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 11, 2025

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 September 8, 2025, through September 11, 2025. The deficiencies contained in this report are based on observation, interview and record review. The census on the first day of the survey was sixty-six (66). The survey sample was twenty-one (21). Abbreviations/definitions used in this state report as follows: ADHW - Assistant Director of Health and Wellness; BCC- Background Check Center; CM – Care Manager; CSS – Culinary Services Supervisor; DHCQ- Division of Health Care Quality; DHSS- Division of Health and Social Services; DLTCRP – Division of Long-Term Care Residents Protection; DHW – Director of Health and Wellness; ED – Executive Director; HCC – Health Care Coordinator; IC - Infection Control; LPN – Licensed Practical Nurse; RN – Registered Nurse; q- every. Activities of daily living (ADL) - tasks needed for daily living,		

Provider's Signature T Cavaccini Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	e.g. dressing, hygiene, eating, toileting, bathing; Antibiotic – a type of medicine used to treat and prevent infections caused by bacteria; Anti-infectives – medications that inhibit or kill microorganisms, such as bacteria, viruses, fungi and parasites; Anxiety- general term for several disorders that cause nervousness, fear, apprehension and worrying; COVID 19/SARS CovV-2/Coronavirus – a respiratory illness that can be spread person to person; Chronic kidney disease- condition characterized by a gradual loss of kidney function over time; Contusion – a bruise; Dementia- a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation; Electronic Medical Record (EMR) - a systematized collection of patient and population electronically stored health information in a digital format; Hyperlipidemia - high cholesterol or triglycerides (fat proteins) associated with increased risk for heart disease and stroke; Hypertension- high blood pressure; leading cause of stroke;		

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225 **3225.8.0** **3225.8.6** **S/S – D**	Infection Prevention and Control Program (IPCP) - a core set of infection prevention and control practices that are required in all healthcare settings; Influenza – a contagious respiratory infection caused by a virus that affects the nose, throat, and lungs; Osteoporosis- weakened bones with increased risk of breaking; Pneumococcal – refers to streptococcus pneumoniae bacteria that can cause lung, bloodstream, brain, and spinal cord infections; Psychotic disorder- severe mental disorders that cause abnormal thinking and perceptions; Quality Assurance Performance Improvement (QAPI) – a program that systematically identify and correct gaps in care, improve processes, and promote better patient outcomes by involving all staff in a continuous proactive improvement; Resident Services Agreement- A written document developed with each resident which describes what services will 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;		

