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	02/13/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to clean 1 of 1 walk-in refrigerator in the main kitchen, failed to label and date opened non-perishable food items stored in the dry goods pantry in the main kitchen, and failed to label juice stored for use in 1 of 2 nourishment refrigerators (Nourishment room [ROOM NUMBER]). This practice had the potential to affect the food served to residents. The findings included: a. During the initial tour of the main kitchen on 2/9/26 at 10:25 AM with Dietary Manager #1 an observation of the walk-in refrigerator revealed a puddle of milk from two busted 8-ounce cartons of milk on the floor under the storage racks on back wall of refrigerator. In an interview with Dietary Manager #1 on 2/9/26 at 10:25 AM he stated the walk-in refrigerator floor was swept multiple times a day. Dietary Manager #1 further stated the walk-in refrigerator floor was swept the night before (2/8/26) and had not been swept yet the morning of 2/9/26 because staff were finishing clean-up from the breakfast service. On 2/9/26 at 2:22 PM an additional observation of the walk-in refrigerator revealed the puddle of milk from the two busted 8-ounce cartons of milk on floor under the storage racks on back wall of refrigerator had not been cleaned. During an interview on 2/9/26 at 2:22 PM with Dietary Manager #1 he stated he planned to clean the floor of the walk-in refrigerator after the lunch service. Dietary Manager #1 further stated his expectation was that kitchen staff check the condition of the walk-in refrigerator between meals. He stated he expected staff to clean up spills as soon as they saw them. Dietary Manager #1 stated he checked the condition of the walk-in refrigerator each morning. On 2/11/26 at 10:29 AM an interview was conducted with Dietary Aide #1. Dietary Aide #1 stated the walk-in refrigerator should be checked and cleaned daily. Dietary Aide #1 stated when he was assigned these tasks he cleaned spills right away. He further stated he was not assigned these tasks on 2/9/26. An interview was conducted with the Administrator on 2/13/26 at 1:21 PM. The Administrator stated his expectation was that nothing should be on the floor in the kitchen areas. He further stated all spills should be cleaned up as soon as possible. b. An observation of the dry goods pantry with Dietary Manager #1 was completed on 2/9/26 at 10:30 AM. During this observation two opened non-perishable food items (brown sugar and cereal) were stored in their original clear packaging, not in their original box containing the expiration date, not labeled or dated. In an interview with Dietary Manager #1 on 2/9/26 at 10:30 AM he stated he expected staff to date all food items once they were opened. Dietary Manager #1 stated he checked the condition of the pantry each morning, however he could not provide an explanation as to why these two dry food items did not have an open date. On 2/11/26 at 10:20 AM an interview was conducted with Dietary Manager #2. Dietary Manager #2 stated the walk-in refrigerator, walk-in freezer, and walk-in dry pantry were supposed to be checked at least once a day, usually by the manager. He further stated other kitchen staff members can also be delegated to do those inspections. An interview was conducted with the Administrator on 2/13/26 at 1:21 PM. He stated any food items that were opened by kitchen staff must be dated. c. On 2/11/26 at 10:35 AM an observation was conducted with Dietary Manager #2 and Regional Dietary Manager of Nourishment room [ROOM NUMBER] which revealed 3 plastic cups of apple juice with plastic lids that were not (continued on next page)

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 - Some	dated on the shelf inside the nourishment refrigerator. During an interview on 2/11/26 at 10:35 AM with Dietary Manager #2 he stated he observed Nurse Aide #1 put the cups of apple juice in Nourishment Room Refrigerator #2. Dietary Manager #2 further stated that the nourishment refrigerators were for resident use only and kitchen staff were responsible for checking the refrigerator temperatures and the contents of the refrigerators for expired items daily. An interview was conducted on 2/11/26 at 1:51 PM with Nurse Aide #1 who confirmed he placed 3 apple juice cups in the nourishment refrigerator. He stated they should have been dated, and he normally did date items, however he got distracted and did not date them. An interview was conducted with the Administrator on 2/13/26 at 1:21 PM. He stated it was his expectation that anything placed in the nourishment refrigerators must be labeled and dated.

