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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345226	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER: Peak Resources-Outer Banks		STREET ADDRESS, CITY, STATE, ZIP CODE: 430 West Health Center Drive, Nags Head, NC 27959	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13030 Based on record review, staff, family, and resident interviews, the facility failed to protect a resident's bank card from being accessed and used without resident permission for 1 (Resident #3) of 2 residents reviewed for misappropriation of resident property. Findings included: Resident #3 was admitted to the facility on [DATE] with multiple diagnoses some of which included chronic congestive heart failure and diabetes. Documentation on a quarterly Minimum Data Set assessment dated [DATE] revealed Resident #3 was cognitively intact. Resident #3 was interviewed on 1/09/2025 at 8:45 AM and revealed the following information. A nurse aide (NA #2) had taken his bank card and used it at a local gas station in May 2024. The amount of money taken was approximately 30 to 35 dollars. The nurse aide was charged with theft, and the district attorney took the matter to court. The nurse aide no longer worked at the facility. Resident #3 indicated more information regarding the event could be obtained from his daughter, who was his power of attorney. The daughter of Resident #3 was interviewed on 1/09/2025 at 3:20 PM. The daughter explained the following events, detailing how she discovered Resident #3's missing bank card. The daughter stated she had her name on the bank account for Resident #3 and she handled his finances for him. The daughter of Resident #3 was alerted by the bank of two suspicious transactions on 5/29/2024, so she called Resident #3 to inquire if he used the bank card on those occasions. Resident #3 revealed to his daughter the bank card that he kept with his phone was missing. The daughter stated she immediately canceled the bank card and alerted the bank to the fraudulent charges, ordering Resident #3 a new bank card. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Administrator was interviewed on 1/09/2025 at 9:30 AM and provided the following information regarding the investigative steps and actions taken by the facility when it was brought to their attention Resident #3's bank card was missing. On 5/30/2024 at approximately noon, the Business Office Manager informed the Administrator that Resident #3 had told her his bank card was missing and had been used. Resident #3 had already left the facility for an appointment. The Administrator immediately contacted the daughter of Resident #3 and was informed the bank card of Resident #3 had been used two times at a local gas station on 5/29/2024 at 11:10 PM and 11:17 PM, the bank card was canceled, and another bank card was to be mailed to Resident #3. The family member revealed the last transaction made by Resident #3 with the missing bank card was on 5/28/2024. The local police department was called at approximately 12:30 PM on 5/30/2024 to file a report. A police officer arrived at the facility at 1:05 PM on 5/30/2024 to take a report but had to be informed Resident #3 was at an appointment and would be returning at 3:30 PM on that day. The responding police officer was provided photographs, of the fraudulent transactions made on Resident #3's bank card, which were provided to the facility by the daughter of Resident #3. On 5/31/2024 the facility interviewed all the cognitively intact residents residing in the same hallway as Resident #3, regarding any missing items, with no concerns voiced by the residents. On 5/31/2024 the Administrator spoke with a detective at the police department, who was working with the manager of the gas station where the fraudulent charges on the bank card of Resident #3 were made, to obtain video evidence to identify the suspect who used the bank card. Interviews with the facility staff were initiated on 5/31/2024 to inquire if anyone knew of the missing bank card of Resident #3, without any acknowledgment or awareness from any of the staff members. At approximately 11:30 AM on 5/31/2024, a facility housekeeper notified the Administrator the lost bank card was underneath the bed of Resident #3. The Administrator collected the bank card in a plastic bag to avoid getting fingerprints on it and notified the detective from the police department that the bank card of Resident #3 had been located. The Administrator notified the family member and Resident #3 that the bank card had been located. On 6/3/2024 the Administrator received a phone call from the detective revealing video evidence of the person using the bank card of Resident #3 was obtained from the local gas station. The Administrator received the image from the detective and identified the suspect using the debit card of Resident #3 as NA #2. On 6/3/2024 the detective came to the facility and was interviewed by the detective. NA #2 confessed to the crime and her employment was terminated with the facility. The Administrator provided the facility investigation file which included transaction details of a purchase made with Resident #3's debit card at a local gas station on 5/29/2024 at 11:10 PM and again at 11:17 PM in the amounts of $14.92 and another for $37.26. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation file provided by the Administrator also included the police report initiated on 5/30/2024 and completed on 6/4/2024. The police report included a supplemental narrative for the following events on 6/03/2024 at 3:00 PM. The detective interviewed NA #2 at the facility during which she was shown the photographs of herself at the local gas station on 5/29/2024 at 11:10 PM and 11:17 PM. NA #2 acknowledged that the person in the picture was her. The detective explained he was investigating the use of a stolen bank card that belonged to Resident #3. The detective told NA #2 that the photographs taken at the local gas station were of the person who used Resident #3's bank card to make purchases, explaining the bank notified Resident #3's family member of suspicious charges. At first, NA #2 denied she used Resident #3's bank card for the transactions for which she was pictured. The detective told her she was not being truthful because she was photographed at the local gas station, working in the facility the day the bank card went missing, and was assigned to the hallway where Resident #3 resided. NA #2 continued to deny she took the bank card from Resident #3 but told the detective she found the bank card in the hallway, used the bank card at the local gas station for food and then gas after the end of her nursing shift, and then returned the bank card to the hallway when she returned to work at the facility the next day. NA #2 denied she put the bank card under the bed of Resident #3 the next day despite being told of the improbability of that occurrence that someone else picked up the bank card from the hallway and put it under Resident #3's bed. NA #2 was informed by the detective that Resident #3 and a family member of Resident #3 were willing to press charges. The detective also told NA #2 he intended to seek a warrant for her arrest from the magistrate and contact her again after he had done so. The detective then went to inform the Administrator, Resident #3, and the daughter of Resident #3 of the results of the interview with NA #2. Current telephone contact information for NA #2 was not available at the time of the surveyor's investigation. The daughter of Resident #3 was interviewed on 1/9/2025 at 3:20 PM and provided the following additional information. The facility oversaw the entire investigation and made Resident #3 the priority. The bank reimbursed Resident #3 for the money charged to his bank card and acknowledged the charges made on 5/29/2024 at the local gas station were fraudulent. The District Attorney reached out to Resident #3 and with the assistance of his family member made a witness statement for the court. The case did go to court and NA #2 was given two years of probation because of her actions in fraudulently acquiring and using the bank card of Resident #3. The Administrator was interviewed again on 1/9/2025 at 1:02 PM and revealed the facility took immediate action when it was discovered Resident #3 had his bank card stolen. The proper reports to all entities required by policy and procedure, the investigation began, and interviews with 100 % of all cognitively intact residents were initiated on 5/31/2024. The QAPI (Quality Assurance and Performance Improvement) Committee met on 5/31/2024, and a Performance Improvement Plan (PIP) was implemented immediately. The facility provided the following corrective action plan with a completion date of 6/10/2024. (continued on next page)

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