STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Silver Bluff		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Silver Bluff Drive Canton, NC 28716	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with the Wound Care Nurse Practitioner (NP), Medical Director (MD) and staff, the facility failed to follow up when a Wound Care NP recommended the staff contact the primary care provider about the condition of the wound and if antibiotics needed to be ordered for a resident who showed symptoms of a wound infection. This deficient practice affected 1 of 2 residents reviewed for pressure ulcers (Resident #11).Findings included:Resident #11 was admitted to the facility on [DATE] with diagnoses that included senile degeneration of the brain, type-2 diabetes mellitus, hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (decreased control and strength on one side of the body) following a cerebral infarction affecting left non-dominant side.A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #11 had severe cognitive impairment. The MDS showed that she required substantial/ maximal assistance with upper body dressing and was dependent on staff for all other activities of daily living (ADL) tasks and mobility. The MDS documented that she was at risk for developing pressure ulcers. It also documented that she had an unhealed stage 3 pressure ulcer and an unstageable pressure ulcer. The MDS further documented she had a pressure reducing device for the bed.A wound care note by Wound Care NP #2 dated 12/31/25 stated current wounds with decline this week. Treatment plans adjusted. Contact primary care physician (PCP) for possible antibiotic treatment due to positive signs and symptoms of infection to hip.Review of the resident's electronic medical record revealed that no antibiotic orders were entered. The record also showed no documentation in the progress notes indicating that the primary care provider had been contacted.A care plan last revised on 1/6/26 was in place for a pressure ulcer to the right heel, left lower leg, and right hip. The care plan interventions included administering treatments as ordered and to monitor for effectiveness. Staff were directed to assess, record, and monitor wound healing every week and report improvements or declines to the MD.A telephone interview was conducted with Wound Care NP #3 on 1/7/26 at 3:12 PM. He stated he remembered Resident #11 and her DTI (deep tissue injury) (damage to the skin and underlying soft tissues that can quickly become a deep pressure ulcer). He explained how a DTI developed and said that an initial insult to the area, such as a scrape or bump, made the area more sensitive to pressure and increased the risk of developing a DTI. He said that he believed the patient herself may have told him she bumped her hip. He explained you could not always see the trauma or where it started, but things like bumping or scrapping could cause trauma to an area and blood vessels to break under the skin. He said for Resident #11 something caused trauma to her hip and then she developed a DTI. He stated a DTI was what she initially had and that it had been covered with eschar. He explained when a DTI opened, it would then be staged as a pressure injury. Wound NP #3 said when Resident #11's DTI opened, it would be staged as a pressure wound because it was over a bony prominence.On 1/7/26 at 9:23 AM an observation was conducted of Resident #11's right hip wound with Nurse #2. The dressing was saturated with copious purulent brown drainage. The (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drainage had leaked out of the dressing and was visible on the under-bed pad. A malodorous smell was present. The wound was circular and opened into a visible cavity. A clumped gray piece of eschar was present at the wound opening. Nurse #2 measured the wound as 4 centimeters (cm) in length, 5 cm in width, and 5.5 cm in depth.An interview was conducted with Nurse #2 on 1/7/26 at 9:44 AM. Nurse #2 was the facility's wound care nurse. She said Resident #11's wound was found on 11/20/25 and was covered with black eschar (hard black dead tissue that forms over a deep wound). She believed that Resident #11's wound on her right hip was a pressure ulcer because it was over a boney prominence and there had been no trauma or transfer related trauma that had happened. She was not sure how Wound Care NP #3 had determined it was a transfer trauma wound. Nurse #2 explained Wound Care NP #3 was no longer coming to the facility and that a new Wound Care NP (Wound Care NP #2) had started coming the previous week. Nurse #2 reported she rounded with Wound Care NP #2 during her visit on 12/31/25 and was present when Resident #11's wound was evaluated by Wound Care NP #2. Nurse #2 recalled the odor to Resident #11's wound had been worse last week. Nurse #2 was aware of Wound Care NP #2's progress note from 12/31/25, which mentioned contacting the primary care provider for a possible antibiotic due to symptoms of infection in the right hip wound. Nurse #2 stated she had mentioned this to NP #1 when NP #1 was at the facility on Thursday (1/2/26). She said NP #1 had not thought Resident #1 needed an antibiotic. Nurse #2 reported that NP #1 did not examine Resident #11's wound. She could not explain why NP #1 believed Resident #11 did not need an antibiotic without evaluating the wound.A