans updated as	
	8/25/23 - R4's full-service description docu-	appropriate.	
	mented that R4 was oriented to person,		
	place and time, required regular employees	Criteria #4 – Success Evaluation	
	assistance in managing bowel and/or blad-		
	der care. R4 required two person assistance	The Executive Director and/or his or her	
	for transfer and received home health re-	designee shall audit the existing resident	5 3 25
	hab services with [P2].	service agreements for updates related to a	
	0/3E/32 9:2E AAA A facility incident report	resident's change of condition weekly for one month and monthly for three months or	
	9/25/23 8:25 AM – A facility incident report documented that R4 was found on the bath-	until substantial compliance is achieved.	
	room floor and complained of right hip pain	unit substantial compliance is achieved.	
	with a pain score of 10/10. R4 was sent to		
	the [hospital] for evaluation and treatment.		
	11/20/23 - R4's significant change service		
	agreement documented that R4 was de-		
	The state of the s	l l	n:

Provider's Signature Hollings

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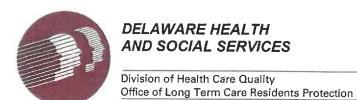
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	pendent with transfers and toileting and received home health rehab services. R4's service agreement lacked evidence that her actual fall with interventions were indicated in the significant change review.	•	
	11/30/23 - R4 was re-admitted to the facility.		
	12/2/23 5:56 PM - A nurse progress note documented, " [R4] voices unable to stand for transfer without assistc/o (complained of) right knee and arm pain. Unable to self-propel via w/c (wheelchair) to dinner"		
	12/5/23 8:30 AM - A nurse progress note documented, "[R4] found lying on the floor in the living room area."		
	The facility failed to ensure that R4's Service Agreement contained fall precautions and interventions when she had an actual fall on 9/25/23.	3225.13.3	
	3/4/25 11:05 AM - Findings were confirmed and discussed with E4 (ADHW).	Criteria #1 - Individual Impacted Resident R1 – The Service agreement was	
	3/4/25 12:15 PM - Findings were reviewed during the exit conference with E1(ED) and E4 (ADHW).	updated to include the physician's name, address, and telephone number. Residents R3, R4, and R9 no longer reside	
225.13.3	The resident's personal attending physi-	at the facility.	
/S - E	cian(s) shall be identified in the service agreement by name, address, and telephone number.	Criteria #2 – Identification of other residents	
	Based on record review and interview it was determined that for four (R1, R3, R4 and R9) out of thirteen residents reviewed the facility failed to ensure that service agreement contained required physician information. Findings include:	The Executive Director and/or his or her designee shall audit all existing resident's service agreements as of 3/28/2025 to ensure it contains the physician's information including name, address, and telephone number.	

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	AT A TOTAL COLOR AND A DESIGNATION OF A	DATE SURVEY COMPLETED: March 4, 2025	
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	1.Review of R9's clinical record revealed: 12/17/24 - An initial service agreement was completed for R9. Review of this service agreement lacked evidence of identification of R9s' attending physicians' information including their name, address, and telephone number. 2/4/25 - A significant change service agreement was completed for R9. Review of this service agreement lacked evidence of identification of R9s' attending physician's information including their name, address, and telephone number. 2/27/25 1:27 PM - During an interview E4 (ADHW) confirmed the finding. 2/28/25 1:38 PM - E1 (ED) provided the surveyor with a revised service agreement that now identified R9's attending physician and the physician's information. 2.Review of R1's clinical record revealed: 4/26/24 - An initial service agreement was completed for R1. Review of this service agreement lacked evidence of identification of R1's attending physician's information including the name, address and telephone number. 3/4/25 11:05 AM - Findings were confirmed and discussed with E4 (ADHW). 3. Review of R3's clinical records revealed: 11/29/23 - An initial service agreement was completed for R3. Review of this service	Criteria #3 – System Changes Root cause analysis – No auditing process for completion of service agreement. The Executive Director and/or his or her designee shall complete re-education for nursing staff to ensure that the service agreement includes the physician's information including name, address, and telephone number. Criteria #4 – Success Evaluation The Executive Director and/or his or her designee shall audit the current resident's service agreements as of 3/28/2025 weekly for one month and monthly for three months or until substantial compliance is achieved.	5/3/25

