STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-OUTER BANKS	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 and complaint investigation survey was conducted on 03/24/25 through 03/27/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 96HP11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/24/25 through 03/27/25. Event ID# 96HP11. The following intakes were investigated NC00227314, NC00227313, and NC00226631. 1 of the 5 complaint allegations resulted in deficiency. The 2567 was amended on 4/17/25 to reflect changes as result of IDR.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a	F 565		4/21/25

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

Electronically Signed | 04/17/2025

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F 565	Continued From page 1 resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to address repeat concerns and to communicate the facility's efforts to address concerns voiced by residents during Resident Council meetings for 2 of 4 months reviewed (November 2024 and February 2025). The findings included: The Resident Council meeting minutes were reviewed for November 2024. Under the heading "New Business", the minutes noted resident complaints of medication not being administered in a timely manner. The Resident Council meeting minutes were completed by the Activity Director. The Resident Council meeting minutes were reviewed for December 2024. Under the heading	F 565	F565 Peak Resources Outer Banks acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Affected resident On 04/16/2025, the Activities Director held an Ad hoc resident council meeting to address all previous grievances from resident council for the months of November 2024 through February 2025 and document these grievances and grievance decisions on the Resident	

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F 565	Continued From page 2 "Old Business", there was no documented follow-up for the November 2024 complaint related to medication not being administered in a timely manner. The Resident Council Meeting minutes were reviewed for January 2025. Under the heading "New Business", the minutes noted resident complaints of nursing assistants often rushing out of resident rooms during mealtimes without checking if they need help with opening condiment packages or containers. The minutes also noted a repeat complaint of medication not being administered at the correct time. The Resident Council meeting minutes were completed by the Activity Director. In the February 2025 meeting minutes, under the heading "Old Business", there was no documented follow-up for the complaints reported in January 2025 meeting related nursing assistants rushing out of resident rooms and medication not being administered at the correct time. Under the heading "New Business", was the repeat complaint regarding medication administration. The Resident Council meeting minutes were completed by the Activity Director A Resident Council meeting was conducted on 3/26/25 at 1:32 PM with the following residents; Resident #83. Resident #19, Resident #53, Resident #25, Resident #66 Resident #40, Resident #35, Resident #11, Resident #69. During the meeting residents voiced on-going concerns of medication not being administered in a timely manner and they felt staff continued to rush out of resident rooms during mealtime without offering help. Residents in the meeting stated they did not know when/if their grievances	F 565	Council minutes. Residents with potential to be affected All residents who attend resident council have the potential to be affected by the alleged deficient practice. On 04/16/2025, the Activities Director held an Ad hoc resident council meeting to address all previous grievances from resident council for the months of November 2024 through February 2025 and document the grievances and grievance decisions on the Resident Council minutes form. No residents suffered any adverse effect related to the alleged deficient practice. Systemic changes On 4/14/2025, the Administrator educated the Activities Director on providing responses from previous resident council concerns and documenting this information on the resident council minutes under old business and having the grievances in hand during meetings to discuss. Social Worker was educated by the Administrator on 4/14/2025, to ensure all resident council grievances have been addressed following grievance policy, form is complete, and a copy given to the Activities Director for her next resident council meeting. Monitoring An audit tool was developed to ensure compliance with the plan of correction. The Administrator/designee will audit all resident council minutes to ensure any prior grievances from the previous month have been addressed and documented on the Resident Council minutes form. This will be completed monthly and ongoing by the Administrator/designee.	

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F 565	Continued From page 3 were resolved, or the outcome of complaints/grievances voiced during Resident Council meetings without asking the Social Worker. An interview conducted with the Activity Director on 3/26/25 at 5:56 PM revealed that when a grievance was brought up in the Resident Council, she would write it down on the Resident Council minutes meeting form. In the morning meeting with the interdisciplinary team, she would let the interdisciplinary team know what the resident's concerns were in the Resident Council meeting. The Activity Director reported that the Corporate Administrator reviewed the Resident Council meeting minutes every month. The Activity Director explained she was informed of a new protocol by the Corporate Administrator in early March 2025 to present the completed grievances at next month's Resident Council meeting. She explained Resident Council for March was held on 3/24/25 and she had not had time to complete the March grievances. An interview conducted with the Social Worker (SW) on 3/27/25 at 8:33 AM revealed that if a resident brought up grievance in the Resident Council meeting, the Activity Director would let her know what concerns she (Social Worker) needed to address. The Social Worker stated she would inform the Activity Director verbally how the grievances were resolved for Resident Council and the Activity Director would go over the grievances from the previous month and inform the residents' how the grievances were resolved at the next Resident Council meeting. The Social Worker stated that she did not attend the Resident Council meetings.	F 565	The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly x 3 months by the Administrator for review and further recommendations. All corrective actions referenced in this Plan of Correction (POC) will be in place by 4/21/2025.	

