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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 000	INITIAL COMMENTS The surveyor entered the facility on 7/23/24 to conduct a complaint survey and exited on 7/25/24. Additional information was obtained through 7/30/24. Therefore, the exit date was changed to 7/30/24. (Event QIGS111) The following intakes were investigated: NC 219524; NC 216320; NC 215509; NC 214280; NC 215525; 213596; NC 219734; and 219707. Four of thirteen complaint allegations resulted in deficiency.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, physicians' interview, and interviews with dermatology office staff, the facility failed to follow through in referring a resident to a dermatologist for treatment after the resident was identified to have basal cell carcinoma. This was for one (Resident # 12) of four residents reviewed for professional standards in the provision of medical care. The findings included: Resident # 12 was admitted to the facility on 9/1/23 with diagnoses which in part included	F 684	F684 1. Resident #12 had a dermatology consult requested by the wound physician on April 12th 2024, and was scheduled on July 16th 2024. The appointment was made for September 16th 2024. 2. Any resident that has an outside physician consult ordered has the potential to be affected by this deficient	8/14/24

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

Electronically Signed | 08/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 1 chronic obstructive pulmonary disease and hypertension. The resident's quarterly Minimum Data set assessment, dated 6/7/24, coded Resident # 12 as cognitively intact. Review of Resident # 12' care plan, updated on 3/20/24, revealed the resident had basal cell carcinoma. This had been added to the care plan on 3/20/24 and remained part of the resident's active care plan. The care plan goal was that the resident have no complications from the carcinoma. Staff were directed to provide treatment as ordered. Review of Wound Physician notes revealed on 3/8/24 Resident # 12 had been evaluated by the Wound Physician for an area on his back which the staff had been treating as a pressure sore and which had not healed. The physician documented, "patient reports long standing mass effect with intermittent bleeding from surface." The area measured 2.5 cm (centimeters) and appeared with a "raised ulcerated mass effect." The Wound Physician further noted he biopsied the area. On 3/15/24 the Wound Physician noted the skin biopsy specimen demonstrated basal cell carcinoma. The Wound Physician noted the treatment plan was for an application of 5 % 5-fluorouracil cream twice per day for the lesion for four weeks. (5-fluorouracil cream is a chemotherapy cream used to destroy skin cancer cells) On 3/29/24 the Wound Physician noted the mass effect was flattened. Under additional treatment,	F 684	practice. All resident charts were audited by 08/09/2024 to ensure all outside consults ordered were scheduled by the Director of Nursing/ designee. 3. Licensed nurses, nursing management, the medical records coordinator, and the transportation coordinator were in serviced by the Assistant Director of nursing / designee on proper scheduling of outside physician consults by 08/12/24. Any newly hired licensed nurses, nurse management, medical record coordinator or transportation coordinator will receive education by the Assistant Director Nursing/ Designee on proper scheduling of physician consults during orientation. 4. A weekly audit of residents□ charts will be completed to ensure all outside physician consults are scheduled by the Director of Nursing/ designee times twelve weeks. The outcome of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee monthly times three by the Administrator/ designee. August 14th, 2024	

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	345317	A. BUILDING _____ B. WING _____	C 07/30/2024

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CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

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F 684	Continued From page 2	F 684		

the Wound Physician wrote "schedule evaluation by dermatology."

On 4/8/24 the Wound Physician noted there had been sloughing (where the dead tissue separates from the living tissue) of the entire surface of the lesion, and the treatment would be to start triple antibiotic ointment daily to the lesion, and to continue with plan for dermatology.

On 4/12/24 the Wound Physician noted the following. The lesion was approximately 2.5 cm X 1.8 cm in diameter, and there had been slough of the majority of the ulcerative/granulation core part of the lesion following the chemotherapy ointment. The treatment would be xeroform daily (xeroform is a type of nonadherent dressing) and the plan for the resident to see the dermatologist should continue.

On 4/19/24 the Wound Physician noted the following information. The lesion measured 2.5 cm X 1.5 cm in diameter and there was resolution of the slough and development of early "reepithelium." (the initial formation of new tissue). The Xeroform application was to be continued daily. Plans for the resident to see a dermatologist were to be continued.

On 4/26/24 the Wound Physician noted the following information. The lesion measured approximately 1.8 cm X 1.2 cm with resolution of the slough and development of early "reepithelium." The Xeroform application was to be continued daily. Plans for the resident to see a dermatologist were to be continued.

