STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325100	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clayton Nursing and Rehab	419 Harding Street Clayton, NM 88415

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record reviewtyg, and interview, the facility failed to provide reasonable accommodations of resident needs and preferences for 1 (R #6) of 1 (R #6) residents reviewed when staff did not ensure R #6 had access to his call light. These deficient practice is likely to result in residents being unable to request assistance in times such as needing help with transferring, after falling, or other acute distress. The findings are: A. Record review of R #6's face sheet revealed R #6 was admitted into the facility on [DATE]. B. Record review of R #6's care plan, dated 06/12/24, revealed R #6 had decreased mobility due to a history of a stroke, left and right sided weakness, and impaired balance which required R #6's call light to be placed within his reach at all times. C. On 10/29/24 at 9:26 am during an observation and interview, R #6's call light pad was on a chair behind R #6's bed and out of the resident's reach. R #6 appeared anxious as evidence by moving back and forth and he stated that he could not reach the call light to ask staff for more water and to take him to a shower. D. On 10/29/24 at 9:34 am during an interview with Nurse Aide (NA) #1, she stated R #6's call light should be placed next to him on the bed. NA #1 confirmed R #6's call light was out of reach for R #6. E. On 10/31/24 at 1:14 pm during an interview with the Director of Nursing (DON), she stated R #6's call light should be near him and within his reach at all times when he was in his room.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41988 Based on record review and interview, the facility failed to notify 4 (R #3, 21, 24 and 25) residents reviewed of the outcomes/resolutions of their grievances. This deficient practice could likely result in the facility not considering the needs of the residents or adequately resolving their grievances and lead to a decrease in resident quality of life. The findings are: A. Record review of the facility grievance log revealed the following: 1. Dated 08/12/24: R #34's son filed a grievance regarding the resident's clothes not changed and snacks thrown out. Staff marked the Resolution of Grievance section Yes The section did not contain the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident ' s concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. 2. Dated 08/19/24: R #35 filed a grievance regarding cold air from air conditioner blew on the residents at meal time. Staff marked the Resolution of Grievance section Yes The section did not contain the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident ' s concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. 3. Dated 09/04/24: R #3 filed a grievance regarding a missing candy dish. Staff marked the Resolution of Grievance section Yes The section did not contain the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident ' s concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. 4. Dated 09/30/24: R #21 filed a grievance regarding a Certified Nursing Assistant (CNA) talking on phone during shower. Resolution of Grievance section was answered and no resolution documented and without confirmation of R #21 knowing the outcome. B. On 10/29/24 at 12:57 pm during an interview with the Resident Council (RC), they stated they are not always told about the facility findings for their grievances. C. On 10/31/24 at 1:17 pm during an interview with the Administrator (ADM), she stated staff did not complete the grievance form. She stated staff should complete the entire grievance form so residents know the resolution of each grievance.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure the care plan was revised for 1 (R #3) out of 1 (R #3) residents reviewed when staff failed to conduct a quarterly care plan meetings as required. These deficient practices are likely to result in staff not being aware of residents' care needs and preferences, and residents not receiving the needed care. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE]. B. Record review of R #3's nursing progress notes revealed R #3's last care plan meeting occurred on 04/30/24. C. On 10/28/24 at 3:26 pm during an interview with R #3, he stated he did not recall having a care plan meeting in awhile. D. On 10/30/24 at 5:00 pm during an interview with the Minimum Data Set Coordinator (MDSC), she stated she was responsible for to schedule and conduct resident care plan meetings. The MDSC stated R #3 did not have his last two quarterly care plan meetings, but he should have.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure the resident's ability to perform activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) was maintained for 2 (R #6 and R #25) of 2 (R #6 and R #25) residents reviewed for restorative therapy (RT; therapy in which a resident trains on abilities they already have to perfect them and help maintain the physical abilities to perform ADLs.) If the facility does not ensure that residents receive restorative services, then the residents are likely to experience a decrease in their ability to walk, transfer (move from one place to another), and do other activities of daily living. The findings are: R #6: A. Record review of R #6's face sheet revealed R #6 was admitted into the facility on [DATE]. B. Record review of R #6's physician orders, dated 02/16/23, revealed R #6 was to receive Restorative Nursing Program (RNP) services two to three times a week for passive range