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F 565	Continued From page 4 An interview conducted with the Administrator and Director of Nursing (DON) on 3/27/25 at 12:30 PM stated the Activity Director was responsible for verbally providing the resolutions to grievances/complaints reported during Resident Council meetings at the next Resident Council meeting the following month.	F 565		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is	F 582		4/21/25

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F 582	Continued From page 5 reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident representative interviews and record reviews, the facility failed to convey (transfer) funds within 30 days to the resident's representative for 1 of 1 resident (Resident #194) reviewed for refund of deposit. Findings included: Resident #194 was admitted to the facility on 12/19/24 for respite care. The resident had an unplanned discharge to the hospital on 12/23/24. Resident #194's medical record revealed there was no documentation of Resident #194's	F 582	F582 Peak Resources Outer Banks acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Affected Resident: Resident #194 discharged from facility with no adverse effects. Resident #194 received a full refund from the facility on	

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F 582	Continued From page 6 cognition. Review of a nursing note dated 12/27/24 written by Nurse # 2 revealed that all medication including narcotics and personal belongings were returned to Resident #194's resident representative and Resident #194 would be discharged from the hospital to home. On 3/25/25 at 03:45 PM an interview via telephone with Resident #194's representative occurred. The resident's representative explained her mother had been at the facility for respite care and she had submitted payment to the facility to cover the full duration of the planned stay for Resident #194. However, the resident's representative explained, the resident was discharged to the hospital, shortening the resident's stay at the facility, and then the resident was discharged from the hospital to home with the resident's representative. The resident's representative explained how she had expected a refund due to the resident's stay not being for the entire duration. She stated she called and talked to the Administrator the week of 3/17/25 about some other matters but the resident's representative had no recollection of the refund check being mentioned during the conversation with the Administrator. She stated she had still not received a refund from the facility. The Business Office Manager was interviewed on 03/26/25 11:02 AM. The Business Office Manager stated she had received payment for the intended full duration from Resident #194's resident representative and the funds were placed into a private pay account. The Business Office Manager stated she oversaw the refunds and had 30-60 days to refund the resident's	F 582	03/26/2025. Potentially Affected Resident: The Business Office Manager (BOM) completed 100% audit for operations and trust refunds on 03/26/2025 for all resident discharges in the last 90 days to ensure if the account has a credit balance and if a refund was given to resident/representative within 30 days of discharge. No other residents were affected related to the alleged deficient practice. Measures/Systemic Changes: The Administrator educated the BOM on the policy for management of resident funds to ensure that any resident who discharges from the facility receives a full refund of any balance within 30 days from the date of discharge. The Administrator educated the BOM to pull the current Accounts Receivable aging report to see if there are any credits for residents discharged the previous week. The BOM was instructed to submit a refund request for those residents identified with credits on their account. The BOM will ensure that any refunds due are processed. In the absence of the BOM, the Administrator will perform this task. Monitoring: A monitoring tool was developed to ensure resident refunds are processed and returned to resident/representative within 30 days of discharge. The Administrator/designee will conduct a 100% audit for residents who have been discharged from the facility weekly for the next 12 weeks. All audits will be brought to the Quality	

