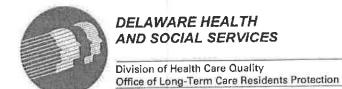


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NAME OF FACILITY: The Summit

SECTION	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR' CORRECTION OF DEF ANTICIPATED DATES TO	ICIENCIES WITH	Completi Date
	An unannounced Annual, Com-			<i>x</i>
	plaint and Emergency Prepared-			
	ness survey was conducted at			
	this facility from September 8,			
	2025, through September 11,			
	2025. The deficiencies con-			
	tained 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).		1	
	, , ,			
	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 Supervi-			
	sor;			
	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;			
	g- every.			
	Activities of daily living (ADL) -			
	tasks needed for daily living,			
	,			



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e.g. dressing, hygiene, eating, toileting, bathing; Antibiotic – a type of medicine used to treat and prevent infections caused by bacteria; Anti-infectives – medications	
Antibiotic – a type of medicine used to treat and prevent infections caused by bacteria;	
used to treat and prevent infections caused by bacteria;	la i
tions caused by bacteria;	
Anti infactives - madications	
Anti-infectives - medications	
that inhibit or kill microorgan-	
isms, such as bacteria, viruses,	
fungi and parasites;	
Anxiety- general term for sev-	
eral disorders that cause nerv-	
ousness, fear, apprehension	
and worrying;	
COVID 19/SARS CovV-2/Coro-	
navirus – a respiratory illness	
that can be spread person to	
person;	
Chronic kidney disease- condi-	
tion characterized by a gradual	
loss of kidney function over	
time;	
Contusion – a bruise;	
Dementia- a severe state of	
cognitive impairment charac-	
terized by memory loss, diffi-	
culty with abstract thinking,	
and disorientation;	
Electronic Medical Record	
(EMR) - a systematized collec-	
tion of patient and population	
electronically stored health in-	
formation in a digital format;	
Hyperlipidemia - high choles-	
terol or triglycerides (fat pro-	
teins) associated with increased	
risk for heart disease and	
stroke;	
Hypertension- high blood pres-	
sure; leading cause of stroke;	

Title Executivi Des Date



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

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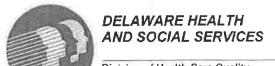
DATE SURVEY COMPLETED: September 11, 2025

SECTION	FATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completio Date
	Infection Prevention and Con-		
	trol Program (IPCP) - a core set		
	of infection prevention and		
	control practices that are re-		
	quired in all healthcare set-		
	tings;		
	Influenza – a contagious respir-		
	atory infection caused by a vi-		
	rus that affects the nose,		
	throat, and lungs;		
	Osteoporosis- weakened bones		
	with increased risk of breaking;		
	Pneumococcal – refers to strep-		
	tococcus pneumoniae bacteria		
	that can cause lung, blood-		
	stream, brain, and spinal cord		
	infections;		
	Psychotic disorder- severe		
	mental disorders that cause ab-	193	
	normal thinking and percep-		
	tions;		
	Quality Assurance Performance		
	Improvement (QAPI) – a pro-		
	gram that systematically iden-		
	tify and correct gaps in care,		
	improve processes, and pro-		
	mote better patient outcomes		
	by involving all staff in a contin-	9 1 2	
	uous proactive improvement;		
	Resident Services Agreement- A		
25	written document developed		
	with each resident which de-		
15.8.0	scribes what services will be		
	provided, who will provide the		
25.8.6	services, when the services will		
В	be provided, how the services		
5 – D	will be provided, and, if applica-		
	ble, the expected outcome;		
	sie, the expected outcome,	* 1	

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Date 10/10/25



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

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STATEMENT OF DEFICIENCIES
SECTION 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 onsite 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.
- 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-

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DELAWARE HEALTH AND SOCIAL SERVICES