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Transmission Based Precautions (TBP) – infection control measures used in healthcare settings to prevent the spread of microorganisms that can be transmitted through contact with an infected patient, their body fluids, or contaminated surfaces or objects; Uniform Assessment Instrument (UAI) - an assessment tool used to evaluate resident function; **Title 16, Health & Safety Delaware Administrative Code** **Assisted Living Facilities** **Medication Management** **Within 30 days after a resident's admission and concurrent with all UAI-based assessments, the assisted living facility shall arrange for an on-site review by an RN of the resident's medication regime if he or she self-administers medication. The purpose of the on-site review is to assess the resident's cognitive and physical ability to self-administer medication or the need for assistance with or staff administration of medication.** This requirement was not met as evidenced by:	**Medication Management** **the facility failed to conduct a RN onsite review of the resident's medication regime concurrent with the UAI-assessment.** 1. The medication review has been completed for R13 and is in the medical record. 2. All residents who self-administer medications will have their records reviewed by the Director of Health and Wellness(RN) or Assistant director of health and wellness to ensure a medication regime review was completed by an RN concurrent with their last UAI. 3. Root cause analysis showed that a system was lacking for identification of residents responsible for their own medication management prior to the completion of the UAI. A tracking process will be implemented to ensure that the medication review process is completed by an RN concurrent with each UAI for residents who administer their own medications. Executive Director will review the tracking process with The Director Of Health And Wellness (RN) and Assistant Director of Health And Wellness to ensure un-	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225 **3225.9.0** **3225.9.5** **3225.9.5.2.** **3225.9.5.2.4** **S/S – E**	Based on record review and interview, it was determined that for one (R13) out of eight residents reviewed for medication management, the facility failed to conduct a RN onsite review of the resident's medication regime concurrent with the UAI-based assessment. Findings include: A review of R13 's clinical record revealed: 12/2/24 – R13 was admitted to the facility with diagnoses including osteoporosis, hypertension, and hyperlipidemia. 4/30/25 – R13's annual UAI assessment was completed. 5/15/25 – R13's Resident Service Agreement was completed indicating that R13 self-administers medication. 9/11/25 10:40 AM – During an interview, E3 (Asst. DHW) stated, "We don't have documentation of an RN assessment of this resident's medication regime." 9/11/25 2:45 PM – Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference. **Title 16 Health and Safety** **Assisted Living Facilities**	derstanding. The Director of Health and Wellness (RN) or designee will be responsible for monitoring on an ongoing basis. 4. As part of QAPI, the UAI assessment process will be reviewed to ensure residents who self-administer medications have a medication review completed by an RN with each UAI. This review will be weekly for 4 weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is maintained and then quarterly. Date of compliance: 10/24/2025 Responsible party for ongoing compliance: Director of Health and Wellness(RN) or designee	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.9.6 S/S – D	**Infection Control** **Requirements for tuberculosis and immunizations:** **Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test such as Quantiferon.** **A report of all test results shall be kept on file at the facility of employment.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for three (E13, E14, and E15) out of ten staff reviewed for staffing, the facility failed to have tuberculosis (TB) test results on file. Additionally, for one (E16) staff, the facility had only one result of one step of the TB testing. Findings include: 9/10/25 1:14 Pm – A review of E16's facility employee file revealed the results of only a one step TB test. The facility failed to have evidence of the required base line	**Infection Control** the facility failed to have tuberculosis (TB) test results on file. 1. E14, and E15 were employed through an agency and no longer work at the facility. E13 and E16's records have been updated to include results of TB testing. 2. Facility HR files will be reviewed to ensure TB records are present and complete. Files of agency employees will be checked for TB testing records prior to scheduling. 3. Root cause analysis showed that the new hire checklist was not reviewed for completion prior to the employee start date. For agency staff, the results of TB testing were not maintained in the facility, but by the agency and so were not reviewed by the facility. The facility new hire checklist will be reviewed to ensure TB test results are included in each employee file. The checklist will be signed by the Human Resource director and/or Executive Director or designee. The agency employee checklist will be revised to include a completed TB test. The checklist will be reviewed by the Director of Health and Wellness or designee prior to scheduling. The Executive Director will review these processes with the Director of Health and Wellness (RN) and Assistant Director of Health and Wellness and Human Resource Director to ensure understanding. The Director of Health and Wellness(RN) or designee will be responsible for ongoing compliance of agency files and the Human Resource Director of employee files. 4. The HR checklists of all new employees and all scheduled agency employees will be reviewed weekly for 4 weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is maintained and then quarterly. Date of Compliance: 10/24/2025	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.9.7 S/S – D	two step TB test or TB blood test for E16. 9/11/25 11:45 AM – A follow up interview with E1 and E3 revealed the facility was not able to obtain documentation of E13, E14 and E15's TB testing from the contracted agency. The facility failed to have documentation of employees' TB testing results. 9/11/25 2:45 PM - Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference. **The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against influenza must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** This requirement was not met as evidenced by:	Responsible party for overall compliance: Executive Director **Influenza vaccine** the facility failed to have on file documentation of annual influenza vaccination being administered or offered and declined 1. Resident R1's responsible party declined the influenza vaccine administered at the 2025/2026 Influenza vaccine clinic in September 2025. A declination was signed and is in the medical record. 2. All residents were offered the influenza vaccine at the Flu Clinic which was held on September 25, 2025. Their records will reviewed to ensure there is documentation of acceptance or declination of the 2025/2026 influenza vaccine and DELVAX checked to ensure it reflects that vaccine's administration. The Director of Health and Wellness(RN) or designee will be responsible for reviewing vaccine records. 3. Root cause analysis showed that the facility did not keep a record of vaccine declinations, only acceptance. The DELVAX system was not used to track vaccine administration by the facility. Education will be conducted by the Director of Health and Wellness and/or Assistant Director of Health and Wellness with the nursing team to ensure understanding of the process of vaccine administration including	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Based on record review and interview, it was determined that for one (R1) out of three residents reviewed for infection control, the facility failed to have on file documentation of annual influenza vaccination being administered or offered and declined. Findings include: A review of R1's clinical record revealed: 2/1/23 – R1 was admitted to the facility with diagnoses including hypertension, hyperlipidemia, and anxiety. 9/8/25 11:00 AM – A request for documentation of influenza vaccination status for R1 was given to E3 (Asst. DHW). 9/11/25 10:40 AM- During an interview E3 stated, "I did not find documentation of influenza or pneumococcal vaccines for [R1]." 9/11/25 2:45 PM – Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference.	documentation of refusals and reporting to DELVAX. A tracking system will be implemented for vaccine administration, documentation and inclusion in Delvax and will be maintained by the Director of Health and Wellness or designee. 4. As part of the QAPI process acceptance or declination of the vaccine and accurate documentation will be tracked during the influenza season, September 2025 until April 2026. This review will be weekly for 4 weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is maintained, and then quarterly. Date of Compliance: 10/24/2025 Responsible party: Director of Health and Wellness(RN) or designee	
3225.9.8 **3225.9.8.2.4** **S/S – E**	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococ-**	**pneumococcal vaccine** the facility failed to have on file documentation of pneumococcal vaccination being administered or offered and declined. 1. Resident R1's responsible party acknowledged that the resident has not had the Pneumococcal vaccine. A declination was signed and is in the medical record.	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	cal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record. This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of three residents reviewed for infection control, the facility failed to have on file documentation of pneumococcal vaccination being administered or offered and declined. Findings include: A review of R1's clinical record revealed: 2/1/23 – R1 was admitted to the facility with diagnoses including hypertension, hyperlipidemia, and anxiety.	2. The records of all residents will be reviewed to check for records of administration or declination of pneumococcal vaccine. For those without documentation in the medical record the DELVAX system will be checked. For those with no documentation in either location the Director of Health and Wellness(RN) or designee will contact their responsible parties and physicians will be contacted to facilitate acceptance of the vaccine or obtain documentation as to why it has beenrefused. 3. Root cause analysis showed that the facility did not keep a record of vaccine declinations, only acceptance. The DELVAX system was not used to track vaccine administration by the facility. Education will be conducted with the nursing team by the Director of Health and Wellness(RN) and Assistant Director of Health and Wellness to ensure understanding of the process of vaccine administration including documentation of refusals and reporting to DELVAX. A tracking system will be implemented for vaccine administration, documentation and inclusion in Delvax and maintained by the Director of Health and Wellness(RN) or designee. 4. As part of the QAPI process acceptance or declination of the pneumococcal vaccine and accurate documentation will be tracked. This review will be weekly for 4 weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is maintained and then quarterly. Date of Compliance: 10/24/2025 Responsible party: Director of Health and Wellness(RN) or designee	