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F 582	Continued From page 7 money if a resident was discharged from the facility. The Business Office Manager stated she spoke with Resident #194's representative last week and she apologized to Resident #194's representative, because she had forgotten to take care of the refund after Resident #194 was discharged. The Business Office Manager stated the money for the refund was received from the corporate office late yesterday, 3/25/25. The Business Office Manager stated her plan was to call the resident's representative in the morning 3/26/25 to tell the resident's representative to come pick up her refund check. On 03/27/25 at 10:34 AM an interview occurred with the Administrator. She explained at the end of the month the facility sent a list of discharged residents sent to the corporate office. The list consisted of residents who were not expected to return and were due refunds. The Administrator stated upon receiving the check/funds from the corporate office, the Business Office Manager would then place a call to the resident or the resident's representative to pick up the refund. Pertaining to Resident # 194 the facility had documented the resident was coming back to the facility and the family chose to take the resident home from the hospital. When the facility realized the family was taking Resident #194 home, it was 15 days past the due date to provide the refund list to the corporate office.	F 582	Assurance and Performance Improvement Committee meeting by the Administrator for review monthly x 3 months. Continued audits will be determined based on results of prior months of audits. All corrective actions referenced in this Plan of Correction (POC) were in place on 04/21/2025.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		4/21/25

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F 761	Continued From page 8 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff resident, and Medical Director interviews, the facility failed to secure a tube of medicated arthritis gel that was observed left at bedside for 1 of 1 resident (Resident #68) reviewed for medication storage. Finding included: Resident # 68 was admitted to the facility on 2/6/2024 with a diagnosis of other specified rheumatoid arthritis. The annual Minium Data Set (MDS) dated 2/15/25 revealed Resident # 68 was moderately cognitively impaired.	F 761	F761 Peak Resources Outer Banks acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Affected Resident The nursing supervisor removed the medication from the resident□s bedside on 3/26/2025. Resident #68 did not suffer any adverse effects related to alleged	

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F 761	Continued From page 9 A physician order dated 3/11/25 for Resident #68 specified for diclofenac sodium topical gel, for arthritis pain reliever to be applied on bilateral hands, neck, right hip, and back twice a day for pain. Observation conducted during medication pass on 03/26/2025 at 11:23AM with Nurse #1 revealed a tube of topical medicated pain relief gel was kept in Resident #68's room in her bedside table in the top drawer. The arthritis pain reliver gel was visible when Resident #68 opened the top drawer. An interview with Nurse #1 on 3/26/25 at 11:23AM revealed that Resident #68 kept the topical medicated arthritis pain relief gel at her bedside. Resident # 68 would call the nurse when she was ready to have the gel applied. Nurse #1 stated the previous shift nurse gave her report that Resident # 68 kept the topical medicated arthritis pain relief gel in her bedside table in the top drawer. Nurse #1 was unaware residents could not keep medication at their bedside. An interview and observation with Resident #68 on 3/26/25 at 11:42AM revealed Resident #68's family brought the topical medicated arthritis pain relief gel from a drug store. The observation revealed the topical medicated arthritis pain relief gel remained in the top drawer of Resident #68's bedside table. Interview with Nurse #3 on 03/26/25 07:46PM revealed there was tube of topical medicated arthritis pain relief gel in the medication cart for Resident #68 that was delivered by the pharmacy.	F 761	deficient practice. Nurse #1 who stated that she did not know the med could not be left at bedside was educated by the Director of Nursing on 03/26/2025 regarding the Self-Administration of Medication policy and the policy of leaving resident medications at bedside. The RN Supervisor educated the resident□s daughter regarding the policy of bringing in medication without the facility knowledge on 03/26/2025. The daughter verbalized understanding of the information provided. The Registered Nurse Supervisor completed a Self-Administration of Medication assessment on 03/26/2025 to determine if the resident could self-administer the medication safely. The assessment concluded that she was able to self-administer the medicated arthritis gel as ordered by the physician. A physician□s order was obtained from the Medical Director on 3/26/2025. Lock box was provided to resident #68 on 03/26/2025 to contain the gel. Residents with potential to be affected Administrative nurses completed an audit of all resident rooms to ensure no medications were at the bedside unless the resident had been assessed for the ability to self-administer medications and there was a physician order to self-administer medications. This was completed on 3/26/25 by nursing staff. No other residents were affected by the alleged deficient practice. Systemic Changes Education was initiated on 3/26/2025 by the Director of Nursing (DON) for all	