telephone interview was conducted with NP #1 on 1/7/26 at 10:23 AM. NP #1 stated she had been at the facility on 12/31/25 and again on 1/2/26. She stated she had not been informed and did not recall anyone contacting her about Resident #11's wound status or the need for an antibiotic.A telephone interview was conducted with Wound Care NP #2 on 1/7/26 at 2:56 PM. Wound Care NP #2 explained 12/31/25 had been her first time coming to the facility. She recalled seeing Resident #11 on 12/31/25 and evaluating her wound. She recalled she ordered Santyl (wound treatment used to debride (remove) dead tissue) for the wound care treatment because the wound was covered in eschar, she said the eschar was not stable and needed to come off. She stated Resident #11's wound was bad and that she had asked the Wound Care nurse (Nurse #2) to contact the primary care provider to get her started on an antibiotic. She said there was no doubt in her mind that there was probably some infection going on because of the amount of purulent drainage and the odor. She stated Resident #11 had moderate purulent drainage when she saw her on 12/31/25. Wound Care NP #2 explained that a wound did not heal correctly if there was infection present and that infection could impede healing. She explained that when an antibiotic was needed, her process was to notify the primary care provider and defer to them to decide about the antibiotic because she felt the primary care provider knew more about what was going on with the resident medically. Wound Care NP #2 said Nurse #2 had rounded with her on 12/31/25. She recalled discussing with Nurse #2 that Resident #11 had symptoms of infection and needed follow up with the primary care provider regarding a possible antibiotic. Wound Care NP #2 stated that she had also documented it in her note.On 1/7/26 at 3:50 PM during an interview with the Administrator, Director of Nursing (DON), and Regional Nurse they were made aware by the surveyor of the condition of Resident #11's wound and Wound Care NP #2's progress note from 12/31/25 recommending antibiotics. The Regional Nurse stated that they would update the provider and see if the provider wanted to start antibiotics.The electronic medical record included an order dated 1/7/26 that read, clindamycin (antibiotic) 300 milligrams (mg) by mouth three times a day for wound infection for 10 days. The January 2026 medication administration record (MAR) documented the clindamycin was administered as ordered on 1/7/26 and 1/8/26.A follow up interview was conducted on 1/8/26 at 11:48 with Wound Care NP #2. She (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported she had evaluated Resident #11's wound today and that it had looked better today than it had looked last week. She explained the santyl was doing its job to remove the eschar and it looked better because all the eschar was gone and there was less odor. Wound Care NP #2 said Resident #11's wound did not look the way it had looked last week but stated she thought Resident #11 would still benefit from antibiotics because of the drainage. She explained she suspected there was some infection present, although the wound looked better than it had last week. She reported the drainage was brown but not as purulent as it had appeared last week. A telephone interview was conducted with the Medical Director on 1/8/26 at 4:48 PM. The Medical Director stated his last day at the facility was on 12/31/25. He said he had not been contacted about Resident #11's wound or the need for an antibiotic. He explained that if the Wound Care NP had recommended antibiotics, he typically would have started an antibiotic. The Medical Director stated that someone should have followed up about the antibiotic for Resident #11 and made sure it happened.An interview was conducted with the Director of Nursing (DON) and Regional Nurse on 1/8/26 at 2:03 PM. The Regional Nurse stated the information should have been communicated to the primary care provider regarding the possibility of an antibiotic being needed for Resident #11. When asked who was responsible for reviewing the wound care providers notes, the DON stated it was a collective effort by the clinical team and that notes were reviewed in the daily clinical meeting. The DON reported he could not say they reviewed all notes in the clinical meeting but said he thought it was the responsibility of the clinical team to make sure provider notes were reviewed. The DON stated any notes from an outside provider should be reviewed and addressed by the clinical team for the best outcome for the resident. The DON did not remember reviewing Resident #11's wound notes from 12/31/25.An interview was conducted with the Administrator on 1/8/26 at 5:00 PM. The Administrator stated there should have been follow-up with the primary care provider regarding Resident #11 possibly needing an antibiotic. The Administrator said there should be a process for reviewing provider notes for orders.