Provider's Signature T Corrocino Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	9/8/25 11:00 AM – A request for documentation of pneumococcal vaccination status for R1 was given to E3 (Asst. DHW). 9/11/25 10:40 AM- During an interview E3 stated, "I did not find documentation of influenza or pneumococcal vaccines for [R1]." 9/11/25 2:45 PM – Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference. **Specific Requirements for COVID-19:** **Facilities must follow recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services and the Division of Public Health regarding the provision of care or services to residents by staff, vendor or volunteer found to be positive for COVID-19 in an infectious stage.** This requirement was not met as evidenced by: Cross Refer 9.9.2 Based on observation, interview, record review and review of facility documentation, the facility failed to ensure that	**Covid 19** the facility failed to ensure that recommendations of the Centers for Disease Control and Prevention (CDC) and the Division of Public Health regarding provision of care or services to residents by staff were followed. 1. Residents R15 and R16 no longer reside in the facility, unable to correct for R15, R16, E7, E8, E10. 2. Based on current CDC, state and local public health guidance concerning Covid 19 prevention and management, facility infection, surveillance and outbreak procedures will be reviewed to determine necessary revisions 3. Root cause analysis showed that Infection Control processes implemented in response to Covid-19 were not maintained by the facility due to a knowledge deficit regarding current covid-19 prevention and management. Resident and Staff education on the prevention and management of covid infections will be conducted by the Director of Health and Wellness (RN) or designee. Based on this guidance Visual Reminders will be posted by the Director of Health and Wellness(RN) or designee reminding visitors, residents and staff on topics including the need to cover coughs/sneezes, handwashing techniques, and the reporting of illness/symptoms. In the event of the identification of covid cases, daily active surveillance will be implemented by the Director of Health and Wellness(RN) or	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	recommendations of the Centers for Disease Control and Prevention (CDC) and the Division of Public Health regarding provision of care or services to residents by staff where followed when two (R15 and R16) residents and three facility staff (E7, E8 and E10) tested positive of Covid-19. Findings include: A facility policy titled, "IC-18 – Respiratory Viruses" dated, 12/13/24, documented "[facility] will prepare steps to reduce the risk of and respond to any incidence of respiratory illnesses including ... COVID ... follow the guidelines and recommendations from the Centers for Disease Control and Prevention (CDC), state, and local public health department ... Procedure 1. d. During respiratory illness season, typically October through April, the Community will: i. Post visual reminders asking residents, staff, visitors, and volunteers to 1. Cover cough/sneezes. 2. Frequently wash their hands and use alcohol – based hand sanitizer. 3. Report symptoms of respiratory illness to a designated staff member ... 6. Respiratory Virus Outbreaks: a. ... an outbreak is identified as three (3) or more positive cases in the Community in a ten (10) day period... e.	designee and CDC, State and local health department guidance followed. The Director Of Health And Wellness (RN) is responsible for the infection control program. 4. As part of the QAPI process, the infection control log will be updated daily and reviewed weekly for accuracy for 4 weeks. After 100% compliance is achieved, reviews will be monthly for 3 months. After 100% compliance is maintained reviews will be quarterly. Date of Compliance: 10/24/25 Responsible party: Director of Health and Wellness(RN)	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Visitor precautions and protocols: i. Post signs notifying visitors they should not visit the community if they are experiencing symptoms of a respiratory illness. ii Post visual reminders asking visitors to cover coughs, practice hand hygiene, maintain social distancing and report symptoms of respiratory illness to a designated person ... j. Initiate the use of the daily active surveillance log and collect data on all newly symptomatic residents and staff until at least fourteen (14) days after the last respiratory illness case occurs. k. Review the infection surveillance and outbreak procedure to determine necessary revisions." According to CDC's Covid-19 Infection Control Guidance: SARS – CoV-2 summary of changes for health care providers and updates as of 5/8/23, Assisted Living residents should be counseled about strategies to protect themselves including but not limited to wearing masks, physical distancing and testing for respiratory viruses. Visiting or shared healthcare personnel who enter the setting to provide healthcare to one or more residents should follow the healthcare recommendations in this guidance.		

Provider's Signature [signature] Title Executive Dir. Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.9.9 **3225.9.9.2** **S/S – E**	9/10/29 10:00 AM – During the Infection Prevention and Control review, Covid-19 surveillance data for residents and staff was requested from E3 (ADHW). E3 stated that the facility's last cases of COVID-19 were "during the last quarter". 1. 9/10/29 11:30 AM – A review of a facility document presented by E3 to the surveyor revealed the following: 4/10/25 – E9 (activity staff) tested +COVID-19; 4/14/25 – E8 (activity staff) tested +COVID-19; and 4/14/25 – E7 (LPN, HCC) tested +COVID-19. 9/10/25 1:30 PM – In an interview E3 stated that they do not collect Covid 19 surveillance data. E3 further stated that if staff is not feeling well, they will be asked to stay home. For staff who turned out positive for Covid-19, "We let them stay at home ... and they report back to work when they don't have the signs and symptoms anymore". 9/11/25 2:00 PM – Findings were discussed with E1 (ED) and E3 (ADHW).		

Provider's Signature T Corracino Title Education Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	2. Review of R15 and R16's clinical records revealed: A. R15 4/8/25 8:34 PM – A resident note documented, "[R15]'s wife took [R15] to (hospital) today... [R15] admitted with ... and Covid+ (positive) ... no s/s (signs and symptoms) of Covid noted in resident prior to leaving for hospital." B2. R16 5/15/25 6:15 AM – A resident note documented that R16 was sent to the hospital for change in mental status and was combative with staff and was very difficult to redirect. 5/15/25 2:47 PM – A follow up resident note documented that R16 tested positive for Covid-19 ... "will be admitted to (hospital) for more observation." 9/10/29 11:40 AM – A review of a facility document presented by E3 to the surveyor revealed that R15 and R16 both tested positive for Covid-19 in the hospital on 4/14/25 for R15 and on 5/15/25 for R16. 9/10/25 1:35 PM – During an interview, E3 (ADHW) stated that the facility is not maintaining COVID-19 surveillance data for residents specifically around that time when R15 and R16		

Provider's Signature T Corracino Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	were identified and tested positive for Covid-19 in the hospital on 4/14/25 for R15 and on 5/15/2 for R16. 9/11/25 9:30 AM – A review of the facility's Infection Prevention and Control Program (IPCP) revealed a lack of data gathering and monitoring of residents for signs and symptoms of respiratory infection for the months of April and May 2025. 9/11/25 10:50 AM – An observation in the facility lobby revealed a lack of postings for information on signs and symptoms and prevention of respiratory infections. 9/11/25 11:00 AM – During an interview, E7 (LPN, HCC) stated that she got sick with Covid19 in April and was taken off the schedule. E7 stated that she remembered back then, the facility had strict screening measures for signs and symptoms of Covid-19 to watch out for. E7 further stated, "I remember there used to be posters on the main entrance door about signs and symptoms of respiratory infections that people should watch out for, but they took them down. I don't see them now". When asked if		

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	residents, staff and visitors received education and information on reporting signs and symptoms of respiratory infection during the identified Covid outbreak in April 2025, E7 shook her head and stated, "No". 9/11/25 11:10 AM – In a follow up interview, E3 confirmed that the postings on respiratory infection in the lobby were taken down because "... There was a big repainting job done and the posters were not put back on yet. They are still in my office, but I should get them out soonest." 9/11/25 2:00 PM – Findings were discussed with E1 (ED) and E3 (ADHW). 9/11/25 2:45 PM - Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference. **Infection Prevention and Control Program**	**Infection Program** the facility failed to develop and implement a comprehensive plan that includes actions to prevent, identify, and manage infections and communicable diseases for all residents receiving antibiotic therapy 1. The antibiotic/anti-infective use tracking process will be revised and include an antibiotic/infection log with specific information related to symptoms, treatment, and culture results as applicable. 2. An Infection Control plan will be developed that includes actions to prevent, identify,	
3225.12.0 **3225.12.1** **3225.12.3**	**The Individual designated to lead the assisted living facility's infection prevention and control program must develop and implement a comprehensive plan that includes actions to prevent, identify, and man-**		

