

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Durham		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 Erwin Road Durham, NC 27705	

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)
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077</p> <p>Based on observations, records review, and resident and staff interviews, the facility failed to apply a left-hand splint for 1 of 3 residents (Resident #31) reviewed for contractures.</p> <p>Findings included:</p> <p>Resident #31 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, contractures of muscle (multiple site), altered mental status, diabetes mellitus type2, and congestive heart failure.</p> <p>Review of the physician orders dated 10/17/24 indicated Occupational Therapy (OT) to be provided 5 times per week for 8 weeks and treat diagnoses of left hemiplegia, contractures, reduced mobility, impaired coordination, and general weakness. This order was discontinued on 12/5/24.</p> <p>Review of the OT discharge summary dated 12/5/24 indicated Resident #31 received OT services from 10/17/24 to 12/5/24. The resident at discharge was able to tolerate left upper extremity wrist/hand orthosis (external devices to correct alignment or provide support) up to 5 hours with no adverse side effects. Discharge recommendations included recommending continuation of orthosis application up to 6 hours continuous duration of wear every day, with regular skin checks and pain monitoring.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment date 1/23/25, revealed Resident #31 was assessed as moderately impaired cognition, with no behaviors exhibited. Assessment indicated the resident had impaired range of motion on one side to upper extremities. The resident required substantial/maximal assistance from staff for most of her activities of daily living (ADL) Care.</p> <p>During an observation and interview on 3/31/25 at 10:40 AM, Resident #31 was observed lying in her bed. She had contractures to her left hand and was not observed to be wearing any splint. The resident's finger tips were not in contact with her palm. During an interview Resident #31 indicated she does not go to therapy and no splints were placed on her left hand.</p> <p>During an observation on 4/2/25 at 11:53 AM, Resident #31 was observed sitting in the Geri chair in her room. The resident did not have a splint applied to her left hand that had contractures.</p> <p>(continued on next page)</p>

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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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/25 at 11:55 AM, Nurse Aide #2 indicated she was frequently assigned to the resident. Nurse aide stated Resident #31 had contractures to her left hand but has never seen any splints applied to her left hand. Nurse Aide indicated splints were applied by nurses assigned to the resident.</p> <p>During an interview on 04/02/25 12:07 PM, Nurse #5 stated she was frequently assigned to the resident. Nurse #5 indicated Resident #31 had contractures to her left hand, however, there were no orders from therapy or no splint available to be placed on the resident's palm. She indicated she does not recollect any orders or education provided by therapy for the splint.</p> <p>During an interview on 04/03/25 11:16 AM, Nurse #4 indicated she was one of the unit managers for the floor. Nurse #4 stated Therapy staff would notify the nurses when they have any recommendations/orders for splint application. These orders were entered into matrix care (electronic health record) and the nursing staff continued to put the splint as per therapy orders. Nurse #4 stated there was no in-service or order sheet for nursing staff acknowledging that the orders were notified, and staff were trained. Nurse #4 stated Resident #31 had contractures to her left hand and was under therapy. However, there were no orders from therapy and there were no splints provided for the staff.</p> <p>During an observation and interview on 4/3/25 at 11:09 AM, the Rehab Director stated based on the OT discharged summary, Resident #31 was discharged with a splint from OT services. The Rehab Director searched the resident's room for splints. An empty mesh bag that was used for splint storage was found in the resident's closet. The Rehab Director indicated she was unable to find Resident #31's splints in her room. The Rehab Director stated that when any resident was discharged from therapy with splints, the nurses would be made aware of the splints and how long they should be worn. If training was needed, then it would be provided for staff. The nurse would then document the information in the resident's record and splints would be applied accordingly. The Rehab Director further stated Resident #31 was discharged from OT on 12/5/24 with recommendations for splint application for 6 hours daily. She indicated the therapy staff would reevaluate the resident and access/treated for new splints.