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

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SECTION	TATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completio Date
3225	Based on record review and in- terview, it was determined that	derstanding. The Director of Health and Well- ness (RN) or designee will be responsible for	
3225.9.0	for one (R13) out of eight resi- dents reviewed for medication	monitoring on an ongoing basis. 4. As part of QAPI, the UAI assessment process	
3225.9.5 3225.9.5.2.	management, the facility failed to conduct a RN onsite review of the resident's medication regime concurrent with the UAI-based assessment. Findings include:	will be reviewed to ensure residents who self- administer medications have a medication re- view 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	
	A review of R13 's clinical record revealed:	and then quarterly. Date of compliance: 10/24/2025 Responsible party for ongoing compliance: Director of Health and Wellness(RN) or designee	
3225.9.5.2.4	12/2/24 - R13 was admitted to	to the training training square	
S/S – E	the facility with diagnoses in- cluding osteoporosis, hyperten- sion, and hyperlipidemia.		
	4/30/25 – R13's annual UAI assessment was completed.		
	S/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		



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

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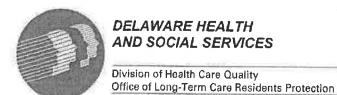
NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

STATEMENT OF DEFICIENCIES ECTION SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
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. 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. 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 	

Provider's Signature

Title Executar Sig Date 10/10/25

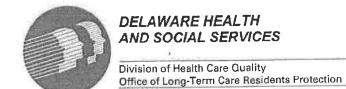


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SECTION	SPECIFIC DEFICIENCIES		ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completio Date
3225.9.7 5/S – D	two step TB test or TB blood test for E16. 9/11/25 11:45 AM – A follow up interview with E1 and 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:	Influence the following signs of the followin	enza vaccine acility failed to have on file documentation of fail influenza vaccination being administered fered and declined Resident R1's responsible party declined the influenza vaccine administered at the 1025/2026 Influenza vaccine clinic in September 2025. A declination was signed and is in the medical record. Ill 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 ocumentation of acceptance or declination of the 2025/2026 influenza vaccine and records will reviewed to ensure there is ocumentation of acceptance or declination of the 2025/2026 influenza vaccine and records administration. The Director of Health and Wellness(RN) or designee will be responsible for reviewing vaccine records. The DELVAX system was not seed to track vaccine administration by the incility. Education will be conducted by the irector of Health and Wellness and/or Assistant Director of Health and Wellness with the cursing team to ensure understanding of the	



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SECTION	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.9.8 3225.9.8.2.4 S/S – E	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	
	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.	

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STATEMENT OF DEFICIENCIES SECTION 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.

Office of Long-Term Care Residents Protection

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.
- 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

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STATEMENT OF DEFICIENCIES
SECTION 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

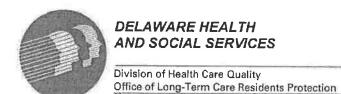
the facility failed to ensure that recommendations of the Centers for Disease Control and Prevention (CDC) and the Division of Public Health regarding provision of care or services to residents by staff were followed.

- 1. Residents R15 and R16 no longer reside in the facility, unable to correct for R15, R16, E7, E8, E10.
- 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

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Title Executive Din

Date /0/10/05



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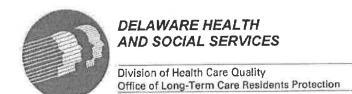
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CT	ATEMENT OF DEFICIENCIES			COMPLETED: Septe	
SECTION	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES		ADMINISTRATOR' CORRECTION OF DEF ANTICIPATED DATES TO	ICIENCIES WITH	Completion Date
	recommendations of the Cen-		designee and CDC, State a	and local health de-	
	ters for Disease Control and		partment guidance follow		
	Prevention (CDC) and the Divi-		Health And Wellness (RN		
	sion of Public Health regarding		the infection control progi		
	provision of care or services to		As part of the QAPI process		
	residents by staff where fol-		trol log will be updated o		
	lowed when two (R15 and R16)		weekly for accuracy for 4		
	residents and three facility staff		compliance is achieved,		
	(E7, E8 and E10) tested positive		monthly for 3 months. A		
	of Covid-19. Findings include:		ance is maintained reviews		
			of Compliance: 10/24/25		
	A facility policy titled, "IC-18 –	ness	onsible party: Director of	Health and Well-	
	Respiratory Viruses" dated,	11033	(1111)		
	12/13/24, documented "[facil-				
	ity] will prepare steps to reduce				
	the risk of and respond to any				
	incidence of respiratory ill-				
	nesses including COVID fol-				
	low the guidelines and recom-				
	mendations from the Centers				
	for Disease Control and Preven-				
	tion (CDC), state, and local pub-				
	lic health department Proce-				
	dure 1. d. During respiratory ill-				
	ness 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 alco-				
	hol – based hand sanitizer. 3.				
	Report symptoms of respira-				
	tory illness to a designated staff				
	member 6. Respiratory Virus				
	Outbreaks: a an outbreak is				
	identified as three (3) or more				
	positive cases in the Commu-				
	Facility of the Committee				

Provider's Signature _ 4

nity in a ten (10) day period... e.