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F 761	Continued From page 10 An interview with the Administrator and Director of Nursing (DON) on 3/27/25 at 8:00AM revealed the family of Resident #68 had brought the topical medicated arthritis pain relief gel to the facility without informing staff. The DON and Administrator stated Nurse # 1 was a new nurse that just started at the facility within the last week and was unaware medications could not be left at the bedside. The DON and the Administrator stated medications should not be left at the bedside and staff should have removed the topical medicated arthritis pain relief gel from Resident #68's room. A phone interview on 3/27/25 at 11:58AM with the Medical Director revealed he did not write an order for Resident #68 to have medication left at her bedside.	F 761	medication aides and licensed nurses including agency nurses on the Self-Administration of Medication policy. This education includes the following: " Medications are not left with a resident unless the resident has voiced the desire to self-administer medications, has been assessed as safe to self-administer medications and has a physician order to do so. This will be completed by the Staff Development Coordinator (SDC)/Designee by 4/21/2025. Any licensed nurse or medication aide out on leave or PRN status will be educated prior to returning to duty by the SDC/designee. Education on self-administration of medication procedures is included as part of orientation for all licensed nurses and medication aides by the SDC/designee. This education is also provided to the nursing agency for any agency nurses working in the facility in their orientation packet of material. Monitoring An audit tool was developed to monitor and ensure that medications are not left at a resident bedside unless they have properly been assessed to self-administer medications and have a physician order to do so. The SDC, DON or designee will monitor 10 residents weekly x 4 weeks on random halls, then biweekly x 4 weeks, then monthly x 1 month. Results will be reported to the Quality Assurance and Performance Improvement (QAPI) team by the DON monthly x 3 months for review and further	

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F 761	Continued From page 11	F 761	recommendations. Date of Completion: 4/21/2025	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain food service equipment free from debris and/or dried spills, failed to remove chipped dishes for safety, failed to maintain properly functioning walk-in freezer door, failed to keep walk-in cooler floor free from standing water, failed to discard expired food from walk-in freezer, failed to ensure dishware was air dried prior to stacking for use and free from dried debris. The facility also failed to remove dented cans from usable stock for 2 of 2	F 812	F812 Peak Resources Outer Banks acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	4/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-OUTER BANKS	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

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F 812	Continued From page 12 kitchen observations. These practices had the potential to affect food served to residents. Findings included: a. An initial observation of kitchen equipment on 3/24/25 at 09:33am revealed the steam table had orange reddish colored debris on the steam table glass, 1 steam table divider, and 3 steam table lids. Brown crumbs were observed on the shelf above the stove. The initial observation further revealed 1 of 3 cake plates had white and tan debris, 1 of 3 cake plates had white debris and 1 of 3 cake plates had a chip approximately 1 inch with a sharp edge. The cake plates were stored on the tray line ready to be used. There were also 15 of 32 dome lid plate covers that were stacked wet and ready for use on the tray line. An interview with the Regional Dietary Manager on 3/24/25 at 09:35am revealed breakfast had just been served, and staff must have missed the dirty areas on the glass, 1 steam table divider and 3 steam table lids as well as the shelf above the stove. The Regional Dietary Manager stated it was her expectation that the steam table be completely cleaned after each meal and that the shelf above the stove was cleaned. The Regional Dietary Manager also said the cake plates should be clean prior to being placed on the tray line for use, broken cake plates should be thrown in the trash and the dome tray lids should be completely dry prior to stacking and placing them on the tray line. A follow up observation and interview with the Certified Dietary Manager in the kitchen on 3/26/25 at 11:33am revealed 1 divided plate with red/brown debris that was on the tray line ready	F 812	Affected Resident: It is expected that our facility will provide food to residents that is stored, procured, prepared, and served in a sanitary manner. No residents suffered any adverse effects related to the alleged deficient practice. On 3/24/25 each of the following areas was addressed by the Dietary Manager or District Dietary manager: a. Kitchen equipment with debris at 0933 and were wiped down immediately, chipped plate was discarded immediately, wet dome covers and plates with residue were removed and re-washed and placed on drying rack. b. On 3/26/25 the surveyor was provided with paperwork showing door repair from the District Dietary manager. The door was thawed by the Maintenance Director and the seal was tightened up at that time. There was already another freezer thermometer in the freezer. c. The frozen sealed plastic bag labeled Angel Food cake with discard date of 01/19/25 was discarded immediately by the District Dietary manager. d. The two dented cans were removed from the top shelf and placed on the bottom shelf for return by the Dietary Manager immediately. Potentially Affected Resident: All residents have the potential to be affected by the alleged deficient practice. On 03/24/2025, the District Dietary manager checked all other open food items in freezer to check the discard date. There were no other items to be discarded. Dietary staff have cleaning	