Provider's Signature Jessy Hallinger

Title Lefutive Dreck Date

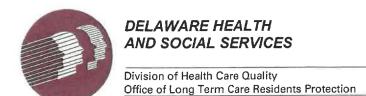
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	of R3's attending physician's information in-			
	cluding the address and telephone number.	a		
	3/4/25 11:05 AM - Findings were confirmed and discussed with E4 (ADHW).	3225.13.6		
	4. Review of R4's clinical record revealed:	Criteria #1 - Individual Impacted		
	7/26/23 - An initial service agreement was completed for R4. Review of this service agreement lacked evidence of identification of R4's attending physician's information including the name, address and telephone number.	R1 Service agreement updated to reflect interventions for heart failure and edema management information. R11 service agreement updated to reflect interventions related to falls and hospice information. Residents R3, R4, and R5 – no longer reside in the facility.		
	3/4/25 11:05 AM - Findings were confirmed and discussed with E4 (ADHW).	Criteria #2 – Identification of other residents		
	3/4/25 12:15 PM - Findings were reviewed during the exit conference with E1(ED) and E4 (ADHW).	The Executive Director and/or his or her designee shall audit the existing resident's		
3225.13.6 S/S - E	The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction	service agreements (as of 3/28/2025) to ensure that it contains all updates of services and changes of condition.		
	with each UAI. Within 1 days of such assessment, the resident and the assisted liv-	Criteria #3 – System Changes		
	ing facility shall execute a revised service agreement, if indicated.	Root cause analysis – No interdisciplinary process for review of changes in condition.		
	Based on record review and interview, it was determined that for five (R1, R3, R4, R5 and R11) out of thirteen residents reviewed the facility failed to ensure that the residents' Service Agreements were updated when there were significant changes. Find-	The Corporate Nurse and/or his or her designee will re-train nursing staff to ensure that the service agreement includes changes of condition or services needed. Resident changes in condition will be		
	ings include: 1.Review of R1's clinical record revealed:	reviewed during the daily stand-up meeting and service agreements updated as appropriate.		
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STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR Completion CORRECTION OF DEFICIENCIES WITH Date ANTICIPATED DATES TO BE CORRECTED
8/31/24 11:39 AM - A nurse documented that R1 was stat mitted to the facility.	
9/24/24 6:13 PM - A nurse documented, "[R1] is on serving home health agency] for leg ed	ice with [P3, designee shall audit the service
documented, "antibiotic for lextremity) cellulitis [P2, he wound care nurse to see reside	LE (left lower 3/4/2024 to 3/28/2025. This shall be completed weekly for one month and
2/14/25 7:42 AM — A nurse produced and a nurse prod	rogress note to return to ymphedema
2/27/25 2:30 PM - Review of agreements lacked evidence to viewed and updated to reflect tions to address R1's heart failure management information.	the interven-
3/4/25 11:00 AM - Findings w with E4 (ADHW).	ere discussed
2. Review of R3's clinical record	s revealed:
6/19/24 – R3's full-service described that R3's mobility status that R3 required employees to push wheelchair because of a patation. R3 has had more than or last three months and utilized ration health [P2] as a third-party provices.	es indicated escort or enysical limi- e fall in the ehab home



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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	
	8/29/24 - R3's hospice start of care date.			
	1/2/25 - R3's full-service description docu-			
	mented that R3's mobility status indicated			
	that R3 required two-person assistance for			
	transfers. Approaches to include:			
	- "Remind resident to wait for transfer assis-			
	tance.			
	-Ensure that two persons are available to			
	assist with the transfer.			
	-Assist resident to transfer using good tech-			
	nique to protect resident and staff.			
	-Report increasing difficulty with transfer or			
	other safety concerns.			
	R3 has had more than 1 fall in the last three			
	months and utilized hospice [P3] service as			
	a third-party provider."			
	2/27/25 1:23 PM - In an interview, P5 (P3 -			
	RN) stated that she got called by the facility			
	for R3's multiple falls. P5 stated, "I always			
	educate her [R3] on the use of the pendant			
	to call for assistance with transfers, but she			
	forgets to do that. I saw her a few minutes			
	ago. I just went to her room, and I saw her			
	in the bathroom. She needs help. She can-			
	not remember to push her pendant to call			
	for help."			
	The facility failed to review and undete B24			
	The facility failed to review and update R3's Service Agreement when R3 was admitted			
	to hospice services.			
	to hospice services.			
	3/4/25 11:02 AM - Findings were discussed			
	with E4 (ADHW).			
	3. Review of R4's clinical records revealed:	1		
ider's Signa	10 11 11.	Executive Director Date 4/14	1	