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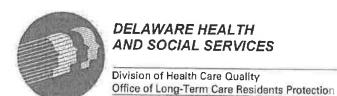
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DATE SURVEY COMPLETED: September 11, 2025

SECTION ST	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Visitor precautions and proto-		
	cols: i. Post signs notifying visi-		
	tors they should not visit the		
	community if they are experi-		
	encing symptoms of a respira-		
	tory illness. ii Post visual re-		
	minders asking visitors to cover		
	coughs, practice hand hygiene,		
	maintain social distancing and		
	report symptoms of respiratory	1	
	illness to a designated person		
	j. Initiate the use of the daily		
	active surveillance log and col-		
	lect data on all newly sympto-		
	matic residents and staff until		
	at least fourteen (14) days after		
	the last respiratory illness case		
	occurs. k. Review the infection		
	surveillance and outbreak pro-		l l
	cedure to determine necessary		
	revisions."		
	According to CDC's Covid-19 In-		
	fection 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		1
	protect themselves including		
	but not limited to wearing		
	masks, physical distancing and		
	testing for respiratory viruses.		
	Visiting or shared healthcare		
	personnel who enter the set-		
	ting to provide healthcare to		
	one or more residents		
	should follow the healthcare		
	recommendations in this guid-		
	ance.		

Title Execution

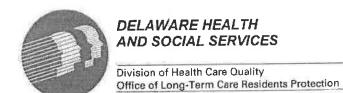


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SECTION	FATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	9/10/29 10:00 AM During the		
	Infection Prevention and Con-		
	trol review, Covid-19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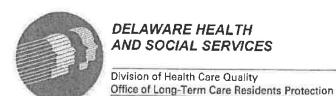
Title Executive & Date 10

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SECTION ST	FATEMENT 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 leav-		
	ing 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 com- bative 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 (hos- pital) for more observation."	3	
	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		



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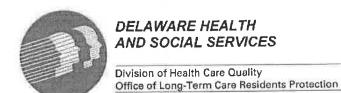
NAME OF FACILITY: The Summit

Provider's Signature & Cavacum

DATE SURVEY COMPLETED: September 11, 2025

	ATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR	Completion
SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Date
	were identified and tested posi-		
	tive for Covid-19 in the hospital		
	on 4/14/25 for R15 and on		
	5/15/2 for R16.	1	
	9/11/25 9:30 AM – A review of		
	the facility's Infection Preven-		
	tion and Control Program		
	(IPCP) revealed a lack of data		
	gathering and monitoring of		
	residents for signs and symp-		
	toms of respiratory infection		
	for the months of April and		
	May 2025.		
	9/11/25 10:50 AM – An obser-		
	vation in the facility lobby re-		
	vealed a lack of postings for in-		
	formation on signs and symp-		
	toms and prevention of respira-		
	tory infections.	1	
	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 re-		
	membered back then, the facil-		
	ity had strict screening		
	measures for signs and symp-		
	toms of Covid-19 to watch out		
	for. E7 further stated, "I re-		
	member there used to be post-		
	ers on the main entrance door		
	about signs and symptoms of		1
	respiratory infections that peo-		
	ple should watch out for, but		1
	they took them down. I don't		
	see them now". When asked if		

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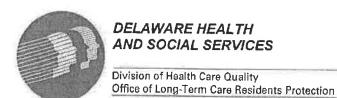


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STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES		ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
municipality of the	residents, staff and visitors received education and information 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 an-	
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-	 tibiotic therapy 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. An Infection Control plan will be developed that includes actions to prevent, identify, 	



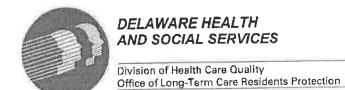
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SECTION	SPECIFIC DEFICIENCIES		CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Date
S/S — E	age infections and communicable diseases. The plan must include mechanisms that result in immediate action to take preventive or corrective 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	Res	and manage infections and communicable diseases based on the infection trends	Date