</p> <p>The Rehab Director was reinterviewed on 4/3/25 at 11:34 AM. The Rehab Director indicated the Occupational Therapist who had worked with Resident #31 was no longer employed at the facility. She further stated that she was unsure where the in-service documentation or order documentation were placed. She was also unsure if nurses were notified about the splints.</p> <p>The occupational therapist was unavailable for an interview.</p> <p>During an interview on 4/3/25 at 12:18 PM, the Administrator stated there must be a breakdown in communication between the OT and nurses, resulting in the splint not been placed. She further stated that a better process needed to be implemented to ensure splints were placed on residents who needed them. Administrator indicated Resident #31 was re-evaluated by the therapy staff and would be treated with new splints.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222</p> <p>Based on observations, record review, and staff interviews, the facility failed to label and shake a new tube feeding formula bottle before hanging for 1 of 3 residents (Resident #307).</p> <p>The findings included:</p> <p>Review of the facility's Enteral Feeding: Using a Pump instructions for nurses dated 2022 read in part: Shake the container of formula to ensure that it is mixed well .Label the bag or container with the type of formula, strength, amount, and rate of administration as well as the date, time, and your initials.</p> <p>Resident #307 was admitted to the facility on [DATE] with diagnoses which included stroke, dysphagia, and gastrostomy status (surgical procedure for inserting a tube through the abdomen wall and into the stomach. The tube is used for feeding or drainage).</p> <p>Review of Resident #307's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired and required substantial/maximal assistance with most activities of daily living (ADL). Resident #307 received all nutrition and hydration through the feeding tube.</p> <p>Review of Resident #307's care plan dated 12/5/24 revealed he received tube feedings related to the risk for aspiration. Interventions included: Elevate head of bed per protocol. Replace the feeding tube as ordered. Monitor feeding tube site for signs/symptoms of infection and inform the provider of any changes. Treatment to feeding tube site as ordered. Administer medications via feeding tube per the orders and policy. Verify placement of the feeding tube by auscultation. Flush feeding tube as ordered. Notify provider of any problems. Labs as ordered. Administer tube feeding as ordered.</p> <p>Review of a physician order dated 2/11/25 revealed an order for Resident #307 to receive Glucerna 1.5 at 73 milliliters (ml) per hour (hr) administered continuously over 24 hours with all shifts required to document in the medication administration record (MAR).</p> <p>An observation of Resident #307's tube feeding formula bottle was conducted on 3/31/25 at 12:16 PM. There were no date/time/initials on the tube feeding bottle, and there was sediment stuck at the top of the bottle, which was almost empty.</p> <p>An observation and interview with the day shift Nurse #7 were conducted on 3/31/25 at 12:19 PM. She stated Resident #307's tube feeding bottle was already hanging when she started her shift at 7:00 AM. Nurse #7 indicated that the tube feeding bottle should be signed and dated when hung. The sediment observed at the top of the feeding bottle was most likely related to it not being shaken. Nurse #7 stated that she received shift change report from the overnight Nurse #10 and nothing was mentioned about the tube feeding bottle.</p> <p>Review of the Marh 2025 MAR revealed that Nurse #11 signed off Resident #307 received his enteral tube feeding during the day and evening shifts, and Nurse #10 signed off during the evening shift.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse #10 was interviewed on 4/02/25 at 9:16 AM. She revealed that she did work with Resident #307 from 7:00 PM - 11:00 PM on 3/30/25 and then was reassigned to another floor from 11:00 PM on 3/30/25 until 7:00 AM on 3/31/25. Nurse #10 stated that her normal process when changing the tube feeding bottle was to label, date, time, and initial the new bottle. Just because she signed off on the MAR during the overnight shift on 3/30/25 did not mean that she hung a new bottle but rather confirmed that the tube feeding was running as ordered. She could not recall if she hung a new bottle or not for Resident #307 on 3/30/25 night shift. She could only recall hanging a new bottle for another resident. Nurse #10 indicated the day shift nurse (Nurse #11) must have hung the tube feeding bottle for Resident #307 because each bottle lasted almost 14 hours.