On 5/3/24 the Wound Physician noted the following information. The lesion measured

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 684	Continued From page 3	F 684		

approximately 1.3 cm X .5 cm with resolution of the sough and development of early "reepithelium." The Xeroform application was to be continued daily. Plans for the resident to see a dermatologist were to be continued.

On 5/10/24 the Wound Physician noted the following information. The lesion measured approximately 0.4 cm X 0.8 cm X 0.1 cm with resolution of the slough and development of early "reepithelium." The Xeroform application was to be continued daily. Plans for the resident to see a dermatologist were to be continued.

On 5/17/24 the Wound Physician noted the following information. The lesion measured approximately 0.4 cm X 1.1 cm X 0.1 cm and directions were given to apply skin prep once daily to the lesion area.

On 5/24/24 the Wound Physician noted "return of raised margin in two quadrants consistent with recurrence of Ba Cell (Basal Cell Carcinoma)." The Wound Physician noted the 5% 5 fluorouracil cream application (the chemotherapy cream) should be restarted twice per and dermatology should be consulted.

On 6/7/24 the Wound Physician noted, "mass measurements 2.6 cm X 1.7 cm with slightly raised margins." The Wound Physician recommended the chemotherapy cream be continued and to "continue to seek dermatology appointment for excision tx (treatment) or alternative tx."

On 6/14/24 the Wound Physician noted the lesion measured 2.4 cm X 2.5 cm with central necrosis (dead skin). The Wound Physician also noted

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

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F 684	Continued From page 4	F 684		

there was a new small satellite lesion at the position of 5 o'clock from the primary lesion. The Wound Physician noted the chemotherapy cream should be continued, and staff should continue to arrange for a dermatologist to see the resident.

On 6/21/24 the Wound Physician noted the primary lesion measured 2.4 cm X 2 cm X 0.1 cm and 4 cm away from the cancer lesion, the resident had a smaller satellite lesion. The Wound Physician continued the chemotherapy cream and noted staff should continue to arrange a dermatology visit.

On 6/28/24 the Wound Physician noted the primary cancer lesion measured 2.4 cm X 2.2 cm X 0.1 cm and 4 cm away from the cancer lesion, the resident had the smaller satellite lesion. The Wound Physician continued the chemotherapy cream and noted staff should continue to arrange a dermatology visit.

On 7/6/24 the Wound Physician noted the primary cancer lesion measured 2.4 cm X 2.2 cm X 0.1 cm. The Wound Physician continued the chemotherapy cream and noted dermatology should evaluate the resident.

On 7/19/24 the Wound Physician noted the primary cancer lesion measured 2.5 cm X 2.6 cm X 0.1 cm. The Wound Physician continued the chemotherapy cream and noted dermatology should evaluate the resident.

Resident # 12 was interviewed on 7/23/24 at 10:53 AM and reported the following information. He had a skin cancer on his back. A physician who came to the facility had been prescribing a chemotherapy cream, but now the cancer had

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

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F 684	Continued From page 5	F 684		

spread from one spot to another spot.

The Wound Care Nurse was observed on 7/24/24 at 2:45 PM as she provided care for the resident's lesion. The resident was observed to have a quarter sized area to his midback with a yellowish film over it. Below this area, there was another smaller, similar area which appeared as a small slither in the skin. The Wound Care Nurse reported at the time of treatment that the area used to be all black. She further reported she was not aware the area had already been biopsied and was cancerous. She thought that was why the resident needed to go to the dermatologist.

Interview with a dermatology office staff member on 7/24/24 at 2:23 PM revealed Resident # 12 was scheduled to see a dermatologist at their location on 9/16/24. The dermatology staff member further reported this appointment had first been made on 7/16/24. Interview with another staff member at the dermatology office on 7/24/24 at 4:22 PM revealed usually they could see patients within 4 to 6 weeks when a patient called for an appointment. At the current time, they were booking appointments 6 to 8 weeks out from time of calling.

