STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345317	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/13/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/9/26 through 2/13/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1E2832-H1.	E0000		02/27/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/9/26 through 2/13/26. Event ID# 1E2832-H1. The following intakes were investigated NC002694914 and NC002733232. 6 of the 6 complaint allegations did not result in deficiency.	F0000		02/27/2026
F0584 SS = A	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services	F0584		02/27/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345317	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/13/2026

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F0584 SS = A	Continued from page 1 necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and resident, resident representative, and staff interviews, the facility failed to maintain a resident bathroom floor and wall in good repair for 1 of 29 residents (Resident #84) on 1 of 4 halls reviewed for safe, clean, homelike environment. The findings included: An interview was conducted on 2/9/26 at 3:25 PM with Resident #84's representative upon Resident #84's request. Resident #84 initially put his representative on speaker phone, and they stated there was an issue concerning the floor in the bathroom in his room. The volume on his cell phone could not be adjusted so the interview was completed with Resident #84's representative. Resident #84's representative stated she was unsure how long the floor had looked discolored, however she stated she had attempted to clean it several times in the last 2 months but could not remove the discoloration. Resident #84's representative stated she told staff about the floor but could not recall exact dates. Neither Resident 84 nor his representative mentioned the hole in the wall. On 2/9/26 at 3:25 PM an observation of the bathroom	F0584		

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F0584 SS = A	Continued from page 2 floor in Resident #84's room was conducted. Brown discoloration was noted on the tile flooring to the right side of the toilet. Two of the flooring tiles appeared slightly buckled, however no separation of the tiles was noted. In addition, a hole was noted in the lower aspect of the wall to the right of the toilet approximately 3 inches from the floor. The hole measured approximately 7 inches in length and 4 inches in height and was missing sheetrock. During an interview on 2/9/26 at 3:31 PM with the nurse assigned to Resident #84, she stated she had not noticed the discolored tile and the hole in his bathroom wall. She further stated she would notify maintenance. On 2/10/26 at 8:56 AM a follow-up observation was conducted of the bathroom in Resident #84's room. The hole in wall was noted to be covered with a white spackle-like substance. The flooring to the right side of the toilet remained with a brown discoloration. On 2/10/26 at 3:14 PM a visual inspection was conducted with the Maintenance Director concerning the discolored tiles and the hole in the wall of the bathroom in Resident #84's room. The Maintenance Director stated it did not appear the toilet was leaking and causing the brown discoloration of the flooring, however, was unsure what caused it. He further stated he repaired the wall as soon as he was notified verbally on 2/9/26 about the hole by a staff member. On 2/13/26 at 10:10 AM a follow-up interview was conducted with the Maintenance Director. He stated visual rounds were conducted of resident rooms weekly and he was not aware of the discolored tiles or the hole in the bathroom wall in Resident #84's room. He further stated the facility has TELS (a web-based software platform for maintenance requests), as well as a maintenance communication book at the nurse's station that staff use to notify him of needed repairs. The Maintenance Director stated the communication book was checked multiple times a day and the TELS system sent an immediate notification when a request was placed. An interview was conducted on 2/13/26 at 1:21 PM with the Administrator. The Administrator stated he expected staff to enter repair requests into the system (TELS), utilize the maintenance communication book and/or	F0584		

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F0584 SS = A	Continued from page 3 notify maintenance. He further stated he expected those repair requests to be tracked and completed.	F0584		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: 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:	F0641	1.Resident #6's 12/15/25 MDS assessment was modified for appropriate contraindication/ diagnosis on 02/13/2026 by the MDS coordinator/ designee. 2.All residents' last MDS assessments were audited to ensure appropriate contraindication/ diagnosis on 03/02/2026 by the MDS Coordinators/ designee. 3. All nursing staff involved in assessments (including MDS Coordinators) were inserviced on appropriate contraindication/ diagnosis for medications, ensuring upon admission correct diagnosis are entered, ensuring new orders are entered with appropriate contraindication/ diagnosis, and ensuring appropriate contraindications/ diagnosis are entered into the MDS assessments by the Director of Nursing/ designee by 02/27/2026 Any licensed agency staff member will receive this inservice prior to their first shift worked by the Director of Nursing or designee. Any new licensed nursing staff member will receive this inservice during orientation by the Director of Nursing or designee. 4. A weekly audit will be completed by the MDS coordinator on MDSs completed that week to validate the contraindication/ diagnosis is accurate times 10 weeks. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. March 6th, 2026	03/06/2026

