STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clayton Rehabilitation and Healthcare Center	204 Dairy Road Clayton, NC 27520

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of medication for 2 of 20 residents (Resident #2 and Resident #17)whose MDS was reviewed. Findings included: 1. Resident #2 was admitted to the facility on [DATE]. A review of Resident #2's Medication Administration Record (MAR) for October 2024 revealed documentation aspirin (an antiplatelet medication) 81 milligrams (mg) was administered to Resident #2 on 10/31/24 at 8:00 AM. A review of Resident #2's November 2024 MAR revealed documentation aspirin (an antiplatelet medication) 81 milligrams (mg) was administered to Resident #2 on 11/1/24 through 11/6/24 at 8:00 AM. A review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was not coded for use of antiplatelet medication during the 7 day look back period of the assessment. On 11/26/24 at 8:36 AM an interview with an interview with the MDS Nurse indicated she coded the medication section on Resident #2's quarterly MDS assessment dated [DATE]. She stated the look back period of the assessment would be from 10/31/24 through 11/6/24. She reported the medication section of this assessment was coded inaccurately. She went on to say there was documentation on Resident #2's MAR's for October 2024 and November 2024 that aspirin was administered to Resident #2 during the look back period of the assessment and the assessment should reflect this. The MDS Nurse stated she might have been interrupted while coding Resident #2's assessment resulting in this mistake. On 11/27/24 at 8:46 AM an interview with the Director of Nursing indicated resident's MDS assessments should be an accurate reflection of the medication they were receiving. On 11/27/24 at 8:52 AM an interview with the Administrator indicated resident's MDS assessments should be an accurate reflection of the medication they were receiving. 2. Resident #17 was admitted to the facility on [DATE]. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #17's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was not coded for use of diuretic medication during the 7 day look back period of the assessment. A review of Resident #17's November 2024 revealed documentation furosemide (a diuretic medication) 80 milligrams (mg) was administered to Resident #2 on 11/2/24 through 11/8/24 at 9:00 AM. On 11/26/24 at 8:36 AM an interview with an interview with the MDS Nurse indicated she coded the medication section on Resident #17's quarterly MDS assessment dated [DATE]. She stated the look back period of the assessment would be from 11/2/24 through 11/8/24. She reported the medication section of this assessment was coded inaccurately. She went on to say there was documentation on Resident #17's MAR's for November 2024 that furosemide was administered to Resident #2 during the look back period of the assessment and the assessment should reflect this. The MDS Nurse stated she had not seen this and had made a mistake. On 11/27/24 at 8:46 AM an interview with the Director of Nursing indicated resident's MDS assessments should be an accurate reflection of the medication they were receiving. On 11/27/24 at 8:52 AM an interview with the Administrator indicated resident's MDS assessments should be an accurate reflection of the medication they were receiving.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50404 Based on record review, staff, resident, and family interviews, the facility failed to invite residents to care plan meetings (Resident #40, Resident #16, and Resident #79) for 3 of 3 residents reviewed for care planning. Findings included: 1. Resident #40 was admitted to the facility on [DATE] with diagnosis that include stroke, anemia and hypertension. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #40 was cognitively intact. The care plan for Resident #40 was initiated on 8/10/21 and last revised on 9/12/24. An interview with Resident #40 on 11/25/24 at 10:00 a.m. revealed he had not been invited to care planning meetings. Record review revealed no previous care plan meetings scheduled prior to 11/26/24. An interview with the Social Worker on 11/26/24 at 10:12 a.m. revealed Resident #40 had a care plan meeting scheduled for that day. The Social Worker could not locate any previous care plan meetings in her record review. The Social Worker did state her expectation would be that care planning meetings were held quarterly. 2. Resident #16 was admitted to the facility on [DATE] with diagnosis that included hypertension, and Alzheimer's disease. The care plan for Resident #16 was initiated on 10/16/23 and revised on 10/11/24. The quarterly MDS dated [DATE] revealed Resident #16 was cognitively intact. Record review revealed there was a care plan meeting held in March 2024 and on 9/24/24. No other care planning meetings were noted in the record. An interview with Resident #16 on 11/24/24 at 12:30 p.m. revealed he had not been invited to care planning meetings. An interview with the Resident Representative for Resident #16 on 11/26/24 at 4:30 p.m. revealed a care planning meeting on the 3/26/24 and sometime in the 4th quarter of 2024, she attended this meeting via telephone. She also stated there were no other care plan meetings and Resident #16 was never invited to participate. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Social Worker on 11/26/24 at 10:12a.m. revealed Resident #16 had one care plan meeting on 9/24/24 with only the MDS nurse and Social Worker in attendance. Resident #16 also had a care plan meeting on 10/29/24 with the only attendee being the MDS nurse. The Social Worker stated her expectation would be that care planning meetings were held quarterly. 3. Resident #79 was admitted to the facility on [DATE] with diagnosis that included stroke, diabetes, and hypertension. The quarterly MDS dated [DATE] revealed Resident #79 was cognitively intact. The care plan for Resident #79 was initiated on 5/15/24 and revised on 11/10/24. Review of Resident #79's medical record revealed no indication that he or his representative had been invited to a care plan meeting. An interview with Resident #79 on 11/24/24 at 10:48 a.m. revealed he did not recall being invited to a care planning meeting. An interview with the Social Worker on 11/26/24 at 10:12a.m. revealed Resident #79 had a care plan meeting on 9/24/24 with the Social Worker and MDS nurse only in attendance. Upon record review there were not any previous care plan meetings. There was no documentation that the resident or his representative had been invited to care planning meetings. The Social Worker stated her expectation would be that care planning meetings were held quarterly. An Interview with the Administrator on 11/26/24 at 11:26 a.m. revealed her expectation was for care plan meetings to be held upon admission, quarterly or if a family had concerns. She would also expect the unit manager, MDS nurse, dietary representative, activities representative, Social Worker, resident and resident responsible party to be in attendance.