</p> <p>An interview was conducted with Nurse #11 on 4/03/25 at 9:29 AM. She stated when hanging a new tube feeding bottle, the patient's name, room number, date, time of hanging, and her initials needed to be labeled on the new bottle. Nurse #11 indicated that she had never shaken the tube feeding bottle before hanging. She changed the tube feeding bottle at the end of the shift around 7:00 PM for Resident #307 on 3/30/25. Nurse #11 stated that she was in a hurry to leave the facility and forgot to label the new bottle properly.</p> <p>During an interview with the Director of Healthcare Services on 4/03/25 at 10:52 AM, she revealed that Resident #307's tube feeding bottle should have been shaken and labeled with the date and time of hanging, as well as Nurse #11's initials when it was hung on 3/30/25.</p> <p>The Administrator was interviewed on 4/03/25 at 10:55 AM. She revealed that Resident #307's tube feeding formula bottle should have been shaken before hanging. After hanging, the bottle should have been labeled with the date and time of the hanging as well as Nurse #11's initials.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234</p> <p>Based on record reviews and interviews with staff, resident, and the Pharmacist, the facility failed to administer medications as ordered for 1 of 6 residents (Resident #64). Staff did not remove medication from the refrigerator believing the medication had not been received by the pharmacy, resulting in 11 missed doses of eyedrops for glaucoma.</p> <p>Findings included:</p> <p>Resident #64 was admitted to the facility on [DATE] with diagnoses including glaucoma.</p> <p>A physician's order dated 1/04/2025 noted Resident #64 was to receive timolol maleate 0.5 % eyedrops twice a day for glaucoma.</p> <p>Resident #64's February 2025 Medication Administration Record (MAR) noted she did not receive her timolol maleate eyedrops on 2/01/2025 at 9:00 AM, 2/01/2025 at 5:00 PM, 2/11/2025 at 5:00 PM, 2/12/2025 at 5:00 PM, 2/13/2025 9:00 AM, and on 2/14/2025 at 9:00 AM. The reasons noted by nursing staff were that the medication was unavailable, and they were awaiting delivery from the pharmacy.</p> <p>Resident #64's March 2025 MAR noted she did not receive her timolol maleate eyedrops on 3/01/2025 at 9:00 AM, 3/01/2025 at 5:00 PM, 3/17/2025 at 5:00 PM, 3/19/2025 at 9:00 AM, and 3/19/2025 at 5:00 PM. The reasons noted by nursing staff were that the medication was unavailable and they were awaiting delivery from the pharmacy.</p> <p>Resident #64's Minimum Data Set (MDS) dated [DATE] documented she was cognitively intact, had impaired vision, and was diagnosed with glaucoma.</p> <p>In an interview on 3/31/25 at 12:29 PM, Resident #64 said the nurses did not give her the eyedrops for her glaucoma. She said the nurses told her it was because it had to be reordered and the pharmacy had not delivered it.</p> <p>In an interview on 4/03/25 at 9:48 AM, Nurse #9 said she was one of the nurses who administered medications during that time. She said if the medication was not available on the cart, a nurse could easily reorder the medication from the MAR computer program. She said she did not remember the specific days she documented she was unable to give the medication or if she reordered the medication on that day.</p> <p>In an interview on 4/03/25 at 2:12 PM, Nurse #7 said she administered medications to Resident #64 on several of the days in February and March 2025 which noted the medication was not available. She said the medication was not on the medication cart and she was told by other nurses (names not recalled) that the medication had been reordered from the pharmacy. She said on one shift she worked (date not recalled), she was about to call the pharmacy to order the medication again, but then remembered that timolol maleate eyedrops were stored in the refrigerator when they were delivered from the pharmacy. She said she went and looked in the medication refrigerator and the medication was there. She said she put the medication on the cart and had not had a problem since.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 4/03/25 at 2:05 PM, the Pharmacy Consultant said the timolol maleate was sent as an automatic refill and was delivered to facility on 1/24/25, 2/11/25, 3/1/25, and 3/19/25. He said he checked the notes in pharmacy system and there were no notes regarding any insurance or delivery issues of the medication with no gap in delivery from the pharmacy records. He said the timolol maleate eyedrops were used to regulate the pressure in the resident's eye to treat glaucoma.</p> <p>In an interview on 4/03/25 at 3:27 PM, the Assistant Director of Health Services said she was the Director of Health Services at the time of the missed doses. She said she received complaints from Resident #64 and her family member (dates not recalled) that Resident #64 had missed several doses of the timolol maleate eyedrops because staff reported the medication was not available. She said she went to the medication refrigerator, where the eyedrops were stored when delivered from the pharmacy, and found the medication. She said she in-serviced the nurses on where to look for the medication and to look for them before ordering from the pharmacy. She said if there was a problem obtaining medications from the pharmacy, the facility had a back-up pharmacy that should have been called so the resident did not miss a dose of the medication.