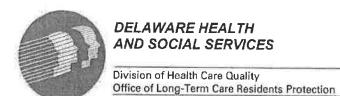


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	and Wellness is responsible for		
	monitoring the on-going com-		
	pliance with the Community's		
	Infection Control Policies.	- 1	
	9/10/25 3:30 PM - In an inter-		
	view E3 (ADHW) stated that		
	during clinical meetings every		
	morning, they discussed resi-		
	dents who are on antibiotic		
	therapy and discuss indications.		
	E3 stated they review the oc-		
	currences and develop topics to		
	educate Staff for prevention.		
	When the surveyor requested		
	documentation of actual resi-		
	dent occurrences in the facility,		
	E3 stated that the information		
	is not available for the surveyor		
	to view since the documenta-		
	tion was part of the facility's		
	QAPI (Quality Assurance and		
	Performance Improvement)		
	and risk management records.		
S/S-E	9/10/25 3:35 PM – A review of		
	the facility's list of residents re-		
	ceiving antibiotic/anti-infective		
	from January 2025 through		
	September 9, 2025, lacked in-		
	formation or the indication of		
	the antibiotic/anti-infective use		
	including start days and stop		
	days.		
	9/10/25 3:45 PM -In a joint in-		
	terview with E1 (ED), E19 (Cor-		
	porate Nurse) and E3, E1 stated		
	that she was not aware how		1
	the previous DHW (E11)	Title Columbia Des Date_	1 1 1

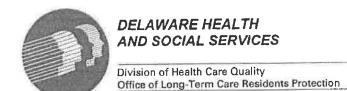


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SECTION	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completio Date
SECTION S/S – E	tracked and monitored the residents' antibiotic/anti-infective use since 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 infor-		
	mation 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		



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		CORRECTION OF DEFICIENCIES WITH	
	2-4 HYGIENIC PRACTICES 2-402.11 Effectiveness (A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES	Title Executive Dig Date_	



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

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STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED

Completion Date

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 SIN-**GLESERVICE 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

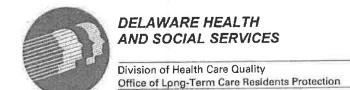
Responsible party: Culinary Services Director ongoing

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3225.16.0

Provider's Signature Towacum

Title Executing Des



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DATE SURVEY COMPLETED: September 11, 2025

STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES			ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
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	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	facilitiserve ness: 1. T e p n n s e c c c c c c c c c c c c c c c c c c	ware Food Code ty failed to ensure food was stored and ad in a manner that prevents food borne ill- to the residents. The expired items were removed. 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. Root cause analysis showed a knowledge deficit regarding storage and stock rotation. Ritchen rounds will be revised to include thecking expiration dates on food items. The culinary Services Director will ensure rounds are ongoing. 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 consible party: Culinary Services Director ones.	

Title Executive Dy

Date



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

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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 OXY-**GEN PACKAGING method as** specified under § 3-502.12, and except as specified in ¶¶ (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CON-TROL FOR SAFETY FOOD prepared and held in a FOOD ES-**TABLISHMENT for more than**

Delaware Food Code

the facility failed to ensure food was protected from contamination.

- 1. The open items were removed.
- 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

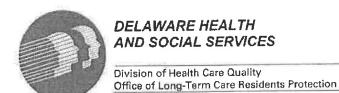
the facility failed to ensure food items were labeled with a date and to ensure label food items were discarded within 7 days of refrigerator storage

- 1. The open items were removed.
- 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-

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Title Execution Sin

Date 10/12/25



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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 PREM-ISES, sold, or discarded when held at a temperature of 5°C (41°F) 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 3:53 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	
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Provider's Signature

Title Expentery Dig Date_



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SECTION	SPEC

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ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED

Completion Date

and E3 (ADHW) during the Exit Conference.