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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** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set Assessments (MDS) for 1 of 29 residents whose MDS assessments were reviewed for accuracy (Resident #6). Findings included:Resident #6 was admitted to the facility on [DATE] with diagnoses that included depression, anxiety and schizoaffective disorder (a chronic mental health condition combining symptoms such as delusions, hallucinations or disorganized speech with major mood episodes).Record review revealed an order dated 10/16/25 for quetiapine (an antipsychotic medication) 25 milligrams three times a day for agitation.Review of a mental health progress note dated 12/4/25 documented a contraindication for a gradual dose reduction (GDR) of antipsychotic medication for Resident #6 due to a history of agitation and an underlying diagnosis of schizoaffective disorder.Review of the December 2025 Medication Administration Record (MAR) revealed Resident #6 received quetiapine 25 milligrams three times daily for agitation from 12/9/25 through 12/15/25.A review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated [DATE] noted Resident #6 received antipsychotic medication on a routine basis but did not include the physician documented GDR as clinically contraindicated information.During an interview with MDS Nurse #2 on 2/13/26 at 9:55 AM who stated she did not see the contraindication for the antipsychotic medication when she coded the 12/15/24 MDS assessment.During an interview with the Administrator on 2/13/26 at 11:30 AM he stated Resident #6's MDS should have been coded to reflect the contraindication of a gradual dose reduction of antipsychotic medication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and Nurse Practitioner, Pharmacist and Medical Director interviews, the facility failed to ensure that identified medication regimen irregularities were acted upon for 1 of 6 residents reviewed for medication regimen review (Resident #5).Findings Included:Resident #5 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, schizoaffective disorder, depression, end stage renal disease with dependence on dialysis, and orthostatic hypotension.A review of physician orders for Resident #5 dated 10/16/2025 and 10/17/2025 revealed:- Midodrine HCl 5 milligram tablets, give 15 milligrams by mouth four times daily, and the medication order listed the diagnosis of hypokalemia. This medication is used to treat low blood pressure. - Lamotrigine 200 milligrams by mouth one time daily, and the medication order listed the diagnosis of generalized muscle weakness. This medication is used to treat epilepsy and bipolar disorder.Review of physician order entry records showed the original medication orders were entered by the prescribing medical provider at admission and by the nurse Practitioner on 10/16/2025.A review of admission Minimum Data Set (MDS) dated [DATE] revealed Resident #5 was cognitively intact. The MDS also documented active conditions including orthostatic hypotension, end stage renal disease/dialysis dependence, bipolar disorder, depression, psychotic disorder and muscle weakness. The MDS indicated that the Resident received medications classified as antipsychotic, antidepressant, anticoagulant, opioid and anticonvulsant during the assessment period.A New admission Drug Regimen Review dated 10/23/2025 completed by the consultant Pharmacist documented recommendations to review and update the diagnosis on the Medication Administration Record for Simethicone, Lamotrigine and Loperamide (as needed). The form was signed by Nurse Practitioner #1 who circled Disagree under Recommendation for all 3 drugs.A Medication Regiment Review (MRR) Recommendation Summary dated 11/30/2025 completed by the consultant Pharmacist documented that the Midodrine order required diagnosis review and update on the Medication Administration Record. The form was acknowledged by Nurse Practitioner #1. A Summary of Nursing Recommendations dated 12/31/2025 completed by the consultant Pharmacist documented that the diagnoses on the Medication Administration Record should be reviewed for accuracy and updated if appropriate. The following medications were listed Lamotrigine muscle weakness is not a sufficient diagnosis, Simethicone, Eliquis, Loperamide and Midodrine. The form was acknowledged by Nurse Practitioner #1. On 02/11/2026 at 1:52 PM Nurse Practitioner #1 was interviewed and stated that Midodrine was prescribed to prevent blood pressure from dropping during dialysis and acknowledged that hypokalemia was not the correct diagnosis. Nurse Practitioner #1 further stated that Lamotrigine was prescribed for bipolar disorder and should not have been linked to generalized muscle weakness. Nurse Practitioner #1 indicated that the diagnosis links would be corrected. Nurse Practitioner #1 stated that she had many patients to see at the facility and just had not gotten around to updating the diagnoses for the medications.On 02/12/2026 at 1:14 PM, an interview was conducted with the Medical Director. The Medical Director stated that his expectation was that Nurse Practitioners received the medication regimen review recommendations and make the necessary adjustments. He stated there was no facility policy establishing a timeframe for implementing medication regimen review recommendations. When asked how long it should take to correct a diagnosis once identified, he stated it should be corrected once the Nurse Practitioner was made aware. He further stated that if the pharmacist notes that recommendations were not corrected, the pharmacist should notify him directly. The Medical Director acknowledged that hypokalemia was an incorrect diagnosis for Midodrine and stated that Midodrine is prescribed for blood pressure management.On 2/18/2026 at 9:40 AM a telephone interview with a Consultant Pharmacist revealed that the Pharmacy forms (MRR Recommendation, Drug Regimen Review) for this facility were completed by a Pharmacy Consultant. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pharmacist stated that he did not know the expectation for these forms or when they would escalate the issue to the Medical Director. The Pharmacist did not have the direct contact information for the facility's Pharmacy Consultant who completed the MRRS for Resident #5.On 2/18/2025 at 2:33 PM a telephone interview with the Consultant Pharmacist who completed the MRRs for Resident #5 revealed that she sends reports monthly to Director of Nursing (DON). The Consultant Pharmacist stated that reports were recommendations to clarify a residents' Medication Administration Record (MAR). The Consultant Pharmacist stated that she reviewed the facility's MARs for inaccuracies, but the incorrect diagnosis would not have affected patients' medication or care. The incorrect diagnoses for Midodrine and Lamotrigine was not something she would have escalated to the Medical Director as she just wanted it corrected for her own records.