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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** 37468 Based on observation, record review, and staff interviews, the facility failed to maintain a medication administration error rate of less than 5% when a nurse failed to prime an insulin pen and failed to administer Tylenol as ordered by the physician. This resulted in an error rate of 8% for 2 of 25 opportunities observed during medication pass. (Resident #95) Findings included: a. Review of the manufacturer's recommendations for the Humalog insulin pen used by the facility dated 7/21/23 revealed the insulin pen was to be primed before each injection. (Priming an insulin pen means to remove the air from the needle and cartridge and ensures the pen is working correctly). To prime the insulin pen, the user was to turn the dose knob to select 2 units, hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top, and push the dose knob in until it stopped and read 0 on the dose window. The user should see the insulin at the tip of the needle. If insulin was not observed at the tip of the needle the steps were to be repeated no more than 4 times. If there was still no insulin observed at the top of the needle, the needle would need to be replaced. Resident #95 was admitted to the facility on [DATE]. Her active diagnoses included diabetes mellitus. Review of Resident #95's orders revealed on 11/20/24 she was ordered Humalog KwikPen subcutaneous solution pen-injector 100 unit/milliliter (mL) inject subcutaneously as per sliding scale: if blood sugar is 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451 - 500 = 12 units >500= 14 units and call the physician. During observation on 11/26/24 at 8:26 AM Nurse #1 was observed providing Resident #95 her medications. The nurse checked Resident #95's blood sugar which was 343. The nurse was then observed to return to her cart, take the insulin pen, place the needle on the Humalog insulin pen, and turn the dial to 6 units. Nurse #1 did not prime the insulin pen needle prior to setting the dose. She then entered the resident's room, held the pen against Resident #95's abdomen, and pressed the dose knob in. During an interview on 11/26/24 at 9:47 AM Nurse #1 stated it was her understanding that priming the insulin pen was to set the number of units to be injected prior to giving the injection. During an interview on 11/26/24 at 10:54 AM the Director of Nursing stated she expected her staff to follow the manufacturer's instructions for insulin pens during medication administration. b. Resident #95 was admitted to the facility on [DATE]. Her active diagnoses included other idiopathic peripheral autonomic neuropathy. Review of Resident #95's orders revealed on 11/20/24 she was ordered Acetaminophen oral tablet 500 mg (milligrams) give 1 tablet by mouth every 6 hours as needed for pain. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 11/26/24 at 8:26 AM Nurse #1 was observed providing Resident #95 her medications. Resident #95 stated to Nurse #1 that she had pain in her shoulder and leg and rated it as a 6 on a scale of 1 to 10. She requested the nurse give her two tablets of Acetaminophen. The nurse was then observed to return to her cart, dispense two 500mg tablets of Acetaminophen into a medication cup. She then entered the resident's room and administered the two tablets of Acetaminophen to Resident #95. During an interview on 11/26/24 at 9:47 AM Nurse #1 stated because Resident #95 told her she gets two tablets of Tylenol, she gave two tablets which were 1000 mg in total. During an interview on 11/26/24 at 10:54 AM the Director of Nursing stated staff were to follow physician orders and the nurse should not have given 2 tablets only because the resident said she took 2 tablets. She further stated the nurse could have clarified with the physician since the resident was contradicting the order for Tylenol 500 mg take 1 tablet as needed every 6 hours.