Office of Long-Term Care Residents Protection

4-5 MAINTENANCE AND OPER-**ATION**

4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization -Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZ-ING 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

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:

as evidenced by:

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

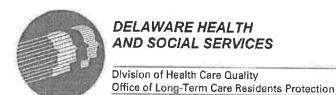


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		ANTICIPATED DATES TO BE CORRECTED	L
3225.19.0	The EPA registered label for the observed chemical sanitizer being utilized by the facility, Ecolab Oasis 146 Multi-Quat Sanitizer, dated 11/9/2017, stated, "Use Multi-Quat to sanitize pre-cleaned hard, non-porous surfaces of food processing equipment, dairy		
3225.19.6	equipment, food utensils,		
S/S -F	dishes, silverware, glassesApply a use solution of 1.04 – 2.72 fl. oz. of <i>Multi-Quat</i> 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 so- lution 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		



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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.

- 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.
- 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 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 Well-

ness

Title Execution Din Date

Date 10/10/25

Provider's Signature



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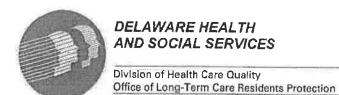
NAME OF FACILITY: The Summit

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DATE SURVEY COMPLETED: September 11, 2025

Title Executive Sy Date 16/10/25

SECTION STA	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
		CORRECTION OF DEFICIENCIES WITH	Date
	terview, 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		

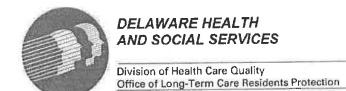


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	of documentation of these em- ployees with regard to their competency in providing ADL care to residents.				
	The facility failed to have documentation of three employees' facility-specific training and skills competencies.				
	9/11/25 2:45 PM - Findings were reviewed with E1 (ED) and E3 (Asst. DHW) during the Exit Conference.				
	Title 16 Health and Safety				
	3225 Assisted Living Facilities Staffing	No action re	equired, corrected.		
	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:				
vider's Signat	ure Y Cavacium	Tielo	Executive ,	Sig. Date /	1/2/5

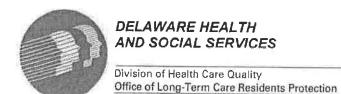


STATE SURVEY REPORT

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NAME OF FACILITY: The Summit

ST SECTION	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completio Date
***************************************	8/27/25 7:42 AM – E23 (Re-		
	gional Vice-President of Opera-		
	tions) submitted an email to		
	the State Agency (DHCQ) stat-		
	ing, "[E12, former ED] has been		
	covering for the administrator		
	as of August 19 th , 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 lam		
	here from August 27th through		
	the 29 th . This was at the re-		
	quest of [E1] to provide sup-		
	port for the nursing administra-		
	tor in her absence. Per the fa-		
	cility policy, in the absence of		
	the Executive Director, the Di-		
	rector of Health and Wellness is		
	in charge of the facility."		
	8/27/25 1:40 PM – An email		
105	from E23 to DHCQ staff docu-		
	mented, "I had to do some due		
	diligence to identify exactly		1
105.4.0	what the coverage plan		
	wasE1 (ED) let the team know		
225.4.1	[E12] and [E17, Corporate Op-		
223,711	erations Specialist] would be		
/\$ - D	providing coverage, placed		
- D	[E12] on the calendar, but did		
	not provide specific details on		
	what responsibilities each		
	would have. Therefore, it could		
	have been handled better"		
	Have been handled better		
	8/28/25 4:31 PM – E24, (RN/Di-		
	vision VP of Residential Care)		
	submitted an email to the State		
	nature Cavacca	Title Executive Is Date_	7 /



STATE SURVEY REPORT

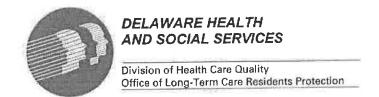
Title Executive Dis Date 10/10/25

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NAME OF FACILITY: The Summit

Provider's Signature Tomper

SECTION STA	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	agency stating, "[E17] is in charge of the community until [E1] returns on Sept. 2 nd . 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	ANTICIPATED DATES TO BE CORRECTED	
	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.	•	
3225.9.0	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."		
3225.9.2 /S – E	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)		



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NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION ST	FATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
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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:

3225.7.0

3225, 7.1.14.1

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

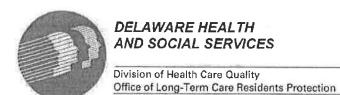
the facility failed to ensure reportable incidents were reported to the Division within 8 hours of occurring and failed to submit follow up incident reports within five days.

