Printed: 06/05/2026
Form Approved OMB
No. 0938-0391

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	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clayton Nursing and Rehab Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, and interviews, the facility failed to properly store medications located in the facility medication storage room when the staff failed to ensure medication fridge temperature log is being monitored routinely. This deficient practice is likely to result in medications being used in resident care at risk of not receiving the full benefits of medication. The findings are: A. On 02/10/26 at 12:55 pm, during an observation of the locked medication storage room, the vaccine fridge temperature log form for the months of January 2025 through February 2026 was not complete, the following dates on vaccine fridge temperature log were left blank: 1. Day Shift: 01/01/25 through 01/18/25, 01/20/25 through 06/01/25, 06/03/25 through 07/23/25, 07/25/25 through 09/12/25, 09/15/25 through 09/31/25, 10/04/25, 10/19/25, 10/21/25, 10/26/25, 10/27/25, 11/01/25 through 11/12/25, 11/15/25, 11/18/25, 11/20/25, 11/21/25, 11/23/25 through 11/30/25, 12/04/25 through 12/12/25, 12/15/25 through 01/02/26, 01/06/26 through 01/08/26, 01/12/26 through 01/16/26, 01/19/26 through 01/25/26, 01/30/26 through 02/01/26, and 02/06/26 through 02/08/26. 2. Night Shift: 01/11/25, 01/18/25, 02/01/25, 02/24/25, 03/01/25, 03/18/25, 03/19/25, 04/04/25, 04/08/25, 05/10/25, 05/19/25, 07/27/25, 08/01/25, 08/15/25, 08/16/25, 09/12/25, 09/26/25, 10/05/25, 10/17/25, 11/13/25, 11/22/25, 12/17/25, 12/19/25, and 12/27/25.B. On 02/10/26 at 12:56 pm, during an interview with Licensed Practical Nurse (LPN) #2, she confirmed the vaccine medication fridge temperature log is not getting done routinely. LPN #2 stated that nurses are responsible for completing all temperature log. C. On 02/11/26 at 1:38 pm, during an interview with Director of Nursing (DON), she confirmed that there has been inconsistency with the vaccine fridge temperature log not being checked routinely. DON stated that fridge temperature should be checked once per shift and should be documented on the appropriate log and it did not occur.

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 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. Based on observation and interview, the facility failed to ensure food was prepared and served under sanitary conditions when staff failed to:1. Properly store dishes in sanitary conditions.2. Keep the stove and oven clean.These deficient practices are likely to affect all 36 residents listed on the resident census list provided by the Administrator on 02/09/26 and are likely to lead to foodborne illnesses in residents if safe food handling practices are not adhered to and food stored properly. The findings are:A. On 02/09/26 at 1:10 pm, a random observation of the kitchen revealed the following:1. Dried food particles, dried liquid splashes and trash in the plate warmer (a device designed to keep clean plates warm and ready to be used for serving meals).2. The stove had what appeared to be dirty, dried food particles and dried liquid splash marks covering the front side. The back of the stove had dirt and grease covering it.3. The oven had baked on food stains throughout the inside. B. On 02/09/26 at 1:43 pm, during an interview with the Dietary Manager (DM), he confirmed the plate warmer, stove, and oven were dirty and did not meet his expectations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation and interviews, the facility failed to implement an ongoing infection prevention and control program (a program that is used to prevent, recognize, and control the onset and spread of infections) by1. Not ensuring Personal Protective equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) was used for residents with required 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).2. Not ensuring that shared resident-care equipment, specifically a mechanical lift (a device designed to help staff move a resident from one place to another within a room or from one position to another), was cleaned and disinfected between use. These failed practices have the potential to affect all 36 residents living in the facility as identified by the census provided by the Administrator 02/09/26. These deficiencies place residents at risk of contracting infections, hospitalization, and death. The findings are: PPE A. On 02/09/26 at 11:25 am a random observation of the 200 hall revealed the following: 1. R #1 had an EPB sign posted on her door. 2. Certified