STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	**300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey were conducted on 10/24/2023 through 10/27/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #IC4T11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 10/24/23 through 10/27/23. Event ID# IC4T11. The following intakes were investigated NC00198465, NC00197809, NC00209092 and NC00195924. 1 of the 11 complaint allegations resulted in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to assess residents' capability to self-apply a topical pain-relieving liquid and barrier ointment for 3 of 3 residents reviewed for self-administration of medications (Resident #47, # 39, #21). The findings included: 1.Resident #47 was admitted to the facility on 4/27/21 with diagnoses of other specified arthritis right knee and aphasia following cerebral infarction.	F 554	F-554 plan of correction The statements included are not an admission and does not constitute agreement with alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the center's	11/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/20/2023

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F 554	Continued From page 1 Review of the quarterly Minimum Data Set assessment dated 9/23/23 revealed Resident #47 was cognitively impaired. Review of the physician orders for Resident #47 revealed there was no physician order to apply a topical pain-relieving liquid. Review of the medical records revealed no assessment was completed for the capability of Resident #47 to self-administer a topical pain-relieving liquid. Review of the active care plan revealed no care plan for self-administration of medications. During an observation on 10/26/23 12:33 PM, a topical pain-relieving liquid roll on was in clear view on top of the television stand in the room of Resident #47. An interview was conducted on 10/26/23 at 12:35PM with Nurse #1 in Resident #47's room. Nurse #1 revealed the pain-reliving liquid should not have been left in Resident #47's room as she did not have an order for it. A telephone interview was conducted with the Medical Director, and she revealed the pain-relieving liquid should have been kept in a secure storage location and not left at the bedside. An interview was conducted with the Administrator on 10/27/23 at 12:43 PM and he revealed that all medications should be kept in a secure area such as the nursing carts or medication storage room unless there was an order for a resident to self-administer their medication.	F 554	allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those observation areas found to have been affected by the alleged deficient practices: Resident #47 lidocaine roll was removed from her room by the Registered Nurse Supervisor (RN Supervisor) on October 25, 2023, and placed on the treatment cart. Residents #39 and #21 barrier cream was removed from the residents beside table by the RN Supervisor on October 25, 2023 and placed in basins in enclosed closets. Residents #47, #39 and #21 remain in the facility and did not suffer any adverse effects from the alleged deficient practice. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice: Nursing supervisors completed a 100% audit of all residents rooms to ensure that no medications or barrier creams were left out at bedside. This was completed on 11/20/23. There were no additional medications or barrier cream left at residents bedsides. Address what measures will be put in place or systemic changes made to ensure the deficient practice will not recur: All licensed nursing staff, medication aides, medication technicians and certified nursing assistants will be educated by the Staff Development	

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F 554	Continued From page 2 2. Resident # 39 was admitted to the facility on 12/21/22 with a diagnoses of diabetes mellitus and macular degeneration. Review of the quarterly MDS assessment dated 8/1/22 revealed Resident #39 was cognitively impaired and required extensive assistance with personal hygiene. Review of the physician orders for Resident #39 revealed no order to self-administer a skin barrier ointment. Review of the medical records revealed no assessment was completed for the capability of Resident #39 to self-administer a barrier ointment. Review of the active care plan revealed no care plan to self-administer medication. During an observation on 10/26/23 at 12: 43 PM a container of zinc oxide barrier cream was observed on Resident #39's bedside table which was located directly beside Resident #39's bed. An interview conducted with Resident #39 on 10/26/23 at 12:43 PM revealed she was not able to recall any information about the container of zinc oxide barrier cream. An interview was conducted on 10/26/23 12:43 PM with Nurse #2 in resident #39's room. She revealed the zinc oxide should have been kept on the nurse's cart for safety and not left at Resident #39's bedside. A telephone interview was conducted with the Medical Director, and she revealed barrier creams should have been kept in a secure storage location and not left at bedside. An interview was conducted with the Administrator on 10/27/23 at 12:43 PM and he revealed that all medications should be kept in a secure area such as the nursing carts or medication storage room unless there is an order	F 554	Coordinator (SDC) or designee that no medications or barrier creams will be left at resident's bedside unless they have been assessed for the ability to self-administer medications. This will be completed by 11/30/2023. All licensed nursing staff, medication aides, medication technicians, and certified nursing assistants out on leave or PRN status will be educated by the SDC or designee prior to returning to duty. This education is provided to all licensed nurses, medication aides, medication technicians and certified nursing assistants as part of orientation by the SDC/designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing (DON) or designee will audit 10% of resident rooms for medications or barrier creams at the bedside weekly x 1 month, then biweekly x l month, then monthly x 1 month. The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly x 3 months for review and further recommendations to ensured continued compliance with this plan of correction. Date of completion November 30, 2023	