of motion (the movement of a joint when an out-side force moves the body part while the person receiving the exercise is relaxed) to both of his arms. C. Record review of R #6's Documentation Survey Report (ADL tracking document) revealed the following: - Dated 09/01/24 through 09/30/24, staff completed RNP services with R #6 one time during the month on 09/27/24. - Dated 10/01/24 through 10/30/24, staff did not complete any RNP services with R #6. D. On 10/29/24 at 9:18 am during an interview with R #6, he stated he use to receive RNP services for his arms, but he has not received the services for awhile. R #6 confirmed he would like to continue with RNP services. E. On 10/29/24 at 5:53 pm during an interview with the Restorative Certified Nursing Assistant (RCNA), he stated he provided RNP services to residents in the facility. The RCNA stated he worked on the floor often and transported residents to appointments. He stated this prevented him from providing RNP services to R #6. RCNA stated R #6 should receive RNP services two to three times a week, but he did not. F. On 10/30/24 at 5:47 pm during an interview with CNA #1, she stated R #6 used RNP services and liked them. G. On 10/31/24 at 10:08 am during an interview with Registered Nurse (RN) #1, she stated RNP services gave R #6 a sense of purpose. RN #1 stated R #6 should receive RNP services, and he enjoyed the services. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. On 10/31/24 at 1:11 pm during an interview with the Director of Nursing (DON), she stated the RCNA was the only Restorative Aide in the facility. The DON stated R #6 should receive RNP services two to three times a week, but he did not. 47031 R#25: I. Record review of R # 25's face sheet revealed R #25 was admitted into the facility on [DATE]. J. Record review of R #25's physician orders, dated 10/16/24, revealed R #25 was to receive RNP services for passive range of motion to upper and lower extremities (arms and legs), three times a week. K. On 10/29/24 at 5:53 pm during an interview with the Restorative Certified Nursing Assistant (RCNA), he stated he provided RNP services to residents in the facility. The RCNA stated he worked on the floor often and transported residents to appointments. He stated this prevented him from providing RNP services to R #25. RCNA stated R #25 should have received RNP services three times a week, but she did not. L. On 10/31/24 at 1:25 pm during an interview with the Director of Nursing (DON), she stated the RCNA was the only Restorative Aide in the facility. The DON stated R #25 should receive RNP services two to three times a week, but she did not.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41988 Based on observation, record review, and interview, the facility failed to ensure the nutritional needs and preferences were met for all 30 residents listed on the facility census provided by the Administrator on 10/28/24 when staff failed to: 1. Serve the food items listed on the menu. 2. Provide residents with an alternate meal menu. If the facility is not providing meal as listed on the menu, an alternative meal or offering an alternate meal menu to residents, then residents are likely to experience weight loss, frustration, and depression. The findings are: Meal Service: A. On 10/28/24 at 4:52 pm, a dinner observation revealed the following: 1. Dinner Menu: Glazed meatloaf, French green beans, garlic seasoned potatoes, herbed dinner roll with margarine, and French orange cheesecake. 2. Staff did not serve the residents cheesecake. Staff served the residents Jell-O with whipped topping. 3. Residents meatloaf did not have a glaze as indicated on the menu. B. On 10/28/24 at 5:06 pm and 5:17 pm, during an interview with Licensed Practical Nurse (LPN) #1, she stated the kitchen informed her they did not have all the ingredients for the cheesecake so they served Jell-O instead. She stated there was not a glaze on the meat loaf, but there should have been according to the menu. C. On 10/28/24 at 5:08 pm during an interview with R #6, he stated he would prefer to be served the cheesecake instead of the Jell-O and was not okay with the substitution nor was R #6 informed of the menu change. D. On 10/28/24 at 5:10 pm during an interview with R #12, she stated she would have loved to have the cheesecake and would have also enjoyed a glaze on the meatloaf. R #12 confirmed that she was was not aware of the change. E. On 10/28/24 at 5:14 pm during an interview with R #30, he stated he would have preferred to eat the cheesecake instead of Jell-O. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F. On 10/28/24 at 5:18 pm during an interview with the Dietary Manager (DM), he stated the facility did not have supplies for cheesecake. He stated the meatloaf did not have a glaze on it, because they did not have ketchup or a glaze available. DM stated the food order had not come in therefore items were not available. G. On 10/31/24 at 1:42 pm during an interview with the Registered Dietitian (RD), he stated the residents should be served what was posted on the menu. The RD stated the kitchen did not have supplies for several meals during the week, but they should have. RD further stated that residents should have meals available as posted or she should be informed so that all meals have the same nutritional value as what is posted. Alternate Menu Posting: H. On 10/31/24 at 12:25 pm during an interview with Dietary Manager, he stated they did not make an alternate meal or offer an alternate meal. DM further stated I talked to my Manager (Regional) and I was told that because the census is low here and we only get one, two, maybe three alternate requests, alternates are not made. I. On 10/31/24 at 1:45 pm during an interview with the RD, he stated the posted menu should include the alternate menu choices, and the posted menus should match the meals that are being served. 47031