The Administrator was interviewed on 7/24/24 at 4:40 PM and reported the following information. The first he knew there was a problem in getting a dermatology appointment for Resident # 12 was during the previous week (the week of 7/14/24 to 7/20/24). He had talked to Resident # 12 and the resident said they were "playing around" with the lesion on his back. At that time, he learned they had missed scheduling a dermatology appointment for the resident. He and the Director of Nursing got involved and made sure the

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 _____	C 07/30/2024

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CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

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F 684	Continued From page 6	F 684		

appointment got scheduled. They were not sure what had gone wrong and contributed to the delay in making the appointment. He did know they had several wound care nurses that had "not worked out" in recent months. The message that the appointment needed to be made should have been given to the transport person from the wound nurse so the transport person could make the appointment. The transport person was the person who made appointments. According to the Administrator, the information had not been passed up the chain for this to occur.

The Wound Physician was interviewed on 7/24/24 at 4:01 PM and reported the following information. He had been telling the Wound Nurses that the resident needed to see a dermatologist. If the staff had first thought the lesion was a pressure sore, he understood why they could have thought this given that it was darkened in color and appeared on the midline of his back. He was asked to see the resident in March 2024 when the resident's area was not responding to treatment. When he first looked at the lesion, it looked abnormal and suspicious enough to biopsy. He had started the chemotherapy cream when the biopsy returned as positive for the basal cell carcinoma, and the lesion did seem to respond initially. It did appear markedly improved at one point. Then the lesion started to deteriorate, and the resident developed the second site as well. Basal cell carcinoma generally does not metastasize, but it can be a local inconvenience for a resident to have. It is generally slow growing. It was his opinion that the staff member at the facility who was responsible for making appointments may have "dropped the ball" in getting the resident to a dermatologist. He (the Wound Physician) had been told the

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 _____	C 07/30/2024

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CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

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F 684	Continued From page 7 previous week for the first time that the staff had finally gotten a dermatology appointment for the resident. The Wound Physician felt a dermatologist had more experience in treating skin cancer and he (the Wound Physician) wanted a second opinion. It was also his opinion that the delay in getting the resident to the dermatologist did not significantly set the resident back. He (the Wound Physician) could not know if the satellite area might have developed even if the resident had gone to the dermatologist earlier. He (the Wound Physician) thought once the resident was able to see the dermatologist, that the dermatologist might order some radiation therapy to the area to eradicate the cancer. The facility's medical director was also interviewed on 7/30/24 at 12:30 PM and reported that basal cell carcinoma in 99.9 percent of cases does not metastasize.	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		

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	345317	A. BUILDING _____ B. WING _____	C 07/30/2024

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F 755	Continued From page 8 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and pharmacist interview the facility failed to ensure accurate accounting for the dispensing and receipt of 15 tablets of Oxycodone. This was for one (Resident # 5) of one sampled resident whose Oxycodone was reported by the pharmacy as delivered but reported by the facility as not definitively received. The findings included: Resident # 5 was admitted to the facility on 2/13/24 and resided there until her discharge on 2/19/24. Review of physician orders revealed Resident # 5 was ordered Oxycodone 5 milligrams every four hours as needed for pain. This order originated on 2/13/24. Nurse # 7 was interviewed on 2/14/24 at 12:00 PM with the Director of Nursing and reported the following information. Resident # 5's supply of	F 755	Past noncompliance: no plan of correction required.	

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	345317	A. BUILDING _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

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F 755	Continued From page 9	F 755		

Oxycodone had not been delivered on the routine delivery of 2/13/24 when the resident was initially admitted. Nurse # 7 reported she called the pharmacy on 2/14/24 to order a special early delivery of Resident # 5's Oxycodone. At the time, the facility was utilizing their emergency back- up supply of Oxycodone, and Resident # 5 was not going without pain medication. She (Nurse # 7) was leaving for the day at the end of the 7:00 to 3:00 PM shift on 2/14/24 when she saw a pharmacy courier bring some medication to the nursing desk. She was leaving and did not know what medication was delivered or what happened afterwards. She only knew the courier had arrived at the end of the 7:00 to 3:00 PM shift. The next morning (2/15/24) she had to call the pharmacy again because Resident # 5 did not have any Oxycodone.

Review of a "packing slip proof of delivery" record from the pharmacy revealed the following information. The delivery record sheet included documentation that 15 tablets of Oxycodone 5 mg tablets were delivered for Resident # 5. At the bottom of the sheet Nurse # 4's name was typed under a section on the delivery record sheet entitled, "signed by." There was a "signature" box below the typed name. Within the signature box there was an electronic mark which was not legible as anyone's signature. It appeared as a large squiggly mark. The date and time on the delivery record sheet was 2/14/24 at 5:57 PM.