Nurse Aide (CNA) #1 was in the room with R #1 and was not wearing any PPE. 3. R #1 was sitting on the bed when CNA #2 walked into R #1's room without putting on PPE and closed the door behind her. 4. Approximately five minutes after closing the door, CNA #1 and CNA #2 opened the door to R #1's room and assisted R #1 out of her room in her wheelchair. B. On 02/09/26 at 11:39 am during an interview with CNA #2, she confirmed that CNA #1 and herself were providing direct care to R #1. She confirmed neither wore PPE and stated they should have been. Disinfecting equipment C. On 02/12/26 at 1:03 pm, during an observation, R #4 was transferred from wheelchair to bed using a mechanical lift. CNA #2, and #3 provided a brief change immediately after the transfer. R #4 is on 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), all staff providing direct resident care donned with mask, gown and gloves as ordered. CNA #2 & #3 donned off their Personal Protective Equipment (PPE), performed hand-hygiene and immediately took the mechanical lift to another room without cleaning or sanitizing the medical equipment. D. On 02/12/26 at 1:18 pm, during an interview with CNA #2 and CNA #3, they both confirmed that they did not follow protocol by not cleaning the medical equipment after using it for direct resident care. CNA #2 and #3 stated they are to clean and wipe down all medical equipment after use with bleach after each use and it did not happen. E. On 02/12/26 at 1:29 pm, during an interview with Director of Nursing (DON), she confirmed she is the Infection Preventionist of the facility. DON stated that all nursing staff after to perform hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hygiene before and after patient care including medication administration. DON stated that nursing staff are to follow all infection control precautions to prevent the spread of infection. DON also stated all medical equipment is cleaned and disinfected after each use.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to ensure a safe, clean, and homelike environment for 3 (R #9, R #13, and R #15) of 9 (R #3, R #4, R #5, R #9, R #13, R #15, R #16, R #33, and R #39) residents reviewed for dining when staff: -Administered medications in the dining area during mealtimes.-Used an overhead paging system to call facility staff.-Maintain the vents in the kitchen to ensure they are free from dirt and dust build up.These deficient practices could likely affect all 30 residents that eat their meals in the dining area, as identified by the list identified by the Dietary Manager on 02/09/26 by creating an uncomfortable and sanitary living environment. The findings are: Administering medications in the dining area during mealtimes:A. On 02/10/26 at 11:45 am, an observation of the lunch meal revealed the following:1. R #13 was seated at a table in the dining area eating lunch when Licensed Practical Nurse (LPN) #2 walked up to him and handed R #13 a medicine cup (a small plastic cup used in the administration of medications). After R #13 took the medicine that was in the cup, LPN #2 told him to put his head back and administered eye drops (liquid medication applied in the eyes). Once LPN #2 was done administering medications, R #13 finished his meal.2. R #9 was seated at a table with R #4 and R #39 in the dining area eating lunch when LPN #2 walked up and handed R #9 a medication cup. R #9 stopped eating his meal to take his medication.3. R #15 was seated at a table with R #5, R #16, and R #33 eating lunch when LPN #2 walked up and handed R #15 a medication cup. R #15 stopped eating his meal to take his medication.B. On 02/10/26 at 12:33 pm, during an interview with LPN #2, she stated that she usually administers medications in common areas and mealtimes because that is where all the residents are. Use of an overhead paging system to call facility staff:C. On 02/12/26 at 8:37 am, a random observation of the dining area revealed an announcement using the overhead paging system asking LPN #1 to contact another staff member. D. On 02/13/26 at 8:14 am, a random observation of the dining area revealed an announcement using the overhead paging system asking LPN #1 to contact another staff member. Maintain the vents in the kitchen to ensure they are free from dirt and dust build up:E. On 02/29/26 at 1:13 pm, a random observation of the kitchen serving area revealed the ceiling vents to be covered with dust and dirt making a portion of the vents and surrounding ceiling appear to be brownish black in color instead of the white they were supposed to be.