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47031 Based on interview, the facility failed to ensure foods were palatable (pleasant to taste) and to the resident's satisfaction for 1 (R #21) of 1 (R #21) residents. This deficient practice is likely to affect residents' ability to eat and enjoy meals, and is likely to cause unplanned weight loss. A. On 10/28/24 at 2:47 PM, during an interview with R #21, R #21 stated that on 10/27/24 during dinner the previous night the macaroni salad was extreme. The resident stated the macaroni salad smelled burnt. R #21 stated the peach cobbler had salt instead of sugar. B. On 10/30/24 at 9:05 am during interview, [NAME] #1 stated they came to work on 10/29/24, and there was burnt pasta in the refrigerator from the dinner the night before (10/28/24). C. On 10/30/24 at 9:16 am during an interview with Food Service Director, he stated the facility hired some new dietary staff, and he was currently training them. He stated the new staff needed a lot of supervision. The Food Services Director stated the nighttime dietary staff were all new, and he was aware of the burnt pasta and the mistake with the peach cobbler. D. Record review of Grievance/concern form dated 10/28/24 revealed. Resident compaint regarding dinner the previous day (Sunday 10/27/24) the cook scorched the pasta for the minestrone soup and it tasted burnt; served the coleslaw without dressing just raw cabbage and added salt instead of sugar to the peach cobbler, totally ruinng the dessert.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47031 Based on observation and interview the facility failed to store food in a manner that prevented cross contamination when staff failed to label and date open food items. These failures have the potential to result in cross contamination, the growth of food borne pathogens, and food borne illness (foods that are contaminated with harmful pathogens such as bacteria, viruses, and fungi). This failure had the potential to affect all 30 residents who ate food from the kitchen. The findings are: A. On 10/28/2024 at 1:38 PM, observation of the Dietary Department refrigerators and freezers revealed the following: - One, four-quart plastic container with an unidentified substance not labeled or dated. - Two, five-pound bags of slightly black colored stalks open to air, not labeled or dated. - One, two-inch pan of a red liquid uncovered and not labeled or dated. - One, six-quart plastic container of unidentified food not labeled or dated. - One tray of 6 oz. glasses of yellow liquid not labeled or dated. - One, ten-pound bag of frozen diced chicken open to air and not dated. -Two, one-pound bags of beef patties open to air and not dated. -Two, one-pound bags of boiled eggs not dated with opened date and were open to air. -Two, ten-pound rolls of Provolone cheese not dated. - One, fifty-pound bag of bread crumbs bag open to air, not labeled or open date. - One, four-inch soiled steel pan with a two-ounce scoop in refrigerator open to air containing crusted, crumbly food unidentified item not labeled or dated. B. On 10/28/24 at 1:41 PM during an interview with the Healthcare Group Services Operationalist (HCGS), he stated it was expected for staff to label and date all items ad should be covered not open to air.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47091 Based on observation, record review, and interview, the facility failed to ensure enhanced barrier precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) were put into place for 6 (R #3, #15, #28, #29, #8 and #7) of 6 (R #3, #15, #28, #29, #8 and #7) residents who had an open wound or a urinary catheter (a thin, flexible tube that is inserted into the bladder through the urethra which is used to drain urine from the bladder when a person is unable to urinate on their own). If EBP are not put in place for residents with sources of multi-drug resistant organisms (MDRO; germs that are resistant to many antibiotics and can cause serious infections.) then the chance of spreading those organisms to all residents in the facility increases. MDROs can have a negative effect on the health of residents and lead to adverse outcomes. The findings are: A. Record review of the facility's Procedure for EBP, revised 05/01/24, revealed staff to use EBP during high contact patient care activities, such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs. assisting with toileting, and device care, to include urinary catheters. Further review of record revealed PPE should be accessible and located outside of the patients room. B. On 10/29/24 at 4:25 pm during random observation of the 200 hallway, R #3, R #6, and R #28 did not have personal protective equipment (PPE-specialized clothing or equipment that protects the wearer from injury or the spread of infection or illness) outside of their rooms or any posted signs to indicate to staff that they should wear PPE when providing direct care to the residents. The residents had PPE stations inside their rooms. Findings for residents identified to have urinary catheters: Findings for R #3 C. Record review of R #3's physicians orders, dated 10/28/24, revealed R #3 had an order for an indwelling catheter. D. Record review of R #3's physicians orders, dated 08/06/24, revealed the following orders for catheter care: - Empty catheter drainage bag at least once every eight