Nurse # 4 was interviewed 7/25/24 at 12:35 PM along with the DON who was present. Nurse # 4 reported the following information. She had worked on the evening of 2/14/24 and she had not received any Oxycodone from the pharmacy that evening, nor had she signed for Oxycodone

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 _____	C 07/30/2024

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CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

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F 755	Continued From page 10	F 755		

from the pharmacy on that date. Someone else had made the squiggly mark on the pharmacy's record on 5:57 PM on 2/14/24. The pharmacy used a courier service for delivery of medications. The couriers would routinely arrive, look at a nurse's badge to obtain a nurse's name, type the nurse's name in themselves into the courier's electronic device, put the electronic device in front of the nurse, and then rush the nurses to sign on the electronic device.

Review of a facility investigation into possible diversion of Resident # 5's Oxycodone revealed the facility investigated what had happened to Resident # 5's Oxycodone that the pharmacy records showed was delivered. According to the investigation file, the Oxycodone was never found at the facility although the pharmacy record indicated it was sent. Review of the investigative file revealed a statement from Nurse # 5 who had received an early delivery from the pharmacy on 2/14/24 before Nurse # 4 received a later delivery on 2/24/24. The statement read, "At 3:46 PM I signed for the package that came from pharmacy. It was a blue bag that didn't appear to look heavy. I didn't open the package but laid it on the nursing station counter by my medication cart. I was giving report to incoming Nurse and didn't' remember seeing package after I left the nurse's station."

An attempt was made to contact Nurse # 5 during the complaint investigation and the nurse could not be reached.

During the interview with the DON on 2/14/24 at 12:00 PM the DON further reported the following information. Nurse # 6 had been assigned to care for Resident # 5 on the evening shift of 2/14/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 755	Continued From page 11	F 755		

She (the DON) was already at home on 2/14/24 during the evening when Nurse # 6 called her and let her know Resident # 5's Oxycodone had not been delivered from the pharmacy. She told Nurse # 6 to continue to use Oxycodone from the facility's back up supply. The facility initiated an investigation into what had happened to the Oxycodone they had ordered as a special delivery for the resident on 2/14/24. They looked multiple places in the facility, and the Oxycodone could not be found. She talked to Nurse # 5 who reported he had been at the nursing desk at the end of the 7:00 to 3:00 PM shift on 2/14/24 when the pharmacy's third party courier arrived. He had not been assigned to Resident # 5, but the nurses shared a desk for multiple halls. When the courier arrived, Nurse # 7 (who had been assigned to Resident # 5 on the dayshift) was walking out the door. Nurse # 5 therefore signed for the courier. Nurse # 5 later reported to the DON there was no hard copy delivery slip that came with the bag, and he set it aside at the nursing desk while he was giving report and forgot about it. He left after finishing his report. Later that evening Nurse # 4 also received medications from the pharmacy but was not assigned to Resident # 5. She (the DON) had talked to Nurse # 4 during the investigation and Nurse # 4 reported there had been no Oxycodone in the delivery she had received from the pharmacy on the evening of 2/14/24. She (the DON) had also talked to Nurse # 6 and she did not know anything about why the Oxycodone was missing. Nurse # 6 just knew that she could not find the Oxycodone when it was needed and alerted the DON about the situation. While investigating the incident, she (the DON) called and talked to the pharmacy's third -party courier service to request they send records of what they

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 755	Continued From page 12	F 755		

had sent at the end of the 7:00 to 3:00 PM shift and for which Nurse # 5 signed. The DON provided a copy of the courier service's record to the surveyor. Review of the courier service's record revealed an unnamed medication was delivered for Resident # 5 on 2/14/24 at 3:46 PM and received by Nurse # 5. The delivery slip did not specify the medication was Oxycodone. According to the DON, Nurse # 5 was suspended during their investigation and inserviced about securing any type of medication when it is received from the pharmacy, but the facility was not able to validate Nurse # 5 or anyone else took whatever medication was delivered at the end of the 7:00 to 3:00 PM shift.