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews with staff, resident, Nurse Practitioner and Pharmacist, the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication ordered not to be crushed was administered crushed and medication omissions (3 medication errors out of 34 opportunities), resulting in a medication error rate of 8.82% for 1 of 3 residents (Resident #116) observed during medication pass.The findings included:Resident #116 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), benign prostatic hyperplasia (condition where the prostate gland enlarges) and age-related bilateral cataract.a. The Physician's Orders in Resident #116's electronic medical record indicated an active order dated 11/2/24 for Oxybutynin Chloride XL oral tablet extended release 24 hour 5 milligrams (mg) - give 1 tablet by mouth one time a day for bladder spasms/urgency. Do not crush.On 1/7/26 at 9:04 AM, Medication Aide (MA) #1 was observed as she prepared and administered Resident #116's medications. MA #1 crushed Resident #116's medication which included an Oxybutynin extended-release tablet while stating that Resident #116 preferred to take his medications crushed without applesauce or pudding. MA #1 administered the crushed medications to Resident #116 who swallowed them with a sip of water afterwards.An interview with MA #1 on 1/7/26 at 9:07 AM revealed she did not notice the order for Oxybutynin included instructions to not crush this medication, so she crushed it. MA #1 explained that the instruction to not crush medications was usually in bold letters and it was not for the Oxybutynin order which was why she didn't notice it. MA #1 stated that she did not know why the Oxybutynin could not be crushed.A phone interview with the Nurse Practitioner (NP) on 1/7/26 at 11:01 AM revealed the recommendation for Oxybutynin extended-release tablet was to not crush this medication because it was intended to work over a 24-hour period and if it was crushed, then the medication would have a tendency to hit at one time. The NP stated that she had noted that Resident #116 was getting his medications crushed per his preference, but they could have substituted this medication for a formulation that could be crushed.A phone interview with the Pharmacist on 1/7/26 at 12:13 PM revealed extended-release tablets were not crushable because crushing them would destroy the integrity of the tablet and would release all the medication at one time. She stated that Oxybutynin extended-release tablet should not be crushed.b. The Physician's Orders in Resident #116's electronic medical record indicated an active order dated 7/29/24 for Refresh Tears ophthalmic solution - instill 1 drop in both eyes three times a day for dry eyes, and an active order dated 12/21/24 for Fluticasone-Salmeterol inhalation aerosol (steroid and bronchodilator combination medication) - 1 inhalation orally two times a day for COPD.On 1/7/26 at 9:04 AM, MA #1 was observed as she prepared and administered Resident #116's medications. MA #1 did not administer the Refresh eye drops and the Fluticasone-Salmeterol inhaler to Resident #116.An interview with MA #1 on 1/7/26 at 10:05 AM revealed she did not administer Resident #116's Refresh eye drops and Fluticasone-Salmeterol inhaler because he kept these medications at the bedside and he administered them to himself.An observation and interview with Resident #116 on 1/7/26 at 10:26 AM revealed he did not keep his Refresh eye drops and Fluticasone-Salmeterol inhaler at the bedside and denied administering them to himself.An interview with the Interim Director of Nursing (DON) on 1/7/26 at 12:25 PM revealed Resident #116 did not have physician orders that he could administer medications to himself, and he was not sure why MA #1 thought he kept his inhaler and eye drops at the bedside. The Interim DON stated that MA #1 should have followed the medication pass administration protocol, which was to make sure she gave the right medication, right dosage, right resident, right strength and right product form. He also stated that MA #1 should not have crushed any medication that was not supposed to be crushed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and staff interviews, the facility failed to date an opened insulin pen and discard an expired stock medication available for use in 1 of 5 medication carts (500 hall long-side medication cart). Additionally, the facility failed to store a heparin flush syringe in a locked cart instead of leaving it unsecured on a resident's bedside table (Resident #8).The findings included: 1. An observation of the 500 hall long-side medication cart with Nurse #1 on 1/8/26 at 10:24 AM revealed an opened and undated Novolog flex pen available for use in the top drawer of the medication cart. The insulin pen had a pharmacy label indicating it was filled by the pharmacy on 11/10/25. A review of the manufacturer's instructions for Novolog pen indicated that it lasted 28 days after its first use. The observation further revealed an open bottle of Acidophilus tablets with manufacturer's expiration date of 11/25. There were approximately 40 tablets left in the bottle. Acidophilus is probiotic bacteria naturally found in the human gut and fermented foods. An interview with Nurse #1 on 1/8/26 at 10:28 AM revealed she wasn't sure whether the expiration date was 28 days or 30 days after the Novolog pen was opened, but it should have been dated. Nurse #1 stated that she was not sure when the Novolog pen was opened, but she remembered administering it this morning to a resident and she didn't notice that it wasn't dated when she used it. Nurse #1 stated that the nurses were responsible for checking the medication carts for undated insulin and expired medications. She shared that