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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 observation, record review, and staff interviews, the facility failed to ensure medications requiring refrigeration were stored in accordance with United States Pharmacopeia standards for 1 of 2 medication refrigerators reviewed for medication storage (Medication room [ROOM NUMBER]'s refrigerator).On 2/10/2026 at 1:33 pm, during an observation with the Director of Nursing (DON) of the medication refrigerator in Medication room [ROOM NUMBER], the refrigerator temperature gauge read 66 degrees Fahrenheit (F). There was a total of 52 medications stored inside of the refrigerator at the time of this observation. Those medications were: Insulin Lispro Kwik Pen 100 units/mL (Humalog) - 20 pens, Humalog (non-Kwik Pen labeled) - 2 pens (House Account), Insulin Glargine (Lantus / Lantus Solostar) - 12 pens/bottles, Toujeo Solostar - 3 pens, Basaglar 100 units/mL - 2 pens, Insulin Aspart Flex Pen (Novolog) - 5 pens, Novolog Flex Pen 100 units/mL - 3 pens, Insulin Aspart Protamine / Insulin Aspart (70/30) - 2 pens, Humulin 70/30 100 units/mL - 1 pen, Novolin N Flex Pen 100 units/mL - 2 pens, Humulin N Kwik Pen (Insulin NPH) - 1 pen, Levemir FlexPen 100 units/mL - 1 pen (House Account), Tresiba FlexTouch 100 units/mL - 1 pen and Ozempic 2 mg/3 mL - 1 pen. Other Refrigerated Medications included Procrit 18 mcg - 7 bottles, Lumigan 0.01% ophthalmic solution - 1 bottle, Latanoprost 0.005% ophthalmic solution - 1 bottle, Formoterol Fumarate 20 mcg/2 mL - 3 boxes (48 of 60 doses remaining; 60 of 60 doses remaining; 40 of 60 doses remaining), Alteplase 2 mg - 2 units and 1 box and 1 bottle of diluent for reconstitution. According to the temperature log attached to the front of the refrigerator, the temperature was 38 degrees F when checked earlier that day (no time given).According to United States Pharmacopeia standards, insulin and other refrigerated biological medications must be stored at controlled refrigerated temperatures between 36 F to 46 F prior to use. Temperatures outside this range may reduce potency, compromise medication integrity, and affect therapeutic effectiveness.On 2/10/2026 at 1:40 pm, the Director of Nursing (DON) was notified of the refrigerator temperature reading. During an interview conducted at that time, the DON stated that all medications stored in the refrigerator would be discarded and reordered from the pharmacy. The DON stated that the medications kept in the refrigerator were overflow medications and stock medications. The DON stated that one of the medications became stuck in the door keeping the refrigerator door from closing. The DON stated that she had already gone to the medication carts to make sure that none of the medications were being used on any of the carts. The DON stated that none of the four nurses on duty reported having to get any of the overflow medications for their carts. The DON indicated that corrected action is needed anytime the temperature in the refrigerator was greater than 41 degrees F. During follow-up interview on 2/10/2026 at 2:01 pm DON reported that the medication refrigerator temperature had been checked earlier that morning and documented as 38 degrees Fahrenheit; however, the exact time of the morning temperature check was unknown.An interview on 2/10/2026 at 2:00 pm with the Administrator revealed that all the medications from the refrigerator had been discarded and reordered from the pharmacy. The Administrator stated that the refrigerator temperature should be checked multiple times throughout the day and that staff should be more careful when removing medications from the refrigerator.