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	7/26/23 - R4's initial service agreement doc-		
	umented that R4 was dependent with trans-		
	fers and toileting services.		
	8/21/23 - R4 was admitted to the facility.		
	8/25/23 - R4's full-service description docu-		
	mented that R4 was oriented to person,		
	place and time, required regular employees		
	assistance in managing bowel and/or blad-		
	der care. R4 required two-person assistance	·	
	for transfer and was receiving home health		
	services with [P2].		
	services with [P2].		
	9/25/23 8:25 AM - A facility incident report		
	documented that R4 was found on the bath-		
	room floor and complained of right hip pain		
	with a pain score of 10/10. R4 was sent to		
	the [hospital] for evaluation and treatment.		
	11/20/23 - R4's significant change service		
	agreement documented that R4 was de-	.,	
	pendent with transfers and toileting and re-		
	ceived home health rehab services. R4's ser-		
	vice agreement lacked evidence that her ac-		
	tual fall with interventions were indicated in		
	the significant change review.		
	11/30/23 - R4 was re-admitted to the facil-	1	
	ity with diagnoses including post joint re-		
	placement surgery (from hip fracture).		
	11/30/23 5:16 PM - A nurse progress note	s	
	documented, "Right leg brace intact. [R4]		
	c/ (complained of) pain in right knee and		
	was unable to stand and transfer to weight		
	chair history of falls"		
	12/2/23 5:56 PM - A nurse progress note		
	documented, " [R4] voices unable to stand		
	for transfer without assistc/o (complained		
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	of) right knee and arm pain. Unable to self-		
	propel via w/c (wheelchair) to dinner"		
	12/5/23 8:30 AM - A nurse progress note		
	documented, "[R4] found lying on the floor		
	in the living room area."		
	The facility failed to ensure that R4's actual		
	fall with interventions were indicated in the		
	significant change review after her fall with		
	a broken hip on 9/25/23		
	3/4/25 11:05 AM - Findings were confirmed		
	and discussed with E4 (ADHW).		
	4. Review of R5's clinical records revealed:		
	2/21/23 - R5's full-service description docu-		
	mented that R5 required regular prompting		
	due to confusion and disorientation, wan-		
	dered in public but not intrusive; was inde-		
	pendent with mobility and has had no falls.		
	2/22/23 - R5's initial service agreement doc-		
	umented that R5 was independent with		
	transfers and walking. R5 did not require an		
	assistive device for ambulation.		
	9/6/23 12:10 PM - A facility incident report	,	
	documented, " [R5] observed with pants		
	at her ankles, no shoes and sitting on the		
	floorattempted ROM (range of motion),		
1	[R5] displays discomfort bottom and		
	hipshospital for eval"		
	11/1/23 - R5 was readmitted to the facility		
	with diagnoses including high fall risk and		
	multiple pelvic and sacral fractures		
	1/22	11	,
ider's Signa	Titl	Executive Director Date 4/14	125



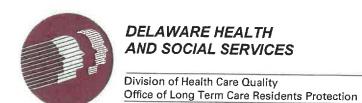
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	11/2/23 1:56 PM - A nurse progress note		
	documented, " s/p (status post) readmis-		
	sion [R5] assisted with ADLs. Alert and		
	oriented to self only. Needs constant redi-		
	rection. Seen by therapy today. Therapy		
	gave resident a walker. [R5] remains a fall		
	risk Caregivers to closely monitor."		
	3/1/25 - A review of R5's incident reports		
	from November 2023 through March 2024		
	revealed the following actual falls:		
	- 11/23/23 4:20 PM - " found on the floor		
	discomfort of her left arm grunt in pain		
	facial grimacing sent out to hospital"		
	- 1/21/24 6:30 PM - " was sitting on the		
	floor, on her bottom with legs in flexed po-		
	sition"		
	- 1/28/24 8:08 AM - " found sitting on the		
	floor in her room"		
	- 3/2/24 8:00 AM - " was dancing and lost	1	
	her balance and fell onto the floor"		
	- 3/3/24 11:30 AM - " collided with an-		
	other resident then fell on the floor"		
	The facility failed to review R5's service		
	agreement when R5 had increasing actual		
	falls with injuries and her needs have		
	changed and in conjunction with R5's UAI.		
	3/4/25 11:08 AM - Findings were confirmed		
	and discussed with E4 (ADHW).		
	5. Review of R11's clinical records revealed:		
	12/19/22 - R11's initial service agreement		9
1010	documented that R11 was independent		
	with transfers and walking. R11 did not re-		
	quire an assistive device or ambulation.		
ider's Signa	ture kum Holling 11 Tit	executive Diccor Date 4/14	Le
_		Dale 7/19	100