she did not give any of the Acidophilus tablets, and she didn't have time to check all of the stock medications in the medication cart for expiration dates. Nurse #1 stated that she only checked the stock bottles she got medications out of during her shift. An interview with the Interim Director of Nursing (DON) on 1/8/26 at 12:30 PM revealed the Novolog pen should have been dated when it was opened because it was good for 28 days after opening, and that the expired stock medication should have been discarded. The Interim DON stated that each nurse on the medication cart was responsible for checking the medications and ensuring that the medications they gave to residents were within date. 2. Resident #8 was admitted to the facility on [DATE]. A physician's order dated 12/8/25 for heparin (anticoagulant) lock flush solution 10 unit/milliliter. Use 5 milliliter intravenously every shift for PICC (peripherally inserted central catheter) line patency. Flush PICC line with 10 milliliters saline followed by 5 milliliters (10 units/milliliter). The order was discontinued on 12/15/25. On 1/5/26 at 11:57 AM an observation of Resident #8's room revealed a syringe in a sealed bag. The syringe was located on a shelf next to Resident #8's chair and was labeled heparin (fast-acting anticoagulant (blood thinner) used to treat and prevent blood clots in the body) lock flush solution 5 milliliters, and the syringe was partially full. On 1/5/26 at 12:04 PM Nurse #1 was interviewed and confirmed the syringe contained medication and removed it from Resident #8's room. Nurse #1 stated he had given Resident #8's medication earlier on 1/5/26 and did not see the medication syringe on the shelf. Nurse #1 indicated he did not know who had left the heparin lock flush in the Resident's room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/26 at 12:31 PM the Director of Nursing (DON) stated medications should never be left in a Resident's room and he did not know who had left the medication at bedside. On 1/8/26 at 5:06 PM the Administrator stated medications should not be kept at bedside unless a resident had an order for self-administration of medication.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Payor source: MedicaidBased on record review, and resident and staff interviews, the facility failed to hold aspirin (an antiplatelet medication that helps prevent blood clots) which resulted in Resident #55 not being able to have an ordered tooth extraction in November 2025 for 1 of 1 resident reviewed for providing dental services (Resident #55). Findings included:Resident #55 was admitted to the facility on [DATE] with diagnoses of severe protein-calorie deficiency and heart disease.A physician's order for one Aspirin Oral Tablet Chewable 81 milligrams at bedtime was ordered on 4/9/25.Resident #55 was care planned on 4/10/25 for dental health problems related to broken teeth and poor repair. The care plan included Resident #55 had recent tooth pain related to abscess and recurring abscesses. The care plan intervention included reporting bleeding gums and complaints of mouth or tooth pain.Resident #55's quarterly Minimum Data Set (MDS) assessment dated [DATE] coded him as cognitively intact, received a mechanically altered diet, and had no significant weight loss. The resident had mouth or facial pain and discomfort with chewing.The dental extraction consent form dated 8/25/25 was reviewed. The form included Resident #55's signature giving consent to have extractions and filling completed by the dentist. Additionally, the consent form indicated Resident #55 was taking blood thinner medication and would need the medication held 24-48 hours prior to a procedure. The form indicated the consent form was valid for 1 year after the physicians' signature. The Medical Director signed the consent form dated 8/25/25. A Dentist progress note dated 8/28/25 read Resident #55 was being seen for pain in the lower right quadrant of his mouth. Resident #55 stated he has had pain all over his mouth and wanted his teeth removed and wanted dentures. The Dentist wrote that a full mouth series (x-rays) had been completed and no remaining teeth were restorable. The note added a full mouth extraction would be planned. A physician's order was written on 10/7/25 to hold aspirin oral tablet chewable 81 milligrams from 10/7/25 to 10/10/25.A review of the October 2025 Medication Administration Record revealed aspirin was held from 10/7/25 through 10/10/25.The dentist's progress note dated 10/09/25 read Resident #55 had extractions of 4 teeth.The Social Worker (SW) stated on 1/6/26 at 3:10 PM that she had a follow-up with the dentist at the conclusion of the facility visit on 10/9/25. The dentist told the SW that Resident #55 was scheduled for more extractions on his next visit on 11/20/25. The SW stated she told the former Director of Nursing that Resident #55 would be having extractions on the next dental visit 11/20/25.There were no physicians' orders to hold Resident #55's aspirin in November 2025. A review of the Medication Administration Record for November 2025 revealed the aspirin was not held on 11/18/25, 11/19/25, or 11/20/25.A Dentist progress note dated 11/20/25 read Resident #55 was unable to be seen due to blood thinner (aspirin) not being held. The resident will be seen on the next visit if the blood thinner is held.Resident #55 