The pharmacy director was interviewed on 7/25/24 at 12:59 PM and reported the following information. He had not been the director on 2/14/24. On 7/25/24 he reviewed the pharmacy records and reported the pharmacy records showed the 15 doses of Oxycodone were put in a tote for delivery to the facility on 2/14/24 at 2:16 PM. Their records showed Resident # 5's Oxycodone was signed for on 2/14/24 at 5:57 PM by Nurse 4. They used a third- party contracting courier to deliver medications to the facility. The pharmacy director was interviewed regarding how they knew the Oxycodone was ever really sent to the facility given that the facility never found the medication. The pharmacy director replied that their records showed that Nurse # 4 signed for it and therefore it would not have been any fault of theirs but with the courier or the facility. The pharmacy manager was interviewed about the issue of Nurse # 4's signature not being legible and that she maintained it was not her signature. The pharmacy director replied that he was not sure what type of device the courier service was

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 755	Continued From page 13	F 755		

using for the nurses to sign, but it would be an expectation that the receiving nurse's signature be legible. The pharmacy director was also interviewed about what medication was delivered by the courier service to the facility at 3:46 PM on 2/14/24, and replied the pharmacy records did not show. The pharmacy director provided the third-party contracting courier's contact information and indicated the courier service could help with that question.

The director of the pharmacy's third -party contracting courier was left a voice mail requesting a return call on 7/25/24 at 1:12 PM and again on 7/26/24 at 8:53 AM with no return call.

Interview with the Director of Nursing on 7/25/24 at 4:30 PM revealed the facility had identified a problem with the signing for controlled substances given that the pharmacy records showed Resident # 5's Oxycodone was sent but there was no legible record showing the actual medication was received by a nurse at the facility and it was never found in the facility.

On 7/25/24 the DON presented the facility had completed the following corrective action plan:

Resident # 5 had fifteen missing Oxycodone 5/325mg identified on 2/14/24 by facility staff. An immediate investigation began. Self-Report initiated to the Department of Health and Human Services. We identified a problem with the facility establishing a system of records of receipt and disposition of controlled drugs in sufficient detail to enable an accurate reconciliation. Narcotic records could not be reconciled with the records the pharmacy had for the dispensing and delivery

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

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F 755	Continued From page 14	F 755		

of Resident # 5's Oxycodone. Nurse #4 whom the pharmacy has as receiving Resident # 5's Oxycodone reported she did not receive it and it was not her signature on the pharmacy's paperwork. Through interviews of facility staff and pharmacy's third- party carrier, it was determined that Nurse #5 signed for a medicine bag that had no documentation of contents on 2/14/24. Pharmacy was notified of this concern.

All residents that have narcotic medications ordered can be affected by this deficient practice. All Residents with narcotic medications ordered were checked/audited by the Director of Nursing on 02/15/2024. No Diversion was found. Nurse Manager/designee ensured a record of receipt and disposition were all able to be reconciled for all other narcotics during this audit.
DON met with Nursing Consultant, Administrator, MDS (Minimum Data Set Nurse), Therapy and ADON (Assistant Director of Nursing) for the implementation of PIP (Performance Improvement Plan) on February 15th, 2024.
This plan of correction initiated 2/15/24.

Licensed staff will be in serviced on ensuring proper narcotic handling which included a new policy that two licensed nurses must sign when a narcotic is received into the facility to ensure reconciliation with pharmacy records by the Assistant Director of Nursing/Designee. Inservice started 2/15/24 and completed on 02/17/24 with all licensed staff nurses and we are continuing with new Nurses with Orientation.

Bi-monthly audit will be performed by the Director of Nursing/designee to ensure all narcotics are reconciled bimonthly for 3 months. The results of these audits/concerns will be tracked and trended

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

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F 755	Continued From page 15 and then forwarded to the Quality Assurance Performance committee monthly for 3 months by the Director of Nursing/ Administrators / designee to ensure solutions are sustained and to address any concerns. Date of compliance: 02/17/24 The facility's corrective action plan was validated by the following. During the interview with Nurse # 4 on 7/25/24 at 12:35 PM, the Nurse validated that following the incident of 2/14/24 where there was no accounting for Resident # 5's Oxycodone, nurses were inserviced and trained that two nurses were to sign when the courier delivered controlled substance medications. According to the nurse, that had "put a stop" to the courier rushing them to sign after typing in their name. The DON provided documentation of inservice training per their plan of correction, documentation of audits, and documentation that their quality assurance committee had been involved in the implementation of the corrective action plan. Review of other residents' controlled substance records received after 2/14/24 revealed two nurses signed legibly by hand on the facility's receipt records noting that they had received controlled substances. The facility's corrective action plan date of 2/17/24 was validated.	F 755		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control	F 925		8/14/24