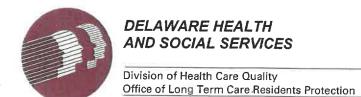


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	R11's safety interventions included 1 hourly safety checks.		
	8/2/23 - R11's full-service description documented that R11 required regular prompting due to confusion and disorientation, wandered in public but not intrusive; was independent with mobility and has had more than one fall in the last 3 months.		
	12/19/23 - R11's annual service agreement documented that R11 required assistance with transfers and walking. R11 did not require an assistive device or ambulation. R11's safety interventions included 1 hourly safety checks.		
	3/4/25 9:48 AM - A review of R11's incident reports from January 2024 through March 2024 revealed the following actual falls:		
	-1/6/24 12PM - fell and was found in the dining room -1/12/24 7:30 AM - found on floor bleeding		
	from his forehead sent to the ER (emergency) -1/20/24 8:00 AM - found on floor with pil-		
	low under head and blanket over him -2/20/24 6:48 AM - fell on floor, combative to staff and was sent to the ER		
	-2/28/24 6:00 PM - tried to sit down, there was no chair, combative to staff -2/29/24 4:50 PM - fell down on floor on		
	right side, combative with assisting up -3/3/24 11:30 AM - collided with another resident then fell on the floor -3/6/24 2:30 AM - [R11] was on the floor in		
	the bathroom -3/7/24 12:27 PM - [R11] on the floor face down		



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	The facility failed to review R11's service agreement in conjunction with R11's UAI. R11 had increasing actual falls with injuries and his needs changed when he was admitted to hospice services on 2/24/24 3/4/25 11:12 AM - Findings were confirmed	•	
	and discussed with E4 (ADHW). 3/4/25 12:15 PM - Findings were reviewed during the exit conference with E1(ED) and E4 (ADHW).		
3225.19.0	Records and Reports		
3225.19.1 5/S - E	The assisted living facility shall be responsible for maintaining appropriate records for each resident.	3225.19.1	
	Based on record review and interview it was determined that for three (R1, R3, and R9) out of thirteen residents reviewed the facility failed to maintain appropriate records. Findings include: 1.Review of R9's clinical record revealed: January 2025 - Review of the ADL's documentation completed by care managers for R9 lacked documentation to attest completion of ADLs, and safety checks. Day shift had twelve missed entries, evening shift had twenty-two missed entries, and night shift had ten missed entries. February 2025 - Review of the ADL's documentation completed by care managers for R9 lacked documentation to attest completion of ADLs, and safety checks. Day shift had sixteen missed entries, evening shift	Criteria #1 - Individual Impacted Resident R1 – The Physician was notified of the of previous missing doses of medication from 12/24 and 1/25. The Executive Director or his or her designee shall be reaching out to the cardiologist and/or the attending physician to review the daily weight orders. Resident R3 and R9 are no longer in the facility. Criteria #2 – Identification of other residents The Executive Director and/or his or her designee shall audit existing resident's medical records from 1/1/2025 to 3/28/2025 for documentation of medication and care.	