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>33778</p> <p>Based on record review, observations and staff interviews, the facility failed to date opened multi-dose pen injectors of insulin medication in 2 of 5 medication administration carts (100 hall and 200 hall), failed to remove expired multi-dose pen injectors of insulin from the medication cart drawer for 1 of 5 medication administration carts (200 hall).</p> <p>Findings included:</p> <p>1.a. On 3/31/25 at 9:55 AM, an observation of the medication administration 100 hall cart with Nurse #1 revealed one opened and undated multi-dose vial of Lantus insulin pen fill. A review of the manufacturer's literature indicated to discard Lantus insulin multi-dose vial 28 days after opening.</p> <p>On 3/31/25 at 10:00 AM, during an interview, Nurse #1 indicated that the nurses who worked on the medication carts, were responsible for discarding opened and undated multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse mentioned she had not administered expired medication this shift.</p> <p>1.b. On 3/31/25 at 10:15 AM, an observation of the medication administration 200 hall cart with Nurse #2 revealed one opened and undated multi-dose vial of Glargine Insulin pen fill, and one Admelog Solostar insulin pen fill, opened on 3/2/25, expired on 3/30/25. A review of the manufacturer's literature indicated to discard Lantus insulin multi-dose vial 28 days after opening.</p> <p>On 3/31/25 at 10:20 AM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible for discarding opened and undated or expired multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse stated she had not administered expired medication this shift.</p> <p>On 4/1/25 at 11:25 AM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible to check all the medications in medication administration carts for expiration date and remove expired medications every shift. She expected that no expired items be left in the medication carts.</p> <p>On 4/1/25 at 12:30 PM, during an interview, the Administrator expected no expired items be left in the medication carts.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43222</p> <p>Based on observation and staff interviews, the facility failed to cover facial hair during food service for 1 of 2 dietary staff (Cook #1) observed and clean the convection oven and the deep fryer. These practices had the potential to affect food served to residents.</p> <p>The findings included:</p> <p>1. During a follow-up tour of the kitchen, an observation and interview with [NAME] #1 were conducted on 4/2/25 at 11:30 AM. [NAME] #1 had facial hair and was without facial hair covering while taking temperatures of the lunch meal items located in the steam table. [NAME] #1 stated he did not cover his facial hair because he was about to go on break. He stated he should have always covered his beard and mustache while in the kitchen.</p> <p>During a follow-up interview with the DM on 4/2/25 at 11:40 AM, she revealed that the dietary staff were trained most recently on facial hair coverings last Friday (3/28/25). All dietary staff should know how to always cover facial hair while in the kitchen and [NAME] #1 should have taken the food temperatures prior to going on break.</p> <p>The Administrator was interviewed on 4/3/25 at 11:03 AM. She revealed that [NAME] #1 should have covered his facial hair while in the kitchen.</p> <p>2. An observation of the kitchen and interviews with the DM and [NAME] #1 were conducted on 3/31/25 at 10:31 AM. The convection oven doors were covered with a brown substance. [NAME] #1 stated the convection oven was last cleaned the weekend before last (3/22/25 or 3/23/25). The DM stated she was in the process of creating/posting a cleaning schedule.</p> <p>During a follow-up tour of the kitchen, an observation and interview with the DM were conducted on 4/02/25 at 11:39 AM. The convection oven doors had the same brown substance on both doors and the deep fryer was full of food particles in the oil and along the sides. The DM stated that the oven doors should have been cleaned after each use, and it looked like it had not been cleaned in a while. She further stated that the deep fryer should also be cleaned after each use, and it was last used yesterday (4/1/25). The last time the deep fryer was cleaned was on 3/28/25. There was an in-service provided on 3/28/25 about keeping kitchen equipment clean.</p> <p>The Administrator was interviewed on 4/03/25 at 11:06 AM. She revealed that a daily cleaning schedule should have been implemented for both the convection oven and the fryer.</p>