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
S/S – E	**age infections and communicable diseases. The plan must include mechanisms that result in immediate action to take preventive or corrective measures that improve the assisted living facility's infection control outcomes.** This requirement was not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to develop and implement a comprehensive plan that includes actions to prevent, identify, and manage infections and communicable diseases for all residents receiving antibiotic therapy from the months of January – through April 2025. Findings include: Cross Refer 9.8.2.4 The facility's policy titled, "IC-01 – Infection Control", dated 11/12/24, documented, "Policy: The Director of Health and Wellness is responsible for ensuring care staff training on infection control and compliance with the Community's infection control policies. Guidance from the Centers for Disease Control and Prevention (CDC) and/ or Public Health Department will be followed at all times...Procedure: The Director of Health	and manage infections and communicable diseases based on the infection trends 3. Root cause analysis showed that the current method of tracking antibiotic use, through the morning clinical meeting, did not include all information necessary to most effectively track and trend infections and their management. Nursing staff will be educated by the Director of Health and Wellness(RN) or designee on the Infection Control Plan including those policies to prevent, identify and manage infections including the process for tracking antibiotics and infections. The Director of Health and Wellness(RN) is responsible for the infection control program. 4. As part of the QAPI process, the infection/antibiotic therapy log will be updated daily and reviewed weekly for accuracy for 4 weeks. After 100% compliance is achieved, reviews will be monthly for 3 months. After 100% compliance is maintained reviews will be quarterly. Date of Compliance:10/24/2025 Responsible party: Director of Health and Wellness(RN)	
S/S – E			

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
S/S- E	and Wellness is responsible for monitoring the on-going compliance with the Community's Infection Control Policies. 9/10/25 3:30 PM – In an interview E3 (ADHW) stated that during clinical meetings every morning, they discussed residents who are on antibiotic therapy and discuss indications. E3 stated they review the occurrences and develop topics to educate Staff for prevention. When the surveyor requested documentation of actual resident occurrences in the facility, E3 stated that the information is not available for the surveyor to view since the documentation was part of the facility's QAPI (Quality Assurance and Performance Improvement) and risk management records. 9/10/25 3:35 PM – A review of the facility's list of residents receiving antibiotic/anti-infective from January 2025 through September 9, 2025, lacked information or the indication of the antibiotic/anti-infective use including start days and stop days. 9/10/25 3:45 PM –In a joint interview with E1 (ED), E19 (Corporate Nurse) and E3, E1 stated that she was not aware how the previous DHW (E11)		

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
S/S – E	tracked and monitored the residents' antibiotic/anti-infective use since January 2025. E19 instructed E3 to extract the infection control data from the QAPI records and create a binder solely for infection control monitoring. E19 told the surveyor that, "... We will get the information and put them in a binder for you to review in the morning." 9/11/25 9:00 AM – Review of the facility Infection Control binder lacked documentation of residents' antibiotic /anti – infective use, tracking and monitoring from January 2025 through April 2025. Further review of records from May through August 2025 revealed incomplete documentation, for example, lacking on indication for the use of the antibiotic/anti-infective or no information of start and stop dates. 9/11/25 9:30 AM – In a joint interview, E1 and E3 both confirmed that there was no information to track and monitor usage of antibiotic/anti-infectives and indications for use. E1 further confirmed the facility's lack of a plan that included actions to prevent, identify, and manage infections and communicable diseases based on		

Provider's Signature T Carraccio Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
S/S- E	the infection trends from January 2025 until April 2025. E1 also stated that some entries in the facility IC (Infection Control) binder for May 2025 lacked indications for the use of the antibiotics and their start and stop dates. E1 also confirmed that they could not find tracking documentation of residents on TBP (Transmission Based Precautions). E1 stated, "The former DHW (E11) left, and I don't know where she kept the files nor how she tracked the residents who were receiving antibiotic/anti-infectives." 9/11/25 2:45 PM - Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference. **Title 16, Health & Safety Delaware Administrative Code** **Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code.** **Delaware Food Code** **2-4 HYGIENIC PRACTICES** **2-402.11 Effectiveness (A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES**		

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225 3225.16.0	**shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLESERVICE and SINGLE-USE ARTICLES.** This requirement was not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that hair restraints were worn to prevent hair contact with exposed food. Findings include: 9/8/25 9:00 AM – E6 was observed not wearing a beard restraint while cutting meat. 9/8/25 9:05 AM – Findings were confirmed with E5 (CSS). 9/11/25 2:45 PM – Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference. **3 Food** **3-1 Characteristics** **3-101 Condition** **3-101.11 Safe, Unadulterated, and Honestly Presented.**	**Delaware Food Code** the facility failed to ensure that hair restraints were worn to prevent hair contact with exposed food. 1. E6 will be Educated about the need to wear a beard restraint when working in the kitchen. 2. All current staff members with facial hair will be educated by the Culinary Service Director or designee about the requirement to wear a beard restraint while in the kitchen. New team members will be educated on this topic in new hire orientation by the Culinary Service Director or designee. 3. Root cause analysis showed that team members were aware of the need to, but at times forgot, to utilize facial hair restraints. Kitchen rounds will be revised by the Culinary Services Director or designee to include checking that facial hair restraints are in place as appropriate. The Culinary Services Director will ensure rounds are ongoing. 4. As part of the QAPI process, the outcome of Kitchen rounds including checking the use of facial hair restraints will be reviewed weekly for 4 weeks. After 100% compliance is achieved, reviews of the rounds will be monthly for 3 months. After 100% compliance is maintained reviews of the kitchen rounds will be quarterly. Date of Compliance: 10/24/2025 Responsible party: Culinary Services Director ongoing	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.16.14 3225.16.14.2 3225.16.4.2.1 3225.16.14.2.2 3225.16.14.2.3 3225.16.14.2.4 3225.16.14.2.5 3225.16.14.2.6 3225.16.14.2.7 3225.16.14.2.8 3225.16.14.2.9 3225.16.14.2.10 3225.16.14.3	**FOOD shall be safe, unadulterated, and, as specified under § 3-601.12, honestly presented.** Based on observation and interview, it was determined that the facility failed to ensure food was stored and served in a manner that prevents food borne illness to the residents. Findings include: 9/10/25 11:17 AM - During the kitchen tour with the E4 (CS), the surveyor observed expired items on the dry storage shelves. Those expired items were seven bags of Quaker grits, six bags of flour tortilla bread and one carton of Sysco nectar orange juice. 9/10/25 2:43 PM - The findings were reviewed with E1 (ED). 9/11/25 2:45 PM - Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference. **3-3 PROTECTION FROM CONTAMINATION AFTER RECEIVING** **3-305.11 Food Storage. (A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (2) Where it is not exposed to**	**Delaware Food Code** facility failed to ensure food was stored and served in a manner that prevents food borne illness to the residents. 1. The expired items were removed. 2. The process for rotating stock and removing expired items will be reviewed with the appropriate members of the culinary department by the Culinary Services Director or designee. New department employees will be educated as appropriate as part of new hire orientation by the Culinary Services Director or designee. 3. Root cause analysis showed a knowledge deficit regarding storage and stock rotation. Kitchen rounds will be revised to include checking expiration dates on food items. The Culinary Services Director will ensure rounds are ongoing. 4. As part of the QAPI process, the outcome of dining department rounds, including checking for expired items, will be reviewed weekly for 4 weeks. After 100% compliance is achieved, the review of the rounds will be monthly for 3 months. After 100% compliance is maintained review of the rounds will be quarterly. Date of Compliance: 10/24/2025 Responsible party: Culinary Services Director ongoing	