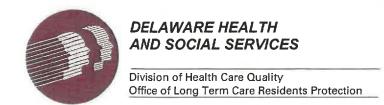


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NAME OF FACILITY: AL-The Summit

Provider's Signature

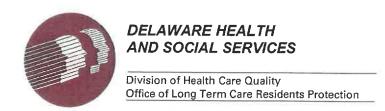


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NAME OF FACILITY: AL-The Summit

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	7/5/24 - R1 had a physician's order for levothyroxine 88 mcg 1 tablet with 100 mcg (total dose = 188 mcg) by mouth once daily for hypothyroidism.		
	8/30/24 - R1 had a physician's order for Humulin N 4 units subcutaneous twice a day for diabetes.	·	
	11/6/24 - R1 had a physician's order for Mjev inject 22 units subcutaneous daily in the afternoon for diabetes.		
	11/6/24 - R1 had a physician's order for Mjev inject 10 units subcutaneous at bedtime for diabetes.	*	
	2/27/25 - A review of R1's MAR (Medication Administration Record) from December 2024 through January 2025 revealed the fol- lowing missing doses: 5 pm - Humulin N 45 units one out of 31 doses on 12/14/24		
	12 pm - Mjev 22 units three out of 27 doses on 1/2/25, 1/12/25 and 1/14/25 8 pm - Mjev 10 units two out of 26 doses on 1/19/25 and 1/22/25		
	8 am - levothyroxine 100 mcg 1 tablet with 88 mcg (total dose = 188 mcg) five out of 31 doses on 1/14/25, 1/18/25, 1/20/25, 1/24/25 and 1/28/25.		
	3/4/25 11:00 AM - Findings were discussed with E4 (ADHW).		
	3. Review of R3's clinical record revealed:		
		itle Jentin Breck Date 4/1	

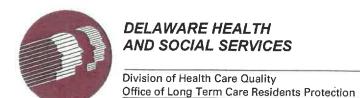


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NAME OF FACILITY: AL-The Summit

RATOR'S PLAN FOR OF DEFICIENCIES WITH ATES TO BE CORRECTED	Completion Date
R5, and R9 are no longer The Executive Director will as available and are not able to recall. Thiness statements will be Thiched to the incident Thinest and/or his or her dit the electronic incident from 1/1/2025 to cumentation of witness dentified shall be	
	ridual Impacted , R5, and R9 are no longer ne Executive Director will as available and are not able to recall. vitness statements will be ached to the incident tification of other ector and/or his or her adit the electronic incident from 1/1/2025 to cumentation of witness dentified shall be ached to the applicable



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NAME OF FACILITY: AL-The Summit