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to complete an accurate Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessment for 3 (R #4, R #8, and R #9) of 5 (R #4, R #6, R #8, R #9, and R #11) residents reviewed for assessments. This deficient practice could likely result in the residents' preferences and care needs not being met. The findings are: R #4 A. Record review of R #4's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Type 2 diabetes mellitus (DM2; a disease in which the body cannot make or properly use insulin) with other diabetic neurological complications, 2. Personal history of traumatic brain injury (TBI; injury to the brain caused by an outside force, usually a violent blow to the head), 3. Quadriplegia (paralysis of all four limbs) C1 to C4, C5 to C7 (spinal cord levels), 4. Encounter for fitting and adjustment of urinary device, 5. Other obstructive (blockage in the urinary tract that impedes urine flow) and reflux uropathy (involves the backward flow of urine from the bladder into the kidneys), 6. Need for assistance with personal care. B. Record review of R #4's physicians order revealed an antibiotic order dated 08/07/23 Nitrofurantoin Macrocrystal oral (antibiotic) capsule 100 milligrams (mg) for urinary tract infection prophylaxis (to prevent disease). C. Record review of R #4's MDS assessment dated [DATE] revealed antibiotic use was not checked.ˆ D. On 11/25/25 at 12:08 pm, during an interview with MDS Coordinator (MDSC), she confirmed R #4 is currently taking an antibiotic. MDS coordinator confirmed that she failed to capture this antibiotic in this assessment. R #8 E. Record review of R #8's Face Sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic obstructive pulmonary disease (COPD; lung disease), 2. Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), 3. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) with agitation, (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), 5. Essential (primary) hypertension (HTN; high blood pressure). F. On 02/10/26 at 9:05 am, an observation of R #8 in her room revealed an oxygen concentrator plugged in next to R #8's bed. G. Record review of R #8's physician orders revealed an order dated 08/05/25 for R #8 to utilize oxygen at two liters per minute via nasal cannula as needed for respiratory distress. H. Record review of R #8's MDS assessment dated [DATE] revealed no indication that R #8 utilizes oxygen. I. On 02/13/26 at 9:20 am, during an interview with the Director of Nursing (DON), she confirmed that R #8 does utilize oxygen as needed. The DON stated that R #8's MDS assessment does not meet her expectations because it is not accurate. R #9 J. Record review of R #9's Face Sheet revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Parkinsonism (a syndrome characterized by uncontrolled movements), 2. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), severe, 3. Obstructive and reflux uropathy (a blockage in the urinary track that stops urine from flowing), 4. Wasting disease (severe, involuntary weight loss, loss of muscle, and fatigue), 5. Sarcopenia (age-related progressive loss of muscle mass, strength, and function). K. On 02/10/26 at 10:30 am, during an observation of R #9 in the dining area revealed R #9 asleep in his wheelchair. R #9's legs and ankles appeared red and swollen. L. Record review of R #9's Physician Progress Note dated 08/21/24 revealed a diagnosis of ankle edema (swelling due to fluid backup). M. Record review of R #9's MDS assessment dated [DATE] revealed no indication of R #9 having ankle edema. N. On 02/13/26 at 9:30 am, during an interview with the DON, she confirmed that R #9 does have ankle edema. The DON confirmed R #9's MDS assessment does not meet her expectation because it is not accurate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop and implement an accurate, comprehensive care plan for 2 (R #8 and R #9) of 4 (R #4, R #8, R #9, and R #28) residents reviewed for care plans. This deficient practice could likely result in residents not getting the needed care and services. The findings are:R #8A. Record review of R #8's Face Sheet revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Chronic obstructive pulmonary disease (COPD; lung disease),2. Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills),3. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) with agitation,4. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),5. Essential (primary) hypertension (HTN; high blood pressure). B. Record review of R #8's physician orders revealed an order dated 08/05/25 for R #8 to utilize oxygen at two liters per minute via nasal cannula as needed for respiratory distress. C. Record review of R #8's care plan dated 08/04/25 revealed no indication that R #8 utilizes oxygen as needed. D. On 02/13/26 at 9:20 am, during an interview with the Director of Nursing (DON), she confirmed that R #8 does utilize oxygen as needed. The DON confirmed that R #8's care plan does not indicate that she utilizes oxygen, and it should. R #9 E. Record review of R #9's Face Sheet revealed he was admitted to the facility on [DATE] with the following diagnoses:1. Parkinsonism (a syndrome characterized by uncontrolled movements),2. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), severe,3. Obstructive and reflux uropathy (a blockage in the urinary track that stops urine from flowing),4. Wasting disease (severe, involuntary weight loss, loss of muscle, and fatigue),5. Sarcopenia (age-related progressive loss of muscle mass, strength, and function). F. On 02/10/26 at 10:30 am, during an observation of R #9 in the dining area revealed R #9 asleep in his wheelchair. R #9's legs and ankles appeared red and swollen. G. Record review of R #9's Physician Progress Note dated 08/21/24 revealed a diagnosis of ankle edema (swelling due to fluid backup). H. Record review of R #9's care plan revised on 07/31/25 revealed no indication of R #9 having ankle edema. I. On 02/13/26 at 9:30 am, during an interview with the DON, she confirmed that R #9 does have ankle edema. The DON confirmed R #9's care does not meet her expectation because it should include his ankle edema and it does not.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) for 1 (R #8) of 1 (R #4, R #8, and R #28) residents reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are:A. Record review of R #8's Face Sheet revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Chronic obstructive pulmonary disease (COPD; lung disease),2. Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills),3. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) with agitation,4. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),5. Essential (primary) hypertension (HTN; high blood pressure). B. Record review of R #8's physician orders revealed an order dated 08/05/25 for R #8 to utilize oxygen at two liters per minute via nasal cannula as needed for respiratory distress. C. Record review of R #8's baseline care plan dated 08/04/25 revealed no indication that R #8 utilizes oxygen as needed. D. On 02/13/26 at 9:20 am, during an interview with the Director of Nursing (DON), she confirmed that R #8 does utilize oxygen as needed. The DON confirmed that R #8's baseline care plan does not indicate that she utilizes oxygen, and it should.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide respiratory care in accordance with professional standards for 1 (R #1) of 3 (R #1, R #3, and R #8) residents reviewed for respiratory care when the facility failed to ensure medical orders indicated the frequency of when to administer R #1 oxygen. These deficient practices are likely to result in residents receiving too much or not enough oxygen and can lead to worsening of their conditions. The findings are:A. Record review of R #1's admission record revealed R #1 was admitted to the facility on [DATE] with the following diagnoses:1. Chronic respiratory failure (a life-term condition where the lungs cannot maintain adequate oxygen levels) with hypoxia (a condition characterized by insufficient oxygen reaching the tissues of the body),2. Chronic obstructive pulmonary disease (COPD; lung disease),3. Obstructive sleep apnea (OSA; a common sleep disorder),4. Emphysema (a respiratory disorder that results in the reduction of air intake),5. Carrier or suspected carrier of Methicillin Resistant Staphylococcus Aurea's (MRSA; bacteria that are resistant to treatment with semi-synthetic penicillin).B. Record review of R #1's physician orders revealed an order dated 09/14/25 for R #1 to use supplemental oxygen at two liters per minute (L/min). C. On 02/10/26 at 10:05 am, during an observation of R #1's room, she was observed lying in her bed wearing a nasal cannula (a medical device used to deliver supplemental oxygen through their nostrils) that was connected to an oxygen concentrator (a medical device that concentrates oxygen and delivers it to someone that needs supplemental oxygen) that was located next to her bed.D. On 02/13/26 at 9:47 am, during an interview with the Director of Nursing (DON), she confirmed the order for R #1's oxygen should specify the frequency of when it should be administered, and it does not.