Provider's Signature _____ Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.16.14.4	**splash, dust, or other contamination.** This requirement was not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure food was protected from contamination. Findings include: 9/8/25 8:45 AM – Open packages of tortilla chips and chicken nuggets were observed in the walk-in freezer. 9/8/25 8:46 AM – Findings were confirmed with E5 (CSS). 9/11/25 2:45 PM – Findings were reviewed with E1 (ED) and E3 (Asst. DHW) during the Exit Conference. **3-5 LIMITATION OF GROWTH OF ORGANISMS OF PUBLIC HEALTH CONCERN** **3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than**	**Delaware Food Code** the facility failed to ensure food was protected from contamination. 1. The open items were removed. 2. The process for storage of open items will be reviewed by the Culinary Services Director or designee with the appropriate members of the culinary department. This will be included in new hire orientation for the appropriate team members and be conducted by the Culinary Services Director or designee. 3. Root cause analysis showed a knowledge deficit regarding storage of open food items, including labeling and dating the items and disposal. Kitchen rounds will be updated to include checking that open items are stored and dated appropriately. The Culinary Services Director will ensure rounds are ongoing. 4. As part of the QAPI process, the outcome of dining department rounds, including checking the storage of open items, will be reviewed weekly for 4 weeks. After 100% compliance is achieved, the rounds will be reviewed monthly for 3 months. After 100% compliance is maintained reviews will be quarterly. Date of Compliance: 10/24/2025 Responsible party: Culinary Services Director ongoing **Delaware Food Code** the facility failed to ensure food items were labeled with a date and to ensure label food items were discarded within 7 days of refrigerator storage 1. The open items were removed. 2. The process for storage of open items including dating and using or disposing of them within 7 days will be reviewed with the appropriate members of the culinary depart-	

Provider's Signature [signature] Title Executive Dir Date 10/20/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.16.0 3225.16.15	**24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.** This requirement was not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure food items were labeled with a date and to ensure label dated food items were discarded within 7 days of refrigerated storage. Findings include: 9/8/25 8:50 AM – Two unlabeled opened 1-gallon containers of pickles were observed in the walk-in refrigerator. 9/8/25 8:53 AM – One container of potato salad labeled 8/28/25 and one container of soup starter labeled 8/13/25 were observed in the walk-in refrigerator. 9/8/25 8:55 AM - Findings were confirmed with E5 (CSS). 9/11/25 2:45 PM – Findings were reviewed with E1 (ED)	ment by the Culinary Services Director or designee. This will be included in new hire orientation for the appropriate team members and be conducted by the Culinary Services Director or designee 3. Root cause analysis showed a knowledge deficit regarding storage of open food items, including labeling and dating the items and disposal. Kitchen rounds will be revised to include checking that open items are stored and labeled appropriately. The Culinary Services Director will ensure rounds are ongoing. 4. As part of the QAPI process, the outcome of dining department rounds, including checking that open items are dated or disposed of within 7 days, will be reviewed weekly for 4 weeks. After 100% compliance is achieved, the rounds will be reviewed monthly for 3 months. After 100% compliance is maintained reviews will be quarterly. Date of Compliance: 10/24/2025 Responsible party: Culinary Services Director ongoing	

Provider's Signature Executive Director Title Executive Director Date 10/15/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	and E3 (ADHW) during the Exit Conference. **4-5 MAINTENANCE AND OPERATION** **4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under ¶4-703.11(C) shall meet the criteria specified under §7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, P and shall be used as follows: (C) A quaternary ammonium compound solution shall: (2) Have a concentration as specified under § 7-204.11 and as indicated by the manufacturer's use directions included in the labeling.** This requirement was not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the kitchen sink sanitizing rinse solution for dishes and utensils met concentration levels required for sanitization effectiveness. Findings include:	**Delaware Food Code** 1. The sanitizer pump was calibrated and replaced on 9/8/25 by Eco lab. 2. The ph level is tested three times a day to assure an accurate and appropriate reading. The levels are recorded and sanitizer changed every two hours. 3. Root cause analysis showed the need for additional training on the steps to take in the event testing results are out of compliance with established parameters. Appropriate dining staff will be educated by the Culinary Services Director or designee on the testing parameters and what to do if results are not within parameter. This will included as part of new hire orientation for appropriate team members and be conducted by the Culinary Services Director or designee. 4. As part of the QAPI process, the outcome of sanitizer checks will be reviewed weekly for 4 weeks. After 100% compliance is achieved, the outcomes of sanitizer checks will be reviewed monthly for 3 months. After 100% compliance is maintained reviews will be quarterly. Date of Compliance: 10/24/2025 Responsible party: Culinary Services Director	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.19.0 **3225.19.6** **S/S -F**	The EPA registered label for the observed chemical sanitizer being utilized by the facility, Ecolab Oasis 146 Multi-Quat Sanitizer, dated 11/9/2017, stated,"Use *Multi-Quat* to sanitize pre-cleaned hard, non-porous surfaces of food processing equipment, dairy equipment, food utensils, dishes, silverware, glasses...Apply a use solution of 1.04 – 2.72 fl. oz. of *Multi-Quat* per 4 gallons of 400 ppm hard water (150 - 400 ppm active quat) or 1.36 – 2.72 fl. oz. of Multi-Quat per 4 gallons of 500 ppm hard water (200 - 400 ppm active quat)...." 9/8/25 8:40 AM – Upon testing with facility provided quaternary sanitizing solution testing strips, the prepared sample solution chemical concentrations were below the required level of 150 ppm in two kitchen sink areas. 9/8/25 8:45 AM - Findings were confirmed with E5 (CSS). 9/11/25 2:45 PM – Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference. **Title 16 Health and Safety** **Assisted Living Facilities**		