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

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F 925	Continued From page 16 program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with residents, staff, dialysis staff, transport company staff, and the facility's pest control provider's service technician, the facility failed to ensure a system was in place on three of four halls to ensure ants did not climb into residents' beds or on residents while the pest control company was baiting underground ant colonies while trying to eradicate them. The findings included: 1a. Resident # 1 was admitted to the facility on 4/3/24. The resident's diagnoses in part included glaucoma, end stage renal disease for which he went to dialysis three times per week, severe peripheral artery disease, and left foot dry gangrene. Resident # 1 resided on the 400 hall. Resident # 1's quarterly Minimum Data Set assessment, dated 6/17/24, coded the resident as cognitively impaired and as needing substantial to maximum assistance with his hygiene needs. The resident was also assessed to have an arterial wound and as being highly visually impaired. Review of orders revealed staff were to provide daily dressing changes to Resident # 1's arterial wound on his left foot. Review of dialysis nursing notes revealed an entry, dated 7/11/24, noting the following information. "Pt (patient) came in with ants on him	F 925	F925 1. Resident #1 had ants on the outside of his foot dressing on July 11th / 16th , 2024. This was identified by dialysis staff and communicated to the facility. Resident #15 reported identifying ants in his bed and room during his stay at the facility from 7/6/24 to 7/22/24. Facility staff immediately deep cleaned room and showered the resident. Resident #16 reported to surveyor on 07/25/24 that ants had been in his room/ bed and did not inform the facility staff. Facility had been diligently involving Ecolab to control ant issue since the beginning of July 2024. 2. All residents have potential to be affected by this deficient practice. Each room and the outside of the facility was treated by Ecolab on 8/12/24 for deterrent of ants. If Any ant issues was identified in a room the resident was moved out of the room for 3 days per the recommendation of Ecolab. 3. All facility staff were in serviced on identification of ants, how and who to report to, pest control, and proper follow through by the Assistant Director of Nursing/ designee by 08/12/24. Any newly hired staff member will receive education on identification of ants, how and who to report to, pest control, and proper follow through during orientation by	

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 925	Continued From page 17 today. Multiple ants were noted on pt's foot dressing. Pt states he was on the porch one time and that was all of his outdoor activity. Called nurse {Nurse # 1} over at {name of facility} and she states that facility is aware and suspects that due to pt's blindness. He is spilling food on himself and is attracting ants." Nurse # 1 was interviewed on 7/26/24 at 11:47 AM and reported the following information. She worked on 7/11/24 from 7:00 AM until 11:00 PM. Resident # 1 usually left for dialysis at 6:45 AM and therefore he was gone when she arrived at work on 7/11/24. Someone from dialysis did call her on the morning of 7/11/24 and told her they had found ants on Resident # 1. They did not say how many or where they were found on the resident. She told her supervisor (Nurse # 2). She sent the Nurse Aide to check the room. There were none in the room. The bed had already been stripped. Nurse # 7 was interviewed on 7/26/24 at 2:24 PM and reported the following information. She did not recall anyone telling her about ants on Resident # 1 on 7/11/24. She did know that on a different day (7/16/24) she was making rounds and checking on residents. Nurse # 3 stopped her and told her there were ants in Resident # 1's room. This was another day where Resident # 1 had already left for dialysis. She went to look herself. When she entered, the ants were not evident right away. There were just a few and they tended to blend in with the floor. She had to kneel down in order to see them. They were not in the bed but on the floor. She immediately went and told the Director of Nursing (DON) and the Maintenance Director. The Maintenance Director went immediately to check and to call the pest	F 925	the Assistant Director of Nursing/ designee. 4. A weekly audit of the outside of the facility and each interior room to identify any issues with ants will be conducted times twelve weeks by the Administrator/ Maintenance Director/ designee. Ecolab will provide deterrent treatment as needed and monthly times three. Room changes will be completed as needed after any identification of an ant concern. The outcome of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee monthly times three by the Administrator/ designee. August 14th, 2024	

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 925	Continued From page 18	F 925		

control company.