- Reports to the Division are now current. Unable to correct lack of timely reporting for R5, R6, R10, and R11.
- 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 Carracum

Title Executive Sis

Date 10/10/25

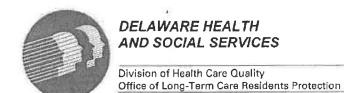


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NAME OF FACILITY: The Summit

SECTION ST	ATEMENT 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.	1.	e of Compliance: 1C/24/2025 consible party: Executive Director on-going	
	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.			



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NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

ST. SECTION	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
11.1	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 Townscom

Title Expecutive Des Date 10/10/25



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

STATE SURVEY REPORT

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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

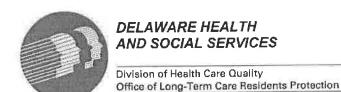
- 1. Reports to the Division are now current. Unable to correct lack of timely reporting for R5, R6, R10, and R11.
- 2. Training will be conducted by the facility Executive Director with the charge nurses, Interim Director of Health and Wellness (RN), Assistant Director of Health and Wellness and management 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 Efection Sy Date_



STATE SURVEY REPORT

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NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

SECTION ST	FATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
11	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.		

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Office of Long-Term Care Residents Protection

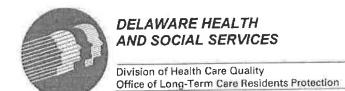
DHSS - DHCQ 263 Chapman Road, Suite 200, Cambridge Bldg. Newark, Delaware 19702 (302) 421-7400

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Provider's Signature

NAME OF FACILITY: The Summit		DATE SURVEY COMPLETED: September 11, 2025			
SECTION ST	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 inci-				
	dent report was submitted to				
	the Division. The 5 day follow				
	up report was due on 3/13/25.				
	The facility submitted the fol-				
	IV.				
	low up report on 3/21/25, 8				
	days after the due date.				
	9/11/25 2:00 PM - In an inter-				
	view, 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 inci-				
	dent reports submitted on	1			
	6/21/25 for R6, 4/1/25 for R10				
	and 3/6/25 for R11.				
	and 3/0/23 for R11.				
	9/11/25 2:45 PM - Findings				
	were reviewed with E1 and E3	1			
	(ADHW) during the Exit Confer-	1			
	ence.				
			1		
	Title 16 Health and Safety				
			1		
	Criminal History and Drug				
	Testing for Nursing and Similar		1		
	Facilities		1		
	Persons Subject to the Law				
	,				
	All persons working in facilities				
	are required to be on the Mas-	BCC (Background check Center) compliance			
	ter List of the BCC (Background	the facility failed to have evidence that E18 was	18		
	check Center). New applicants	on the Master list of the BCC with [agency] as the			
	must be processed through the	employer.			
	BCC and will automatically be	1. E18 was employed through an agency and no			
	placed on the Master List if	longer works in the facility.			
	hired.	2. HRs file for employees will be reviewed to en-			
	mrea.	sure all employees have been processed			
	/	through the BCC. Agency files will be checked			



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NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

STATEMENT OF DEFICIENCIES
SECTION 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 Canacur

Title Guesters Dy Date 10/10/25



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

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

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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

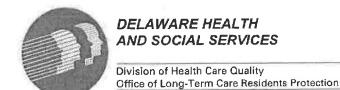
Drug test

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.
- 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.
- The Human Resource checklists of all new employees and all scheduled agency employees will be reviewed weekly for 4 weeks until

e Executive Des

Date 10/10/25



STATE SURVEY REPORT

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NAME OF FACILITY: The Summit

DATE SURVEY COMPLETED: September 11, 2025

	STATEMENT	OF	DEFICIENCIES
SECTION	SPECIF	IC I	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.

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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

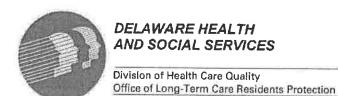
the facility failed to document the vaccines given in the facility in DELVAX, Delaware's online immunization registry.

- 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.
- 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.
- 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.
- 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.

Title Lecutor Des

Date 10/10/25

Provider's Signature &



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STATEMENT OF DEFICIENCIES SECTION 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		

Title Executive Dis Date 10/10/25

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