Provider's Signature [signature] Title Executive Dir Date 10/10/25

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 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Staffing **Assisted living facilities resident assistants shall at minimum:** **Participate in a facility-specific orientation program that covers the following topics:** **Fire and life safety, and emergency disaster plans;** **Infection control, including Standard Precautions;** **Basic food safety;** **Basic first aid and the Heimlich Maneuver;** **Job responsibilities;** **The health and psychosocial needs of the population being served;** **The resident assessment process; and** **The use of service agreements;** **16 Del Ch. 11, pertaining to residents' rights; reporting of abuse, neglect, mistreatment, and financial exploitation; and the Ombudsman Program;** **Hospice services** **Receive, at minimum, 12 hours of regular in- service education**	**Staffing/Training** it was determined that for three staff (E13, E14 and E15) out of ten reviewed for staffing, the facility failed to have evidence of the facility-specific orientation topics, proof of the employees' 12 hours of in-service training and documentation of their competency in providing ADL care. 1. E14, and E15 were employed through an agency and no longer work in the facility. E13's records have been updated to include proof of required education. 2. For agency employees, the pre-hire checklist will be revised to include the required topics related to facility specific orientation, proof of competency in providing ADL care and proof of the 12 hours of required in-service training. 3. The non-compliant records were those of agency staff. Root cause analysis showed that for agency staff, only partial education records were maintained in the facility file. The facility will maintain complete education files for agency staff and they will be reviewed by the Director of Health and Wellness (RN) or designee prior to scheduling. 4. As part of the QAPI process, the pre-hire checklist for agency employees will be reviewed weekly for 4 weeks until 100% compliance is achievec, then monthly for 3 months until 100% compliance is maintained and then quarterly. Date of Compliance: 10/24/2025 Responsible party: Director of Health and Wellness	

Provider's Signature T Corcoran Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225 3225.19.0 3225.19.6 S/S – E	**annually which may include but not be limited to the topics listed in 16.14.2;** **Receive training to competently assist in activities of daily living or provide documentation of such training.** These requirements were not met as evidenced by: Based on facility documents and interview, it was determined that for three staff (E13, E14 and E15) out of ten reviewed for staffing, the facility failed to have evidence of the facility-specific orientation topics, proof of the employees' 12 hours of in-service training and documentation of their competency in providing ADL care. Findings include: 9/10/25 3:35 PM - During an interview, E17 (COS) stated, "We don't have documentation of these trainings." 9/11/25 11:45 AM – An interview with E1 and E3 revealed the facility was not able to obtain documentation of E13, E14 and E15's facility-specific trainings to done by the facility, and proof of their annual 12 hours of in-service training from the contracted agency. Additionally, the facility lacked evidence		

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	of documentation of these employees with regard to their competency in providing ADL care to residents. The facility failed to have documentation of three employees' facility-specific training and skills competencies. 9/11/25 2:45 PM - Findings were reviewed with E1 (ED) and E3 (Asst. DHW) during the Exit Conference. **Title 16 Health and Safety** **3225 Assisted Living Facilities** **Staffing** **The assisted living facility shall have a staffing plan which shall specify supervisory responsibilities, including the person responsible in the Assisted Living Director's absence.** **This requirement was not met as evidenced by:** Based on emails and interview, it was determined that the facility failed to have a staffing plan known by and followed with specified supervisory responsibilities while E1 (Assisted Living Director) was absent on vacation from 8/19/25 to 9/2/25. Findings include:	No action required, corrected.	

Provider's Signature T Carrasco Title Executive Dir. Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3105 **3105.4.0** **3225.4.1** **S/S – D**	8/27/25 7:42 AM – E23 (Regional Vice-President of Operations) submitted an email to the State Agency (DHCQ) stating, "[E12, former ED] has been covering for the administrator as of August 19th, when [E1, ED] started her vacation." 9/27/25 9:19 AM – E12 (former ED) submitted an email to the State Agency stating, "I was in the facility August 18th through August 21st and this week I am here from August 27th through the 29th. This was at the request of [E1] to provide support for the nursing administrator in her absence. Per the facility policy, in the absence of the Executive Director, the Director of Health and Wellness is in charge of the facility." 8/27/25 1:40 PM – An email from E23 to DHCQ staff documented, "I had to do some due diligence to identify exactly what the coverage plan was...E1 (ED) let the team know [E12] and [E17, Corporate Operations Specialist] would be providing coverage, placed [E12] on the calendar, but did not provide specific details on what responsibilities each would have. Therefore, it could have been handled better..." 8/28/25 4:31 PM – E24, (RN/Division VP of Residential Care) submitted an email to the State		

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.9.0 3225.9.2 S/S – E	agency stating, "[E17] is in charge of the community until [E1] returns on Sept. 2nd. The community is aware of her support." The facility failed to clearly identify and implement a staffing plan for coverage in the absence of the executive director. 9/4/25 – The facility submitted an acceptable corrective action plan to the State Agency that included a root cause analysis of the lack of identified coverage for the NHA, procedural changes, and staff training. 9/10/25 1:30 PM- During an interview, E1 (Executive Director) stated that she was on vacation from 8/19/25 to 8/29/25, (returning to work on 9/2/25). E1 stated, "There was a plan for who was in charge, but it failed to be executed." Due to the facility's submitted action plan this deficient practice was identified as past noncompliance with a correction date of 9/4/25. No additional issue with administrative coverage was identified during the survey. 9/11/25 2:45 PM - Findings were reviewed with E1 (ED)		