NA (Nurse Aide) # 1 had cared for Resident # 1 on the shift which began on 7/10/24 at 11:00 PM through 7:00 AM on 7/11/24. NA # 1 was interviewed on 7/26/24 at 2:07 PM and reported the following information. Resident # 1 did not go outside before going to dialysis. He waited inside for the transport team. Generally, he would refuse a complete bath, but she would assist him to wash his face and private area. He generally wore a sock over his feet, but he would not wear a boot. He would generally say his sock had recently been changed or did not need to be changed. She had not seen any ants on him or in his room on the morning of 7/11/24 before he went to dialysis.

The dialysis nurse, who worked with Resident # 1 on 7/11/24, was interviewed on 7/26/24 at 8:54 AM and reported the following information. When Resident # 1 arrived, he had ants on him. They were concentrated in the area of his dressing to his foot. They "appeared" to be going under his dressing, but they did not have wound supplies to change the dressing to see if they were under the dressing. The transport team reported to the dialysis nurse that the ants had been on Resident # 1 when he was picked up and that "the staff didn't seem horribly concerned" about them. The transport team picked ants off of him, and once he was at dialysis they (dialysis staff) also picked more of them off of him. He (the dialysis nurse) called and spoke to a facility staff member who reported the resident was blind and could spill food that might attract them. Resident # 1 had been brought in again with ants on him. He (the dialysis nurse) did not see them the second time, but the transport team had seen them.

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 925	Continued From page 19	F 925		

The director of the transport company, which transported Resident # 1 to dialysis, was interviewed on 7/29/24 at 11:30 AM and reported the following information. He had reviewed his crew's records and there was documentation that Resident # 1 had ants on him when they transported Resident # 1 also on 7/16/24. The documentation included there were about 12 to 15 ants observed near the foot area on 7/16/24. Their communication call center had called and talked to the facility on that date about the ants.

Nurse Aide # 3 had cared for Resident # 1 on the night shift which began at 11:00 PM on 7/15/24 and ended at 7:00 AM on 7/16/24. NA # 3 was interviewed on 7/24/24 at 10:15 AM and reported she had assisted Resident # 1 with a bath before he left for dialysis on 7/16/24 and put his sock on. At that time, there had been no ants on the resident.

Resident # 1's wound care was observed on 7/24/24 at 9:00 AM as the treatment nurse provided care. There were no ants present on the resident or in his wound. Interview with the treatment nurse at that time revealed someone from dialysis had reported ants had been on his sock, but she routinely changed his dressing and had never witnessed ants on the resident or in his room.

Resident # 1 was interviewed on 7/23/24 at 4:30 PM and again on 7/25/24 at 4:20 PM and reported the following. He had been told by the dialysis workers that there were ants on him, but he was blind and could not see them. The resident did not indicate that this had bothered him. When asked about his care, the resident

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 925	Continued From page 20	F 925		

reported the staff took good care of him and did not appear distressed about having ants on him.

1b. Resident # 15 resided at the facility from 7/6/24 until 7/22/24 on the 300 hall. Review of Resident # 15's admission Minimum Data Set revealed the resident was cognitively impaired and his vision was severely impaired. He required partial to moderate assistance with bathing.

NA # 2 was interviewed on 7/25/24 at 3:10 PM and reported the following information. There had been a time in July, 20024 when the resident resided at the facility that there were ants on him while he was in the bed. The resident was partially blind and could not see them. He kept rubbing his arm and could feel them crawling. There were a lot on the floor and only a few on the resident. She reported it right away. She took the resident to the shower and the room was cleaned and treated. She reported that the family would keep snacks for the resident in his drawer.

1c. Resident # 16, who resided on the 200 hall, was admitted to the facility on 3/20/24. Review of Resident # 16's significant change Minimum Data Set assessment, dated 5/10/24, revealed the resident was cognitively intact. Resident # 16 was interviewed on 7/25/24 at 8:45 AM and reported the following. There had recently been ants in his room and the facility had been working on the problem and trying to resolve the issue. During two occasions, they had crawled up in his bed. He thought the bedspread had gotten on the floor and they had crawled up the bedspread and onto his bed. The resident did not report that the ants had bothered him.