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F 554	Continued From page 3	F 554		

for a resident to self-administer their medication.

3. Resident #21 was admitted to the facility on 11/8/22 with diagnoses including rash and other nonspecific skin eruption, paranoid schizophrenia and altered mental status.

Review of the quarterly Minimum Data Set assessment dated 8/18/23 revealed Resident #21 was cognitively intact.

Review of physician order dated 11/8/22 revealed an order to apply barrier cream every shift.

Review of the physician orders for Resident #21 revealed there was no order to self-administer a skin barrier ointment.

Review of the medical records revealed no assessment was completed for the capability of Resident #21 to self-administer a skin barrier ointment.

Review of the active care plan revealed no care plan to self-administer medications.

During an observation on 10/25/23 at 1:23 PM a tube of skin barrier ointment was found on Resident #21's bedside table.

An interview conducted with Resident #21 on 10/25/23 at 1:23 Pm revealed she did not understand what the cream was for.
An interview was conducted with Nurse #3 on 10/25/23 at 1:25 PM and she revealed the ointment should not have been left at the bedside as this medication should be stored on the medication cart and that the nursing assistant must have forgotten to return it to the nurse after

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F 554	Continued From page 4 use. A telephone interview was conducted with the Medical Director, and she revealed that the skin barrier ointment should have been kept in a secure storage location and not left at bedside. An interview was conducted with the Administrator on 10/27/23 at 12:43 PM and he revealed that all medications should be kept in a secure area such as the nursing carts or medication storage room unless there is an order for a resident to self-administer their medication.	F 554		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 4 of 31 residents reviewed (Resident #20, Resident #21, Resident #36 and Resident #3). Findings included: 1. The facility's Pre-Admission Screening and Resident Review (PASRR) query form dated 4/20/2022 indicated Resident #20 had a Level II PASRR determination due to mental illness. Resident #20 had been admitted on 4/22/2022. His diagnoses included Schizoaffective disorder Bipolar type. The most recent Annual MDS assessment dated 3/7/2023 did not indicate Resident #20 was currently considered by the state Level II PASRR	F 641	F-641 Plan of correction The statements included are not an admission and do not constitute agreement with alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those observation areas found to have been affected by the	11/20/23