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.7.0 3225. 7.1.14.1	and E3 (Asst. DHW) during the Exit Conference. **Title 16, Health & Safety Delaware Administrative Code** **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.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for four (R5, R6, R10 and R11) out of eleven residents reviewed for records and reports, the facility failed to ensure reportable incidents were reported to the Division within 8 hours of occurring and failed to submit follow up incident reports within five days. Findings include: State reportable incidents within 8 hours 9/11/25 11:00 AM – Review of the Division's Complaint Summary Report revealed the following facility reported incidents:	**Records and Reports** the facility failed to ensure reportable incidents were reported to the Division within 8 hours of occurring and failed to submit follow up incident reports within five days. 1. Reports to the Division are now current. Unable to correct lack of timely reporting for R5, R6, R10, and R11. 2. Training will be conducted by the facility Executive Director with the charge nurses, interim Director of Health and Wellness(RN), Assistant Director of Health and Wellness and management team as to what events require reporting, the timeframes for reporting, how to report and responsibility. New manager orientation will include the event reporting process and responsibilities, conducted by the facility Executive Director. 3. Root cause analysis showed that responsibility for the reporting process was unclear to members of the management team who should have been doing the reporting, resulting in delays. Daily the Executive Director, Director of Health And Wellness(RN) or Assistant Director of Health and Wellness reviews a report of incidents which occurred in the prior 24-72 hours and checks to ensure any reportable events have been reported to the division. 4. As part of the QAPI process, the effectiveness of this incident review will be evaluated weekly for 4 weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is maintained and then quarterly.	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	6/2/25 12:15 AM -- R5 suffered a fall per incident report filed by the facility to the Division. On 6/4/25 the facility filed an incident report with the Division that R5 had fallen. A report was filed two days after the fall incident. 3/31/25 8:30 PM - R10 had a fall with injury; facility reported to the Division on 4/1/25 3:21 PM, approximately 19 hours after the incident. 3/2/25 8:43 AM – R11 had a fall with injury; facility reported to the Division on 3/6/25 2:51 AM, approximately 90 hours after the incident. 9/11/25 2:00 PM – In an interview, E1 (ED) confirmed that the facility failed to comply with the Division's requirement to submit the reportable incidents on 6/2/25, 3/1/25 and 3/2/25 within 8 hours. 9/11/25 2:45 PM - Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference. Five day follow up report 6/21/25 7:49 AM – R6's incident report was submitted to the Division. The 5 day follow up report was due on 6/27/25.	Date of Compliance: 10/24/2025 Responsible party: Executive Director on-going	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	The facility submitted the follow up report on 7/3/25, 6 days after the due date. 4/1/25 3:21 PM – R10's incident report was submitted to the Division. The 5 day follow up report was due on 4/8/25. The facility submitted the follow up report on 4/18/25, 10 days after the due date. 3/6/25 2:51 PM – R11's incident report was submitted to the Division. The 5 day follow up report was due on 3/13/25. The facility submitted the follow up report on 3/21/25, 8 days after the due date. 9/11/25 2:00 PM – In an interview, E1 (ED) confirmed that the facility failed to comply with the Division's requirement to submit the 5 day follow up reports for the following incident reports submitted on 6/21/25 for R6, 4/1/25 for R10 and 3/6/25 for R11. 9/11/25 2:45 PM - Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference. **Assisted Living Facilities** **Records and Reports**		

Provider's Signature T Carracino Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	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. This requirement was not met as evidenced by: Based on record review and interview, it was determined that for four (R5, R6, R10 and R11) out of eleven residents reviewed for records and reports, the facility failed to ensure reportable incidents were reported to the Division within 8 hours of occurring and failed to submit follow up incident reports within five days. Findings include: State reportable incidents within 8 hours 9/11/25 11:00 AM – Review of the Division's Complaint Summary Report revealed the following facility reported incidents: 6/2/25 12:15 AM – R5 suffered a fall per incident report filed by the facility to the Division. On 6/4/25 the facility filed an incident report with the Division that R5 had fallen. A report	**Records and Reports** the facility failed to ensure reportable incidents were reported to the Division within 8 hours of occurring and failed to submit follow up incident reports within five days 1. Reports to the Division are now current. Unable to correct lack of timely reporting for R5, R6, R10, and R11. 2. Training will be conducted by the facility Executive Director with the charge nurses, Interim Director of Health and Wellness (RN), Assistant Director of Health and Wellness and management team as to what events require reporting, the timeframes for reporting, how to report and responsibility. New manager orientation will include the event reporting process and responsibilities, conducted by the facility Executive Director or designee. 3. Root cause analysis showed that responsibility for the reporting process was unclear to members of the management team who should have been doing the reporting. Daily the facility Executive Director, Director of Health and Wellness (RN) and Assistant Director of Health and Wellness review a report of incidents which occurred in the prior 24-72 hours and checks to ensure any reportable events have been reported to the division. 4. As part of the QAPI process, the effectiveness of this incident review will be evaluated weekly for 4 weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is maintained and then quarterly. Date of Compliance: 10/24/2025 Responsible party: Executive Director ongoing	

Provider's Signature _____ Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	was filed two days after the fall incident. 3/31/25 8:30 PM - R10 had a fall with injury; facility reported to the Division on 4/1/25 3:21 PM, approximately 19 hours after the incident. 3/2/25 8:43 AM – R11 had a fall with injury; facility reported to the Division on 3/6/25 2:51 AM, approximately 90 hours after the incident. 9/11/25 2:00 PM – In an interview, E1 (ED) confirmed that the facility failed to comply with the Division's requirement to submit the reportable incidents on 6/2/25, 3/1/25 and 3/2/25 within 8 hours. Five day follow up report 6/21/25 7:49 AM – R6's incident report was submitted to the Division. The 5 day follow up report was due on 6/27/25. The facility submitted the follow up report on 7/3/25, 6 days after the due date. 4/1/25 3:21 PM – R10's incident report was submitted to the Division. The 5 day follow up report was due on 4/8/25. The facility submitted the follow up report on 4/18/25, 10 days after the due date.		