Provider's Signature _

STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES SPECIFIC DEFICIENCIES Were retained with witness statements regarding fall incident reports that were unable to be located. Findings include: 1.Review of R9's clinical record revealed: 1/17/25 - An incident report was created in reference to R9 experiencing a fall. The incident report lacked documentation of witness statements. 2/7/25 - An incident report was created in reference to R9 experiencing a fall. The incident report lacked documentation of witness statements. 3/4/25 11:17 AM - During an interview E1 (ED) confirmed the facility was unable to locate witness statements to correlate with the incident reports that documented R9's falls. E1 stated, "We do them, but I just can't locate them." 2. Review of R3's clinical record revealed: March 2024 - February 2025 - Twentyseven (27) incident reports were created in reference to R3 experiencing multiple falls. Seventeen (17) incident reports lacked documentation of witness statements. 3/4/25 11:02 AM - Findings were discussed with E4 (ADHW). 3. Review of R4's clinical record revealed: September 2023 - December 2023 - Two (2) incident reports lacked documentation of witness statements. complete on the A experiencing multiple falls. Two (2) incident reports were created in reference to R4 experiencing multiple falls. Two (2) incident reports were created in reference to R4 experiencing multiple falls. Two (2) incident reports lacked documentation of witness statements.	NAME OF	FACILITY: AL-The Summit	DATE SURVEY COMPLETED:	March 4, 2025	
garding fall incident reports that were unable to be located. Findings include: 1.Review of R9's clinical record revealed: 1/17/25 - An incident report was created in reference to R9 experiencing a fall. The incident report lacked documentation of witness statements. 2/7/25 - An incident report was created in reference to R9 experiencing a fall. The incident report lacked documentation of witness statements. 3/4/25 - An incident report was created in reference to R9 experiencing a fall. The incident report lacked documentation of witness statements. 3/4/25 - An incident report was created in reference to R9 experiencing a fall. The incident report lacked documentation of witness statements. 3/4/25 - An incident report was created in reference to R9 experiencing a fall. The incident reports of R9's experiencing multiple falls. Seventien (17) incident reports were created in reference to R9 experiencing multiple falls. Seventeen (17) incident reports lacked documentation of witness statements. 3/4/25 - An incident report was created in reference to R9 experiencing a fall. The incident reports for follow-up. The Executive Director shall be responsible for reviewing all incident reports for completeness and signature. Criteria #3 - System Changes Root cause analysis - No audit of incident reports to relident reports to were abing uploaded. The Corporate Nurse and/or his or her designee shall re-train nursing staff to ensure that witness statements are collected and then scanned and attached to the incident reports for follow-up. The Executive Director shall be responsible for reviewing all incident reports for completeness and signature. Criteria #3 - System Changes Root cause analysis - No audit of incident reports to relident reports to relidence relevant documents were being uploaded. The Corporate Nurse and/or his or her designee shall re-train nursing staff to ensure that withs executive Director shall be responsible for reviewing all incident reports for completeness and signature. Criteria #3 -	SECTION		CORRECTION OF DEFICIENCIES WITH	-	
		garding fall incident reports that were unable to be located. Findings include: 1.Review of R9's clinical record revealed: 1/17/25 - An incident report was created in reference to R9 experiencing a fall. The incident report lacked documentation of witness statements. 2/7/25 - An incident report was created in reference to R9 experiencing a fall. The incident report lacked documentation of witness statements. 3/4/25 11:17 AM - During an interview E1 (ED) confirmed the facility was unable to locate witness statements to correlate with the incident reports that documented R9's falls. E1 stated, "We do them, but I just can't locate them." 2. Review of R3's clinical record revealed: March 2024 - February 2025 - Twenty - seven (27) incident reports were created in reference to R3 experiencing multiple falls. Seventeen (17) incident reports lacked documentation of witness statements. 3/4/25 11:02 AM - Findings were discussed with E4 (ADHW). 3. Review of R4's clinical record revealed: September 2023 - December 2023 - Two (2) incident reports were created in reference to R4 experiencing multiple falls. Two (2) incident reports lacked documentation of wit-	Root cause analysis – No audit of incident reports to validate relevant documents were being uploaded. The Corporate Nurse and/or his or her designee shall re-train nursing staff to ensure that witness statements are collected and then scanned and attached to the incident reports for follow-up. The Executive Director shall be responsible for reviewing all incident reports for completeness and signature. Criteria #4 – Success Evaluation The Executive Director and/or his or her designee shall perform random audits for witness statements entered into and/or uploaded into the electronic incident reporting system and to ensure that they are attached to the applicable incident reports. This shall be performed weekly for one month and monthly for three months or	5 3 25	



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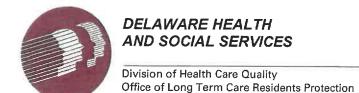
NAME OF FACILITY: AL-The Summit

DATE SURVEY COMPLETED: March 4, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
16 Del. Code, Chapter 11 Subchapter		CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED 16 Del. Code, Chapter 11 Criteria #1 - Individual Impacted Resident R9 is no longer at the facility. Criteria #2 – Identification of other residents An audit of all current assisted living	
II Abuse, Neglect, Vistreat- nent or Fi- nancial Ex-	illness. Neglect includes all of the follow- ing: a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals and safety.	residents as of 3/28/2025 was conducted to verify that the space for diet order is completed on the current service agreement.	