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F 641	Continued From page 5 process to have a serious mental illness. An interview with the Social Worker (SW) and MDS Nurse #1 was conducted on 10/25/23 at 12:55 PM. The SW stated she was responsible for including the PASRR information on the comprehensive MDS assessments except when she is off, then it would be the responsibility of the MDS nurses to include it in the assessment. The SW checked Resident #20's annual MDS assessment and stated it should have included the Level II PASRR for mental illness information. She further explained it had missed being marked. On 10/26/23 at 11:48 AM an interview with the Administrator was conducted. He stated he would expect the MDS nurse to code the PASRR information and any other resident information accurately on each applicable assessment. 2. The facility's Pre-Admission Screening Resident Review (PASRR) notification letter dated 11/17/22 indicated Resident #21 had a Levell II determination with no expiration date. Resident #21 was admitted on 11/8/22. Her diagnoses included Paranoid Schizophrenia. The most recent Annual MDS assessment dated 11/21/22 did not indicated Resident #21 was currently considered by the state Level II PASRR process to have a serious mental illness. An interview with the Social Worker (SW) and MDS Nurse #1 was conducted on 10/25/23 at 12:55 PM. The SW stated she was responsible for including the PASRR information on the	F 641	alleged deficient practices: Resident #20 Minimum Data Set (MDS) dated 03/07/2023 was modified by MDS Nurse #1 on 10/25/23 to code for Level II Pre-Admission Screening and Resident Review (PASRR). Resident #21 MDS dated 11/21/2022 was modified by MDS Nurse #1 on 10/25/2023 to code for Level II Pre-Admission Screening and Resident Review (PASRR). Resident #3 MDS dated 10/11/2023 was modified by MDS Nurse #1 on 10/26/2023 to remove coding for Pneumonia. Resident #36 MDS dated 07/26/2023 was modified by MDS #1 on 10/26/23 to correct coding for prognosis. Residents #20, #21, #3 and #36 remain in the facility and did not suffer any adverse effects from the alleged deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice: MDS Nurse #1 and MDS Nurse #2 reviewed 100% of all residents' MDS' with Level II PASRR, hospice and pneumonia to identify if any other residents' MDS' were incorrectly coded. There were additional Level II PASRR that needed to be modified by MDS nurse #1. Resident #1 MDS date 1/5/2023 modified by MDS nurse # 1 on 11/14/2023. Resident #2 MDS date 2/23/23 modified by MDS nurse #1 on 11/14/2023. Resident #3 MDS dated 6/09/2023 modified by MDS nurse #1 on 11/14/2023. Resident #4 MDS dated 9/11/2023 modified by MDS nurse #1 on 11/14/2023. Resident # 5 MDS dated 3/02/23 modified by MDS nurse #1 on 11/14/2023. Adress what measures will be put into	

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F 641	Continued From page 6 comprehensive MDS assessments except when she is off, then it would be the responsibility of the MDS nurses to include it in the assessment. The SW checked Resident #21's annual MDS assessment and stated it should have included the Level II PASRR for mental illness information. She further explained it had missed being marked. On 10/26/23 at 11:48 AM an interview with the Administrator was conducted. He stated he would expect the MDS nurse to code the PASRR information and any other resident information accurately on each applicable assessment. 3. Resident #3 was admitted to the facility on 06/28/2012. Record review indicated that resident had a physician order for Azithromycin antibiotics that started on 5/19/2023 and ended on 5/29/2023 for pneumonia. Resident #3 quarterly Minimum Data Set (MDS) assessment dated 10/11/2023 revealed that resident had a diagnosis of Pneumonia coded. An interview with the MDS Nurse #2 was conducted on 10/26/23 at 12:11pm. The MDS Nurse stated resident #3 had a history of pneumonia that was treated from 5/19/2023 to 5/29/2023 with antibiotics and did not have pneumonia diagnosed since. MDS nurse stated that pneumonia should not have been coded because it was not an active diagnosis during the look back period of the quarterly assessment.	F 641	place or systemic changes made to ensure the deficient practice will not recur: MDS Nurse #1 and MDS Nurse #2 were educated by the Administrator on the importance of ensuring all MDS' are accurately coded. This was completed on 11/16/2023. Any newly hired MDS Nurse will be educated on this during orientation by the Regional Reimbursement Manager. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: MDS Nurse #1 will audit 10% of MDS Nurse #2 MDS' for accurate coding. MDS Nurse #2 will audit 10% of MDS Nurse #1 MDS' for accurate coding. These audits will be done monthly x 3 months. The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee by the MDS Nurses monthly x 3 months for review and further recommendations to ensure continued compliance with the plan of correction. Completion date November 20, 2023	

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F 641	Continued From page 7 4. Resident #36 was admitted to the facility on 05/10/2019. A hospice admission agreement dated 4/12/2023 was reviewed for Resident #36. The hospice admission agreement revealed Resident #36 was admitted to hospice services on 4/12/2023 and certified Resident #36 had less than 6 months to live. Resident #36 significant change in status Minimum Data Set (MDS) assessment dated 04/25/2023 revealed that resident's prognosis was coded as "no". Resident #36 Quarterly assessment dated 07/26/23 revealed that resident's prognosis was coded as "no". An interview with the MDS Nurse #2 was conducted on 10/26/23 at 12:11pm. The MDS Nurse stated Resident #36 elected hospice and had a life expectancy of less than 6 months documented. She further indicated that resident's prognosis should have been coded as "yes".	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		11/28/23