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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 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. 41009 Based on observations and staff interviews the facility failed to label and date leftover food items stored in the walk-in refrigerator for one of one walk in refrigerators observed for food storage. This practice had the potential to affect food served to residents. Findings included: On 11/24/24 at 10:38 AM an observation of the walk in refrigerator with the Assistant Dietary Manager revealed a 4 quart clear plastic container with a green lid which contained approximately 2 quarts of whole corn in liquid with no label to identify the contents or the date it was placed in the refrigerator, a 4 quart clear plastic container with a green lid which contained approximately 4 quarts of cooked rice, a 4 quart clear plastic container with a green lid which contained approximately 2 quarts of red colored liquid, a 4 quart clear plastic container with a green lid which contained approximately 1/2 quart of a mayonnaise based salad, approximately 1/2 of a small cooked ham wrapped in plastic wrap, a large silver container covered in plastic wrap containing whitish liquid, a bowl of fruit cocktail, and a plastic storage container of sliced peaches in liquid. None of the stored food items were labeled to identify them or the date the items were placed in the refrigerator. During an interview on 11/24/24 at 10:45 AM with the Assistant Dietary Manager she stated the red liquid was marinera sauce, the whitish liquid was biscuit gravy and the mayonnaise based salad was tuna salad. She went on to say she did not see any labels or dates on the leftover food items stored in the walk in refrigerator. She stated she had to come to work in the kitchen unexpectedly that morning when the scheduled cook had not shown up and she had not had a chance to check the walk in refrigerator yet. The Assistant Dietary Manager stated it was the cooks' responsibility to ensure all leftover food items that were placed in the walk-in refrigerator were labeled and dated with the date they were placed in the refrigerator. She went on to say the corn, rice and peaches were from yesterday, but she was not sure how long the other items had been stored. On 11/26/24 at 10:24 AM a telephone interview with [NAME] #1 indicated she had been the cook on 11/23/24 from 5:30 AM until 1:00 PM. She stated it was the cook's responsibility to ensure all leftover food items placed into the walk-in refrigerator were labeled and dated with the date they were placed into the refrigerator. She reported all the unlabeled food items were from her shift on 11/23/24 and she had left them for the afternoon [NAME] #2 who told her he would label and date them. On 11/25/24 at 3:41 PM a telephone interview with [NAME] #2 indicated he was the cook on 11/23/24 from 1:00 PM until 7:30 PM. He stated as a cook it was his responsibility to check the walk-in refrigerators at the start of his shift to ensure all leftover food items were labeled and dated when they were placed in the refrigerator. He reported on 11/23/24 he had not done this. He went on to say he had immediately started cooking when he arrived for his shift on 11/23/24, and after he finished cooking, he cleaned up. [NAME] #2 stated he did not recall having any conversation with [NAME] #1 regarding leftover food. He went on to say he had last worked on 11/21/24, and did not recall seeing any leftover food in the walk-in refrigerator that day. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/26/24 at 1:25 PM an interview with the Dietary Manager indicated all leftover food should be labeled and dated when placed in the walk in refrigerator for storage. She went on to say it was the cook's responsibility to ensure this was done, and to discard any leftover storage food that was unlabeled and undated. On 11/27/24 at 8:54 AM an interview with the Administrator indicated there should not be any leftover unlabeled and undated food stored in the walk-in refrigerator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41009 Based on observations, record review, and staff interviews the facility failed to implement their infection control policy when Nurse Aide (NA) #1 did not perform hand hygiene during meal delivery and set-up after knocking on the room door, handling the bed control, moving the overbed table and handling bed linens for 1 of 2 NAs observed passing meal trays on 1 of 4 halls. This had the potential to result in the cross contamination of microorganisms (germs) between residents. Findings included: A review of the facility's policy titled Handwashing/Hand Hygiene dated last revised August 2019 revealed in part the following: This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. 7. Use an alcohol based hand rub containing at least 62 percent alcohol, or alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations: l. After contact with objects in the vicinity of the resident. On 11/24/24 from 1:10 PM until 1:14 PM a continuous observation of the lunch meal tray delivery service was conducted in the facility on the 100 Hall. Four hand sanitizing dispensers were observed in place at intervals on the wall on this hall, including one on the wall outside Resident #245's room. At 1:12 PM Nurse Aide (NA) #1 was observed to sanitize her hands and remove a lunch meal tray from the meal delivery cart, knock on the door to Resident #245's room, enter the room, place the meal tray on Resident #245's overbed table, use Resident #245's bed control to adjust the head of Resident #245's bed, adjust Resident #245's bed linen, and leave Resident #245's room without performing hand hygiene. At 1:14 PM NA #1 was then observed to remove another resident's lunch meal tray from the cart without performing hand hygiene. NA #1 was interrupted before delivering this meal tray. On 11/24/24 at 1:14 PM an interview with NA #1 indicated she should have performed hand hygiene after contact with Resident #245's environment before removing another meal tray from the cart. She stated she had been educated to do this to prevent the spread of germs. She reported there were hand sanitizing dispensers available on the hall. She stated she had just been moving too quickly and had forgotten. On 11/26/24 at 12:12 PM an interview with the facility's Regional Clinical Director indicated she was currently working as the facility's Infection Preventionist. She stated NA #1 should have performed hand hygiene after delivering Resident #245's lunch meal tray and contact with Resident #245's environment prior to removing another lunch meal tray from the cart to prevent the spread of germs. She stated NA #1 had been re-educated on this. On 11/27/24 at 8:46 AM an interview with the Director of Nursing indicated NA #1 should have performed hand hygiene after delivering Resident #245's meal tray and contact with Resident #245's environment prior to removing another lunch meal tray from the cart. She stated this should have occurred to prevent the spread of germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/24 at 8:54 AM an interview with the Administrator indicated NA #1 should have performed hand hygiene after delivering Resident #245's meal tray and contact with Resident #245's environment prior to removing another lunch meal tray from the cart to prevent the spread of germs.