Provider's Signature Hally

Title Director Date 4/14/25



STATE SURVEY REPORT

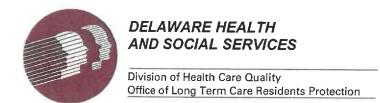
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NAME OF	FACILITY: <u>AL-The Summit</u>	DATE SURVEY COMPLETED: M	arch 4, 2025	
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date	
of Residents or Patients	This requirement is not met as evidenced by: Based on record review and interview it was determined that for one (R9) out of seven residents reviewed for accidents the facility failed to prevent resident neglect when on	Criteria #3 – System Changes Chefs in the dietary department have been		
	1/2/25 R9 was served a meal that was not the dietary texture required and experienced a choking episode, placing R9 at risk for a serious outcome including death. When R9 began to choke, staff performed the Heimlich maneuver. R9 was then sent to the hospital where diagnostic imaging identified a broken rib. On 2/28/25 at 10:29 AM The facility was notified of the identification of an immediate jeopardy related to neglect and an IJ template was provided. On 2/28/25 at 3:29 PM The facility provided an abatement plan. The IJ was fully abated on 3/2/25 at 3:00 PM. Findings include: Review of R9's clinical record revealed: 12/17/24 - An initial service agreement was completed for R9. Review of this service	re-educated on the preparation of mechanically altered diets. Chefs will use diet order communication from nursing staff to identify residents with altered diets. The altered diets will be prepared in the main kitchen and then transferred to the memory care units. Servers will deliver*food prepared by chefs in the kitchen to the correct residents. Reviewed and revised the communication process from the physician order to the notification of the culinary staff of mechanically altered diets. Cooks are labeling food with the resident's name and diet and it on only removed when served to the resident. Triple check system implemented to validate correct diet and resident completed by cook, server, and manager.		
	agreement lacked evidence of R9's diet order. The space for diet order was left blank. 12/18/24 - R9 was admitted to the facility. 12/18/24 - A diet notification form documented that R9 was to receive a mechanical soft textured diet. 1/2/25 6:00 PM - A facility incident report documented, "Resident in dining room, observed choking on food. Heimlich maneuver performed by caregiver in the dining room the nurse immediately notified. Heimlich	A CPR course, including the Heimlich Manuver, was provided to staff who had an expired certification. Med Techs will be designated as the CPR certified employee on each shift.		

Provider's Signature

maneuver [three times], resident expelled a

Title Director Date 4/14/25



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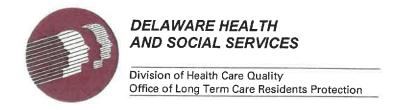
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NAME OF FACILITY: AL-The Summit

NAME OF	FACILITY: <u>AL-The Summit</u>	DATE SURVEY COMPLETED: 1	March 4, 2025	
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date	
	large chunk of food. 911 notified. Resident transported to [hospital] ER for further evaluation." 1/2/25 untimed - A statement written by E16 (server) documented, "On the night of 1/2/25 I was a server. I prepared a plate that was mechanical soft and gave it to the caregiver [care manager] to give to the resident. Resident ended up choking on a piece of meat that I thought was chopped up enough." 1/2/25 untimed - A statement written by E15 (CM) documented, "I was in the dining room when I received a plate from the server to give to the resident. I was not aware at the time that the resident was on a mechanical soft diet." 1/2/25 - E18 (former DHW) and E6 (CSS) implemented a "change in procedure for preparing mechanically altered dietsall mechanically altered diets Including mechanical soft and puree diets will be prepared by Chef in the main kitchen before being transferred to the memory care kitchens on the [units]. The servers will no longer be responsible for altering meals for mechanical soft diets."	Criteria #4 – Success Evaluation The Executive Director an/or his or her designee shall perform random audits of CPR certified employees on each shift. The Director of Culinary/designee will perform random audits of documented checks of food consistency for mechanically altered diets. This will be completed weekly for one month and monthly for three months or until substantial compliance is achieved.	5/3/25	
	1/3/25 3:18 AM - A CT of R9's chest and abdomen was performed at the hospital for "blunt abdominal trauma". The results of the CT indicated that R9 had a new broken rib.			
	1/3/25 5:02 AM - Hospital discharge paper- work documented R9 was seen in the ER for a broken rib.			

Provider's Signature Juny Holl

Title secution Director Date 4/14/25



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NAME OF FACILITY: AL-The Summit

DATE SURVEY COMPLETED: March 4, 2025

STATEMENT OF DEFICIENCIES		ADMINISTRATOR'S PLAN FOR	Completion
SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Date
	1/3/25 6:13 AM - A progress note in R9's clinical record documented, "Emergency Room/Visit -Resident returned to facility from ER via family transport. Accompanied by daughter and spouse. Discharge paperwork given to nurse on duty. Discharge paperwork states resident was seen for fracture of rib to the left side." 1/3/25 3:00 PM - E1 (ED) conducted education to the cooks in the dining services department on modified and mechanically altered diets and implementation of the new procedure for altered diets.	•	
	1/3/25 untimed - E18 (former DHW) and E3 (MCD) provided education to the facility's care managers, including E15 (CM), on resident service agreements as a resource for resident diet information. This training was conducted following the choking incident involving R9 on 1/2/25, when E15 (CM) served the resident.		
	2/4/25 - A significant change service agreement was completed for R9. Review of this service agreement lacked evidence of R9's diet order. The space for diet order was left blank.		
	2/27/25 11:15 AM - During an interview E17 (server) assigned to the basement dining area of the memory care unit denied receiving recent education regarding dietary textures of residents.		
	2/27/25 11:20 AM - During an interview E16 (server) assigned to the first floor dining		