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F 657	Continued From page 8 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise care plans to reflect changes in dental status for 1 of 20 residents whose care plans were reviewed (Resident #15). The findings included: Resident #15 was admitted to the facility on 10/8/28 with diagnoses that included dysphagia. A review of the dental progress note dated 7/5/23 revealed "patient has broken 10 mil, 24, 25, 26 edges are broken, recommended extractions 9, 10, 11." An annual Minimum Data Set (MDS) assessment dated 8/21/23 indicated Resident #15 was cognitively impaired. No dental changes were noted.	F 657	F-657 The statements included are not an admission and do not constitute agreement with alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those observation areas	

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F 657	Continued From page 9 A care plan that was noted to be last revised on 8/16/23, did not indicate Resident #15 was care planned for broken teeth. A telephone interview was conducted with the dental assistant on 10/25/23 2:16 PM. She revealed that the dentist discovered Resident #15's broken teeth during a routine examination and cleaning on 7/5/23 and recommended extractions. She further revealed that the extractions had not yet occurred due to Resident #15 having no related pain at the time of the examination but that the facility staff should have been monitoring Resident #15 to let the dentist know if pain developed which would have expedited the date for the extractions. On 10/25/23 at 5:08 PM, an interview occurred with the Minimum Data Set (MDS) Coordinator. After reviewing Resident #15' s active care plan and medical record she confirmed she had failed to update the care plan to reflect the change in dental status and felt that this was an oversight. The Director of Nursing was interviewed on 10/25/23 at 5:10 PM and indicated it was her expectation for the care plan to be an accurate representation of the resident.	F 657	found to have been affected by the alleged deficient practices: Resident #15 care plan was updated to reflect current dental status. This was completed by Minimum Data Set (MDS) Nurse #1 on 10/25/23. How will the facility identify other residents that have the potential to be affected by the same deficient practice: All residents care plans with dental issues were reviewed by the Director of Nursing or designee to ensure that the care plan accurately reflects the resident's current dental status. This was completed on November 28, 2023. There were no additional care plan revisions required. Address what measures will be put into place or systemic changes to be made to ensure the deficient practice will not recur: The Administrator educated MDS Nurse #1 and MDS Nurse #2 on 11/16/2023 on the following: • The importance of ensuring that care plans accurately reflect the current condition of the resident. • Care plan review and revisions will occur after each assessment, including the comprehensive, quarterly review and significant change in status assessments. • Care plan review and revision will occur with any changes in condition to ensure accuracy. • All orders, progress notes and consults will be reviewed daily during clinical meetings and care plans will be reviewed and revised at that time for any pertinent changes. Any newly hired MDS nurse will be educated on this during orientation by the	

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F 657	Continued From page 10	F 657	Corporate Reimbursement Manager. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON/designee will audit 10% of resident's care plans monthly x 3 months to ensure the care plan accurately reflects the current status of the resident. The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly x 3 months for review and further recommendations to ensure compliance with the plan of correction. Completion date 11/28/2023	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews with residents and staff the facility failed to serve food that was palatable and at temperatures acceptable to 4 of 5 residents review for cold foods. (Resident #42, Resident #67, Resident #174, and Resident #177) This	F 804	F-804 plan of correction The statements included are not an admission and da not constitute agreement with alleged deficiencies herein. The plan of correction is	11/28/23