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	3/6/25 2:51 PM – R11's incident report was submitted to the Division. The 5 day follow up report was due on 3/13/25. The facility submitted the follow up report on 3/21/25, 8 days after the due date. 9/11/25 2:00 PM – In an interview, E1 (ED) confirmed that the facility failed to comply with the Division's requirement to submit the 5 day follow up reports for the following incident reports submitted on 6/21/25 for R6, 4/1/25 for R10 and 3/6/25 for R11. 9/11/25 2:45 PM - Findings were reviewed with E1 and E3 (ADHW) during the Exit Conference. **Title 16 Health and Safety** **Criminal History and Drug Testing for Nursing and Similar Facilities** **Persons Subject to the Law** **All persons working in facilities are required to be on the Master List of the BCC (Background check Center). New applicants must be processed through the BCC and will automatically be placed on the Master List if hired.**	**BCC (Background check Center) compliance** the facility failed to have evidence that E18 was on the Master list of the BCC with [agency] as the employer. 1. E18 was employed through an agency and no longer works in the facility. 2. HRs file for employees will be reviewed to ensure all employees have been processed through the BCC. Agency files will be checked	

Provider's Signature T Carreon Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	This requirement was not met as evidence by: Based on facility documents and interview, it was determined that the facility failed to have evidence that E18 was on the Master list of the BCC with [agency] as the employer. Findings include: 9/3/25 1:48 PM – A DHCQ (Division of Health Care Quality) internal email with C1 (ERP System Specialist with State BCC) revealed that E18 (aide) was listed in the BCC registry under [agency], however, "the status is in registry check the provider has not completed the hiring process in the BCC. I cannot confirm that was hired by the provider." 9/11/25 11:45 AM – An interview with E1 (ED) and E3 (ADHW) revealed the facility was not able to produce documentation that E18 had been cleared by the BCC prior to starting employment at the facility. 9/11/25 2:45 PM - Findings were reviewed with E1 and E3 (ADHW) during the Exit Conference. **Drug test**	prior to scheduling to ensure the BCC check is present. 3. Root cause analysis showed that the application for completion of a BCC check was placed in the file instead of the BCC check result. The facility new hire checklist has been reviewed to ensure BCC review results are included in each employee file. The checklist is signed by the Human Resource Director and/or Executive Director or designee. The agency employee checklist has been revised to include a completed BCC check. The checklist is reviewed by the Director of Health and Wellness (RN) or designee prior to scheduling. The Executive Director will review these processes with the Director of Health and Wellness (RN), Assistant Director of Health and Wellness and Human Resource Director to ensure understanding. The Director of Health and Wellness (RN) or designee will be responsible for ongoing compliance of agency files and the HR Director of employee files. 4. The HR checklists of all new employees and all scheduled agency employees will be reviewed weekly for 4 weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is maintained and then quarterly. Date of Compliance: 10/24/2025 Responsible party: Executive Director ongoing	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Evidence of all drugs not transmitted through the BCC which have been represented to have been secured must be maintained in a discrete file and be available for inspection, without delay, upon request from an agent of DLTCRP. This requirement was not met as evidenced by: Based on record review and interview, it was determined that for two (E13, E18) out of ten staff reviewed for staffing, the facility failed to have [urine] drug test results on file. Findings include: 9/11/25 11:45 AM – A follow up interview with E1 and E3 revealed the facility was not able to obtain documentation of E13 and E18's drug test results from the contracted agency. The facility failed to have documentation of two employees' drug test results. 9/11/25 2:45 PM - Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference. **Title 16 Health and Safety** **4202 Control of Communicable and Other Disease Conditions**	**Drug test** The facility failed to have [urine] drug test results on file. 1. E13 and E18 were employed through an agency and no longer work in the facility. 2. HR files for employees will be reviewed to ensure all files contain a completed drug test. Agency files will be checked prior to scheduling to ensure the drug test results are present. 3. Root cause analysis showed that the new hire checklist was not reviewed for completion prior to the employee start date. For agency staff, the results of drug tests were not maintained in the facility, but by the agency and so were not reviewed by the facility. The new hire checklist has been reviewed to ensure drug test results are included in each employee file. The checklist is signed by the Human Resource director and/or Executive Director or designee. The agency employee checklist has been revised to include drug test results. The checklist is reviewed by the Director of Health and Wellness or designee prior to scheduling. A new Human Resource Director is in place who is aware of this process. The Executive Director will review these processes with the Director of Health and Wellness(RN) and Assistant Director of Health and Wellness and Human Resource Director to ensure understanding. The Director of Health and Wellness(RN) or designee will be responsible for ongoing compliance of agency files and the Human Resource Director of employee files. 4. The Human Resource checklists of all new employees and all scheduled agency employees will be reviewed weekly for 4 weeks until	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Control of specific Contagious Diseases **Physician and other health care providers who give immunizations shall report information about the immunization and the person to whom it was given for addition to the immunization registry in a manner prescribed by the Division director or designee.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R2) resident out of four residents reviewed for vaccines, the facility failed to document the vaccines given in the facility in DELVAX, Delaware's online immunization registry. Findings include: Review of R2's clinical record revealed: 2/4/22- R2 was admitted to the facility. 4/14/24 – The facility administered the influenza vaccine to R2. The facility failed to document R2's influenza vaccines in the Delaware immunization registry.	100% compliance is achieved, then monthly for 3 months until 100% compliance is maintained and then quarterly. Date of Compliance: 10/24/2025 Responsible party: Executive Director ongoing **DELVAX** the facility failed to document the vaccines given in the facility in DELVAX, Delaware's online immunization registry. 1. R2 received the influenza vaccine at the September 25 2025 vaccine clinic. A record is in the medical record and DELVAX system. The vaccine clinic is conducted by an outside provider, a local pharmacy. They manage the entire process other than consent and physician orders. 2. Following the 2025 Influenza clinic DELVAX records will be reviewed to ensure that vaccines administered during the clinic are present in the system. If not, that provider and the DELVAX administrator will be notified. The Executive Director and Assistant Director of Health and Wellness have system access, The Director of Health and Wellness is in the process of getting access to the DELVAX system. 3. Root cause analysis showed that the facility was not using the DELVAX system for vaccine tracking. The facility does not administer vaccines but does track them. Documentation in the DELVAX system will be reviewed and compared to facility documentation on an ongoing basis by the Director of Health and Wellness (RN) or designee to ensure continuity. 4. A sample of 10% of resident records will be reviewed to ensure facility records correspond with DELVAX records weekly for 4 weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is maintained and then quarterly.	

Provider's Signature [signature] Title Executive Dir Date 10/10/25

NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	9/11/25 2:45 PM - Findings were reviewed with E1 (ED) and E3 (ADHW) during the Exit Conference.	Date Of Compliance: 10/24/2025 Responsible Party: Director of Health and Wellness (RN) ongoing	

Provider's Signature [signature] Title Executive Dir Date 10/10/25