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F 812	Continued From page 13 for use during lunch. An interview with the Certified Dietary Manager further revealed the expectation was all dishes be clean prior to placing them on the tray line for use and she removed the dish from the tray line. b. A continued initial observation and interview on 3/24/25 at 09:40am revealed the door to the walk-in freezer door was ajar and did not close when pressed. There was ice build-up around the top of the threshold that covered the thermostat, and the temperature of the walk-in freezer was not visible/readable. There was a puddle of water on the floor at the entrance of the walk-in freezer. The Certified Dietary Manager revealed the freezer needed to be repaired so that it could close. The Certified Dietary Manager also stated the water on the floor in front of the walk-in freezer was condensation. An observation and interview the Certified Dietary Manager of the kitchen on 3/26/25 at 11:37 am further revealed the freezer door closed properly but ice remained around the threshold covering the thermostat and the temperature remained not visible/readable and the puddle of water was gone from in front of the walk- in freezer door but was now inside the walk-in cooler on the hinged side of the cooler door, in front of the produce. An interview with the Certified Dietary Manager revealed she did not know what caused the ice around the threshold or covering the thermostat but stated the water was from condensation. An interview with the Regional Dietary Manager on 3/24/25 at 09:43am revealed the walk-in freezer had previously been repaired and said she would provide paperwork and put in a new work order to repair the door by the following day.	F 812	schedules and cleaned the steam table and the shelf above stove were cleaned prior to setting up line for lunch. This was completed on 03/24/2025. Measures/Systemic Changes: The District Dietary manager educated the Dietary Manager and all the kitchen staff on the following by 04/18/2025: + Following cleaning schedule with cleaning between meals. + Placing dome covers on racks to ensure complete drying before stacking on serving line + Remove chipped plates prior to stacking on the serving line. + Ensure freezer door is closed and latched to prevent ice from building up + Complete walk through to ensure items in freezer are discarded by date written on item + Ensure any can item with a dent is placed on the bottom shelf for return Monitoring: An audit tool was developed to ensure daily cleaning schedule is being completed daily for 2 weeks, then weekly for 6 weeks and will be completed by the dietary manager. An audit tool was developed for Maintenance Director to monitor freezer door weekly for 8 weeks to ensure ice doesn□t build up on door and heat strip is working. An audit tool was developed to ensure all items in freezer have been discarded by the date written on package and will be completed weekly by Dietary manager for 8weeks. An audit tool was created to ensure all	

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F 812	Continued From page 14 c. An observation and interview took place on 3/24/24 at 09:45 with the Regional Dietary Manager. A frozen sealed plastic bag labeled Angel Food Cake that had a discard date of 1/19/25 was found in the freezer. The Regional Dietary Manager revealed the Angel Food Cake should have been discarded already and must have been missed with the last check which she stated should have occurred on 3/21/25. d. An observation and interview with the Regional Dietary Manager and the Certified Dietary Manager took place on 3/24/25 at 09:50am of the dry food storage revealed one 7 pound can of original baked beans with 2-small, shallow linear dents at the top seal line and one 6.5 pound of canned sliced apples with one large, irregular, shallow dent along the seal line that was placed in the rack for use. An interview with both the Certified Dietary Manager and Regional Dietary Manager revealed the expectation was for dietary staff to remove dented cans from shelves and place dented cans on the bottom shelf for return. An interview with the Administrator and Director of Nursing on 3/27/25 at 1:15pm revealed the expectation was for kitchen staff to maintain clean food service equipment and follow all rules and regulations to maintain a safe and sanitary kitchen.	F 812	dented cans are placed on bottom shelf return and will be completed twice a week for 8 weeks by the Dietary Manager. The results of the audits will be brought to the Quality Assurance and Performance Improvement Committee by the respective auditors monthly x 2 months for review and further recommendations. All corrective actions referenced in this Plan of Correction (POC) were in place on 04/21/2025.	