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PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 11 practice had the potential to affect other residents. Findings included: a. Resident #42 was admitted to the facility on 10/31/19 and re-admitted on 12/08/20. A review of the Minimum Data Set (MDS) dated 10/13/23 revealed Resident #42 was cognitively intact and independent with eating after assistance with meal set up. During an interview with Resident #42 on 10/26/23 at 2:30 pm she indicated she had concerns with all her meals being cold, this morning her breakfast was cold, she indicated she was served oatmeal, eggs, and toast. She indicated she did not eat her egg or oatmeal. She indicated she only ate her toast . "Resident #42 indicated that she has complaint before, about the meals being cold." b. Resident #67 was admitted to the facility on 04/11/23 and re-admitted on 07/05/23. A review of the Minimum Data Set (MDS) dated 10/12/23 revealed Resident #67 was cognitively intact and independent with eating after assistance with meal set up. During an interview with Resident #67 on 10/26/23 at 2:30 pm she indicated she had concerns with her meals being cold, this morning she indicated her oatmeal and eggs were cold, and she had toast . Resident #67 revealed she ate the cold food because no one would heat the food up. Resident #67 indicated that she has complained before, and no one did anything	F 804	completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those observation areas found to have been affected by the alleged deficient practices: Resident #42, Resident #67, Resident #174 and Resident #177 all remain in the facility and did not suffer any adverse effect secondary to the alleged deficient practice. Dietary Manager addressed concerns for Resident #174 and resident #177 on 10/26/2023. Residents were interviewed by Dietary Manager regarding temperature, portion size and food taste on November 2, 2023 and no further concerns were noted. Residents stated food was warm, understood portion size after dietary manager explained each portion size and food taste had improved. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice: Random meal trays were monitored for acceptable temperatures on all resident corridors. There were no additional issues identified by this audit. Random meal trays from each hall were also monitored for tray accuracy and portion sizes. There were no additional issues identified by this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 10/27/2023

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F 804	Continued From page 12 about the meals being cold. c .Resident #174 was admitted to the facility on 10/19/23. Resident #174 Admission Minimum Data Set had not been completed. Resident #174 was cognitively intact and independent with eating after assistance with meal set up. Interview with Nursing Assistant (NA) # 2 on 10/25/23 at 10:15am who worked with Resident #174 indicated she was able to make her needs known. NA #2 also indicated she would set up Resident # 174 breakfast and lunch tray, however she was able to feed herself. During an interview with Resident #174 on 10/24/23 at 11:15am she indicated she had concerns with her meals being cold and the taste of the food was not good. She stated she would only receive a small amount of food and it would be cold on her meal trays. An interview was conducted on 10/26/23 at 9:15 am with Resident #174 during her breakfast meal and she revealed her breakfast was cold, and she also indicated her portion was very small. Resident #174 indicated she had reported to staff that the food was cold before and she hoped that it get better. d. Resident #177 was admitted to the facility on 10/16/23. A review of the Admission Minimum Data Set (MDS) assessment dated 10/23/23 included that Resident #177 was cognitively intact and independent with eating after assistance with	F 804	audit.This was completed by Dietary Manager on November 17, 2023 Address what measures will be put in place or systemic changes made to ensure the deficient practice will not recur: The dietary manager will educate all dietary staff on acceptable temperatures for serving food, ticket to tray accuracy, and portion size appearance of food. This will be completed by 11/28/2023. Any newly hired dietary staff are educated on this process during orientation by the dietary manager. Any dietary staff out on leave or PRN status will be educated on this prior to returning to duty by the Dietary Manager or designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An audit tool was developed to monitor acceptable temperatures of food served to the resident, portion size, food appearance, and missing items. 10% of resident trays on random shifts will be audited monthly x 3 months by the Dietary Manager to ensure compliance with the plan of correction. The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly x 3 months by the Dietary Manager for review and further recommendations to ensure continued compliance with the plan of correction. Date of completion November 28, 2023	

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F 804	Continued From page 13	F 804		

meal set up.

During an interview with Resident #177 on 10/24/23 at 11:12 am she indicated she had concerns with her meals being cold at breakfast and the taste of the food was not good.

An interview was conducted on 10/26/23 at 9:30am with Resident #177 during her breakfast meal and she revealed that the oatmeal and grits were running and cold. Resident #177 indicated she had no eggs this morning.

An observation of the meal tray line service in the kitchen was conducted on 10/26/23 at 7:40am. The food items were placed on heated plates from a plate warmer. The plated meals were covered with insulated, dome shaped lids with bottoms. .

During an interview on 10/26/23 at 11:00 am., the Dietary Manager revealed he began working at the facility in May 2023 and did not frequently receive complaints from residents concerning the quality of the food.

During an interview with the Dietary Manager and District Manager on 10/26/23 at 11:00 am indicated that their expectation was that all residents would receive good hot food and food on time daily.

Interview was conducted with Administrator on 10/27/23 at 1:15pm he indicated that his expectation was for the dietary staff to provide palatable and hot meals to all residents daily.