was interviewed on 1/6/2026 at 10:43 AM. He stated his teeth had been hurting him off and on for a few months and was supposed to have them pulled so he could get dentures. He said when he chewed tougher foods his teeth hurt. Resident #55 stated he had some of his teeth pulled in October 2025 and was supposed to have the rest pulled in November 2025. Resident #55 indicated the November 2025 dentist appointment had to be canceled because the medication was not stopped before the dentist visit. The SW was interviewed on 1/6/26 at 3:10 PM. She stated the dental clinic would send a resident list 7-10 days prior to the facility visit. The list contained which residents would be seen and what they would be seen for. The SW reviewed the list to remove any residents who had been discharged from the facility. Residents who were to have extractions needed to sign a dental extraction form which included a signature from the physician. The dental extraction form included orders to hold blood thinner medications for 24-48 hours prior to tooth extractions and the order was active for 1 (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	year. The SW added Resident #55 had half of his teeth extracted on 10/09/25 and was to have the rest of his teeth extracted on 11/20/25. The SW explained Resident #55 was unable to have his teeth extracted on 11/20/25 because his thinner blood medication had not been held.On 1/8/26 at 3:50 PM the previous Director of Nursing (DON) was interviewed. She stated Resident #55's blood thinner (aspirin) was held for the teeth extractions on 10/09/25. The signed physician's consent form did state the order to hold blood thinners was valid for 1 year. The previous DON stated the consent form was scanned into the resident's chart and the resident's nurses may have forgotten about the consent form being valid for 1 year and were looking for a new order to hold Resident #55's blood thinner. She added the consent form order to hold Resident #55's blood thinner was missed for the 11/20/25 dental visit. The DON added she did not remember the SW telling her about Resident #55's extractions being scheduled for 11/20/25. The former DON did not know when the Dentist was coming back and expected a new physician's order to hold the resident's blood thinner. The former DON stated the nurses would not know when to hold the blood thinner if they did not know when the Dentist was coming to the facility. The Administrator was interviewed on 1/8/26 at 5:08 PM and stated the facility needed to ensure a proper process was in place that included checks and balances for dentist visits so residents would not miss appointments.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to dispose of food stored past the use by date in 1 of 3 refrigerators (walk-in refrigerator). Furthermore, the facility failed to maintain clean air vents located directly above the kitchen's tray line free from gray debris and practice hand hygiene during tray line service for 1 of 4 kitchen staff (Kitchen Staff #1) observed in the kitchen. The deficient practice had the potential to affect food served to residents. Findings included:a. On 1/5/26 at 10:34 AM an observation was conducted in the walk-in refrigerator with the Dietary Manager. An opened 1-gallon container of soy sauce was observed on the top shelf of a storage rack. The container contained a written date 6/11 -12/11. On 1/5/26 at 10:43 AM the Dietary Manager stated the soy sauce useful date range was 6 months after it was opened on 6/11/25. The soy sauce should have been disposed after 6 months (12/11/25).b. On 1/7/26 at 11:31 AM during tray line service Kitchen Staff #1 was observed removing his hat and rubbing his hair with his bare hands. The Kitchen Staff #1 did not wash his hands before putting on a pair of gloves. The continued observation revealed the kitchen staff left the kitchen wearing gloves, entered the dining room area and then returned to the kitchen without washing his hands. Kitchen Staff #1 was plating hot tray liners into plate covers and then onto trays used to plate food. He also was observed touching covered dessert containers used on the tray line. On 1/7/26 at 12:30 PM the Kitchen Staff #1 stated he may have forgotten to wash his hands after he touched his hair while in the kitchen. He stated he knew he needed to wash his hands when entering the kitchen and when changing gloves and he thought he had washed his hands every time he was supposed to.c. On 1/7/26 at 11:45 AM an observation made during tray line service found an air vent located directly above the tray line covered in debris. The air vent was covered in a thick, clumpy, and grayish in color substance.On 1/7/26 at 12:01 PM the Dietary Manager stated the Kitchen Staff #1 should have washed his hands after he touched his hair and each time, he entered the kitchen and changed gloves. Furthermore, the Dietary Manager stated the air vents in the kitchen should be cleaned every 3 to 4 months and did not know when they were last cleaned. She added, maintenance was responsible for cleaning the air vents and she would put in a work order to have them cleaned.The Administrator stated on 1/8/26 at 5:04 PM the food stored past its usable date should have been disposed. The air vents above the tray line needed to be cleaned and maintained and the kitchen staff needed to follow good hand hygiene.