Provider's Signature Juny Holling

Title Jeantive Direct Date 4/14/55



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

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NAME OF FACILITY: AL-The Summit

DATE SURVEY COMPLETED: March 4: 2025

NAME OF FACILITY: AL-The Summit		DATE SURVEY COMPLETED: N	: March 4, 2025	
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date	
	area of the memory care unit denied receiv- ing recent education regarding dietary tex- tures of residents.			
	2/27/24 12:48 PM - During an interview E5 (CSS) stated, "The nurse explained the plate must not have been chopped up enough and said we need to be more careful between the servers and the aides [care managers] and moving forward we decided that instead of the servers it [mechanical soft diets] would come from the kitchen like the pureed plates do. The servers used to chop it up and put the gravy on it. We told her to be more careful and that we would have the [mechanical soft] plates come from the kitchen. She [E16 (server)] made it seem like the aides [care managers] gave the wrong plate."			
	2/28/25 at 10:29 AM - The facility was notified of the identification of an immediate jeopardy related to neglect and an IJ template was provided.			
	2/28/25 10:33 AM - During an interview E15 (CM) stated "I think the person working that day was not aware or didn't know the food wasn't chopped enough. I didn't know [R9] was on a special diet". E15 then confirmed receiving education after R9's choking accident and was able to articulate where to find information on resident diets.			
	The facility provided the following corrective measures:			
	2/28/25 11:50 AM - E6 (CSS) began to inservice all kitchen staff on altered diets. E16 (server) that provided R9's meal on 1/2/25			

Provider's Signature Terry Hollinger Title wentive Directer Date 4/14/25



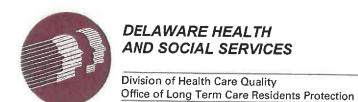
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	during the choking incident was educated at that time.		
	2/28/25 1:38 PM - E1 (ED) provided the surveyor with a revised service agreement that now identified R9's diet order.		
	2/28/25 3:29 PM - The facility provided an acceptable abatement plan in response to the identified immediate jeopardy concerning R9.		
	3/2/25 3:00 PM - The of education of all kitchen staff was completed by E6 (CSS).		
	3/3/25 12:28 PM - E1 (ED) confirmed that the facility abatement time for the immediate jeopardy was 3/2/25 at 3:00 PM.		
	The following interviews were conducted to confirm receiving education and ability to articulate contents:		
	2/27/25 11:57 AM - E13 (LPN; HCC).		
	2/27/25 12:05 PM - E19 (CM; MT).		
	2/28/25 10:33 AM - E15 (CM).		
	2/28/25 12:06 PM - E20 (CM) and E21 (CM).		
	2/28/25 12:10 - E17 (server).		
6	2/28/25 12:24 PM - E23 (CM) and E24 (CM).		
	2/28/25 12:20 - E27 (LPN; HCC).		
	2/28/25 1:35 PM - E25 (cook).		
	3/3/25 11:10 AM - E35 (CM).		
	3/3/25 11:30 AM - E22 (CM).		
	3/3/25 11:40 AM - E26 (CM)		
	3/3/25 11:14 AM - E28 (server).		



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NAME OF FACILITY: AL-The Summit

DATE SURVEY COMPLETED: March 4, 2025

TRAIL OF FACILITY. AL-THE SUMMIT		DATE SURVEY COMPLETED: March 4, 2025		
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date	
	3/3/25 11:25 AM - E16 (server).			
	3/3/25 1:30 PM to 1:37 PM - The following servers confirmed receiving education and were able to articulate contents: E29, E30, E3, E32, E33 and E34.	ile:		
	3/4/25 12:15 PM - Findings were reviewed during the exit conference with E1(ED) and E4 (ADHW).			

Provider's Signature Kun Hollinge

Title Director Date_

4/14/25