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F0641 SS = D	Continued from page 4 Resident #6 was admitted to the facility on 6/24/25 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 12/15/25 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.	F0641		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F0756	F756-D-Drug Regimen Review 1.The facility failed to ensure that identified medication regimen irregularities were acted upon for resident #5. 2. This had the potential to affect all residents in the facility. 3. Resident #5's midodrine diagnosis was changed to Hypotension and Lamotrgine diagnosis was changed to Bipolar Disorder on 02/27/2026 by Nurse as recommended on the Drug Regimen Review. On 02/27/2026 Administrator updated pharmacy to ensure all of the facility points of contact were up to date with Pharmacy system to	03/06/2026

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F0756 SS = D	Continued from page 5 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: 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 10/16/2025 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	F0756	Continued from page 5 ensure all pharmacy recommendations are received and/or reviewed timely. Resident #5 discharged from the facility on 02/27/2026. All licensed nursing staff inserviced on how to properly complete and timely complete Drug Regimen Reviews regarding diagnosis by the Director of Nursing/ designee by 02/27/2026 Any licensed agency staff member will receive this inservice prior to their first shift worked. Any new licensed nursing staff member will receive this inservice during orientation. All residents' Drug Regimen Reviews involving diagnosis were audited by the Director of Nursing/designee on 03/02/2026 to ensure they were completed and accurate. 4. A weekly review of all Drug Regimen Reviews involving diagnosis will be completed by the Director of Nursing/ Designee to ensure they are completed timely and accurately times ten weeks. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. March 6th, 2026	

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F0756 SS = D	Continued from page 6 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 10/20/2025 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	F0756		

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F0756 SS = D	Continued from page 7 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. 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.	F0756		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F0761	1.Medication Room #1's medications were immediately discarded and reordered due to the refrigerator's temperature being out of range on 2/10/26.	03/06/2026

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F0761 SS = D	Continued from page 8 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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 #1'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 #1, 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	F0761	Continued from page 8 2. All Medication Room refrigerators were checked on 2/10/26 by the Director of Nursing/ designee and no further issues identified- the medication refrigerators were in proper temperature range. 3.All licensed staff will be inserviced on appropriate temperature range for medication refrigerators and how often to check the temperatures by the Director of Nursing/ designee by 02/27/2026 Any licensed agency staff member will receive this inservice prior to their first shift worked by the Director of Nursing or designee. Any new licensed nursing staff member will receive this inservice during orientation by the Director of Nursing or designee. 4.Five days a week audit will be completed on any medication refrigerators to ensure the temperature is within the appropriate range by the Director of Nursing/ designee times ten weeks. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. March 6th, 2026	

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F0761 SS = D	Continued from page 9 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.	F0761		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary	F0812	1.On 02/09/2026 the facility failed to clean 1 of 1 walk-in refrigerator in the main kitchen, failed to	03/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345317	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/13/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = E	Continued from page 10 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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 #2). 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	F0812	Continued from page 10 label and date opened non-perishable food items stored in the dry goods pantry in the main kitchen, ans failed to label juice stored for use in 1 of 2 nourishment refrigerators. 2. This practice had the potential to affect all residents. 3. Dietary Manager #1 is no longer employed by the facility. The walk in refrigerator was cleaned on 02/09/2026 by the Account Manager. All non perishable foods in the kitchen pantry were labelled and dated on 02/09/2026 by the Account Manager/ designee. All juices in the nourishment room were disposed of on 2/09/2026 by the CNA/designee. All dietary staff inserviced on appropriate cleaning of the kitchen walk in refrigerators, labelling and dating non perishable foods in the kitchen, and labelling and dating food items in the nourishment room refrigerators by the Administrator/ designee by 03/02/2026 4. Five days a week audit will be completed on the kitchen walk in refrigerator to ensure cleaned, non perishable food items in the kitchen are labelled and dated, and refrigerated items are labelled and dated in the nourishment room refrigerators by the Administrator/ designee times ten weeks. New hires will be educated upon hire. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. March 6th, 2026	

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

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F0812 SS = E	Continued from page 11 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.	F0812		

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F0812 SS = E	Continued from page 12 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 #2 which revealed 3 plastic cups of apple juice with plastic lids that were not 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.	F0812		