hours when it becomes 1/2 to 2/3 full. - Replace drainage system if disconnections or leakage occur, as needed. - Perform indwelling catheter care (includes cleaning tubing and inspecting the catheter for any problems) every day and night shift. Findings for R #6 E. Record review of R #6's physicians orders, dated 10/14/24, revealed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An order for an suprapubic catheter (a device that drains urine from your bladder through your belly button). - Change when occluded(blocked and not draining) as needed. - Catheter care every morning and at bedtime. Findings for R #28 F. Record review of R 28's physicians orders, dated 10/01/24, revealed R #28 had an order for an indwelling catheter. G. Record review of R #28's physicians orders, dated 08/14/24, revealed the following orders for catheter care: - Change indwelling catheter when occluded (blocked) or leaking, as needed. - Empty catheter drainage bag at least once every eight hours when it becomes 1/2 to 2/3 full, every 8 hours and as needed. - Replace drainage system if disconnections or leakage occur, as needed. - Perform indwelling catheter care every day and night shift. Findings for residents identified to have wounds: H. On 10/30/24 at 1:00 pm during random observation of the 100 hallway, R#29, R #8, and R #7 did not have any PPE in their rooms or any signage to signify to staff that they should wear PPE when providing direct care to the residents. The residents had PPE stations inside their rooms. The residents had wounds. Staff were observed providing care to the residents and were not observed using PPE. Findings for R #29 I. Record review of R #29's skin and wound evaluation, dated 10/30/24, revealed R #29 had a [NAME] terminal pressure ulcer (a skin wound that appears in some people during their final weeks of life and can an appear and develop over a few hours) to her right heel. Findings for R # 8 J. Record review of R #8's wound evaluation, dated 10/28/24, revealed R #8 had an open hematoma (a localized area of swelling resulting from broken blood vessels under the skin) on the front of her left, lower leg. Findings for R # 7 K. Record review of R #7's wound evaluation, dated 10/28/24, revealed R #7 is being treated for a Stage 2 pressure injury (a partial-thickness skin loss that appears as a shallow open wound with a red or pind wound bed) to the left gluteus (buttock). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	L. On 10/30/24 at 1:17 pm during interview with Skin Care team lead (SHTL) nurse, when asked why R #'s 29. 8 & 7 did not have EBP in place she stated it was just recently brought to her attention that the guidelines for EBP have been updated. M. On 10/30/24 at 1:19 pm during interview with the Director of Nursing/ Infection Preventionist (DON/IP), she stated there was available PPE in the closet in her office, and the nurses could access it at any point if there was an outbreak. She stated We are in-servicing our staff on the use of EBP.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 47091 Based on interview and record review, the facility failed to have a current consent form signed to acknowledge that vaccines had been given or refused or and that the residents were educated about the vaccine 5 residents (R #11, #18, #6, #25, and #1) out of 5 (R #11, #18, #6, #25, and #1) residents reviewed who received the Influenza (Flu) vaccine (shot) did not sign a current Influenza Vaccine Informed Consent Form (ICF) form prior to receiving the vaccination. If a current ICF form is not signed each time the vaccination is offered, then there is not a way to know if it had been given or refused by the residents. T 1. Residents have received education regarding the pro's and con's of receiving the flu shot. 2. The resident understands the education provided, 3. The resident consents to receiving the flu shot at the time it is given. A. On 10/30/24 at 11:30 am during an interview with the Director of Nursing (DON), she stated Liscensed Vocational Nurse (LVN) #1 and the Skin Health team lead nurse (SHTL) held a flu clinic the first week of October 2024 and obtained ICF for all residents who received the Influenza vaccination. DON confirmed that consents should be part of the medical record. B. On 10/30/24 at 3:01 pm during interview with LVN #1, she stated they only have residents sign the ICF once since the form states annually. She stated if the resident refused the vaccination, then they had them sign a declination form. She stated those residents would be required to sign a new ICF for any future flu vaccines. LVN #1 further stated forms should be part of the residents medical record. Findings for R #11 C. Record review of R # 11's vaccinations in the electronic medical record (EMAR) revealed R # 11 received the flu vaccine on 10/06/23. The record did not contain an ICF. Findings for R# 18 D. Record review of R # 18's EMAR revealed R #18 received the flu vaccine on 10/01/24. The record did not contain an ICF. Findings for R #6 E. Record review of R # 6's EMAR revealed R #6 received the flu vaccine on 10/01/24. The record did not contain an ICF. Findings for R #25 F. Record review of R # 25's EMAR revealed R #25 received the flu vaccine on 10/01/24. The record did not contain an ICF. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325100	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clayton Nursing and Rehab	419 Harding Street Clayton, NM 88415

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings for R #1 G. Record review of R # 1's EMAR revealed R #1 received the flu vaccine on 10/01/24. The record did not contain an ICF.