1d. During initial tour of the facility on 7/23/24 at

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 925	Continued From page 21	F 925		

10:42 AM, it was observed that a random resident (Resident # 17) rolled up to a nurse on the 400 hall and reported there were ants in his 400 hall room. Observations revealed the staff immediately went to deal with the ants and the housekeeping staff went into the room to clean. During a follow up observation of Resident # 17's room two days later (on 7/25/24) at 9 AM there were a few black, small ants crawling in the corner of the room near the resident's bedside nightstand. The Administrator and Maintenance Director were also asked to view the room and observed the few ants. In order to see the ants, one had to look closely due to their small size. The Administrator reported they had been checking the rooms, and Resident # 17's room had not been observed earlier that morning with any ants.

Review of facility pests control records revealed the following information from the facility's pest control service provider:
On 6/11/24 the technician had found no insect activity noted during inspection in the interior of the facility.
On 7/9/24 the technician noted he had serviced seven rooms on the 300 hall and two rooms on the 400 hall. Two of the rooms were Resident # 1's room and Resident # 15's room. The technician noted he had replaced bait as needed.
There was no pest control technician note for the date of 7/11/24 (the date on which dialysis found ants on Resident # 1).
The next pest control technician's note was on 7/16/24. On this date, the technician noted he serviced seven rooms on the 400 hall. One of the rooms was Resident # 1's room..
The next pest control technician's note was on 7/23/24. On this date, the technician noted he

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 925	Continued From page 22	F 925		

serviced four rooms on the 300 hall, two rooms on the 200 hall, and two rooms on the 400 hall. The technician noted he found ants in two rooms. One of the rooms was Resident # 16's room and the other room was Resident # 17's room.

The Administrator and Director of Nursing were interviewed on 7/26/24 at 10:56 AM and again on 7/26/24 at 2:38 PM and reported the following information. Neither of them had been told about ants being found on Resident # 1 the first time (the date of 7/11/24). Nurse # 1 had not reported the phone call she received from dialysis. The first time they heard about ants on Resident # 1 was on 7/16/24 and the pest control company did come out that day. On 7/16/24 the business office manager had informed the Administrator that the transport company had called very early that morning to let the facility know ants had been on the resident. They had "jumped on it that day" and made sure they were checking the resident routinely daily for skin checks and his room was clean. The resident had never had bites and no ants had been observed in his wound. Neither the Administrator nor the DON had heard about ants on Resident # 15 or in Resident # 16's bed. The Administrator further reported the following information. The maintenance director was new within the last few weeks. Around 7/8/24 he had been checking on maintenance issues and noted ants in rooms on the 300 and 400 halls. They cleaned well and their pest control technician came out the next day to do treatments. The pests control technician was continuing to come, inspect, and treat at least on a weekly basis and as needed since the problem had been identified on 7/8/24. They were working to resolve the issue.

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 925	Continued From page 23	F 925		

The facility's pest control technician was interviewed on 7/24/24 at 3:10 PM and reported the following information. The facility was an older building and built on a slab. He suspected that there were ant colonies underneath the slab. Just because the ants appeared in one room did not mean that the colony was right below that room. The ants might be traveling under the building and coming up in different rooms. Therefore, one of the best ways to eradicate them was to use bait. The ants would take the bait back to the underground colonies. This took time but it did work. It was not an instantaneous quick kill. The downside of putting quick kill spray down was that the colonies would continue to persist. He had been coming for three consecutive weeks working on the problem. He had not identified any structural problems that the facility needed to fix. He also had checked for sanitation issues that might be drawing the ants and routinely pulled back dressers and looked for old food droppings, but the facility appeared to be clean. The soil outside was sandy and naturally conducive to ants. There had never been any fire ants, only black ants. He also routinely treated the exterior of the building but in recent weeks it had been raining a great deal, and the rain would just wash the treatment away. He felt they were in the middle of the eradication process with the bait and anticipated by mid- August or sooner they would see a difference. During a follow up interview with the pest control technician on 7/25/24 at 10:45 AM, the technician was interviewed about the ants that were in Resident # 17's room during the initial tour of the facility on 7/23/24 and observed again two days later on 7/25/24. The technician reported that the room had been baited and the staff might see ants in the room for 3 to 4 days following the bait

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 _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 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
F 925	Continued From page 24 treatment because he wanted the ants to take the bait back to the colony. The technician was interviewed about measures the facility might take to keep the ants off of beds while the ants were being baited and indicated the staff should look into the reasons that they were being drawn into the beds, and that at times covers/blankets that hit the floor allowed access from the floor to the beds.	F 925		