accepted & received 1/13/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL NURSING AND REHABILITATION CENTER	3000 HOLSTON LANE RALEIGH, NC 27610

(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 2567 amended on 11/30/11. 2567 amended on 01/13/12.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident interviews and record reviews the facility staff failed to maintain dignity for Resident#66 by allowing a cognitively impaired dependent resident to eat a meal in a room with an offensive odor of urine while sitting in a urine soiled brief. The facility staff failed to enhance Resident#23 dignity by delaying incontinence care. This was evident in 2 of 6 residents in the sampled survey who were dependent on staff for care. 1. Resident #66 has cumulative diagnoses which included diabetes, CVA (stroke) and dementia. Review of the quarterly Minimum Data Set assessment tool dated 10/17/11 revealed the resident had moderately impaired cognition and required extensive assistance for toileting of 2 or more staff. Resident #66 was coded as frequently incontinent of urine. Review of the care plan updated 10/6/11 revealed several problems which included: " I (referring to Resident #66) continent of bowel and bladder	F 241	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. **Corrective Action for Resident Affected** Resident # 66 received incontinent care and mattress and sensor pad was changed on 11/2/11 at 10:35am. Resident #23 received incontinent care on 11/4/11 at 1:50pm. **Corrective Action for Resident Potentially Affected** All residents who are incontinent have the potential to be affected by this alleged deficient practice those residents were checked on 11/04/2011 by nursing management to ensure the residents maintained dignity during their meal service. **Systemic Changes** An in-service was conducted by the Staff Development Coordinator on November 2nd November 11th, November 14th, November 15th and November 25th. Those who attended all CNAs, FT, PT, and PRN. Any in-house staff member who did not receive in-service training by December 1, 2011 will not be allowed to work until training has been completed. The in-service topics included Dignity, respect, grooming residents, timely incontinent care, mattresses that are torn or strong odors must be reported and replaced as needed, This information has been integrated into the standard orientation training for the CNAs and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained	12/2/11 PB for all tags.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy S. Hunley
TITLE: Administrator
(X6) DATE: 12/1/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 with some episodes of urinary incontinence. " The approaches included to " check for incontinence and change per P& P [referring to policy and procedure). " One of the other problems indicated the resident was at risk for pressure sore development due to a history of a pressure sore. Two of the approaches included to provide incontinence care with moisture barrier as needed and to please assist me (referring to Resident#66) to toilet. Observation on 11-2-2011 at 9:20 AM room revealed a strong odor of urine from Resident#66 ' s room. Resident #66 was lying in bed with her breakfast tray positioned on the bedside table after just completing her meal. NA#5 (nursing assistant) entered the room and checked Resident #66 ' s incontinent brief. NA#5 picked up the under pad that was on top of the bedspread. It was heavy, wet and smelled of urine. The bedspread was wet and smelled of urine. NA#5 asked Resident#66 who had checked on her that morning (referring to the NA assigned on 11/2/11), and the resident replied " nobody. " The NA pulled the brief away from the resident ' s body. The brief was heavily saturated with urine that was strong and dark golden color. The sensor pad on the mattress was dry and had a strong smell of urine. The mattress had numerous dried stains in the center of the mattress with several areas were the mattress cover was peeling. The mattress had an indentation and a strong urine smell. Interviewing on 11/2/11 at 10 AM with NA#1 in the presence of MDS#2 indicated she had not provided care or checked on Resident#66 her since she arrived on duty today (11/2/11) until	F 241	**Quality Assurance** The DON, ADON, Nurse Managers and Weekend RN Manager or designee will monitor this issue using the "Survey QA Tool for Timely Incontinent care". The monitoring will include verifying that all residents who are incontinent will receive incontinent care before dining and timely response to requests for incontinent care during meal delivery time. 10% of the residents who are incontinent will be audited. See attached monitoring tool. This will be done daily Monday thru Friday by DON, ADON and Nurse Managers and on weekends by the Weekend Nurse Manager designee for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The date of completion is December 1, 2011.	

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F 241	Continued From page 2 after her breakfast because she had to get certain residents out of bed for the first and second breakfast meal service. An interview on 11/2/11 at 10 AM was conducted with NA#1 (NA assigned to the resident) who indicated she had not provided care for Resident#66 or checked on her since she arrived on duty today for the 7 a.m.-3 p.m. shift (11/2/11) until after her breakfast because she had to get certain residents transferred out of bed for the first and second breakfast times. Interview on 11/2/11 at 10:35 AM with NA#3 indicated he could smell the urine from the sensor and the mattress. NA#3 then replaced the sensor pad and mattress." Interview on 11/2/11 at 12:41 p.m. with Nurse##3 revealed "I asked who gave her the tray this morning, No one knew. " Unable to interview the staff person who set-up the resident ' s meal tray Interview on 11/4/11 at 3:11 p.m. with the administrator and director of nurses (DON) was held. The administrator indicated that her expectations were to have a clean environment without odors, and that NA#1 left the facility on 11/2/11. The administrator and the DON indicated that their expectations were that each resident receive an excellent standard of care. 2. Resident #23 was admitted to the facility on 9/18/06 with cumulative diagnoses of status post bilateral amputation of her lower extremities, CVA (cerebral vascular accident) with late effect Hemiplegia of right side. According to the quarterly MDS (minimum data set) dated	F 241		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 241	Continued From page 3 10/12/11. Resident # 23 required extensive assistance with bed mobility and toileting. The resident was totally dependent on the staff for transfers with the assistance of a mechanical lift and toileting. She propelled herself independently around the facility. She was incontinent of bowel and bladder. Resident #23 was alert and oriented and able to make her needs known. Review of her Care Plans dated originally dated 9/12/2009 and updated 9/15/11 revealed in part: " I have risk for skin breakdown related to incontinence of B&B (bowel & bladder), and decreased mobility. Interventions included: I will need staff to assist with my incontinence care. Keeping me clean and reduce my risk for skin breakdown. " " I have risk for skin breakdown related to incontinence of B&B (bowel & bladder), and decreased mobility. Interventions included: I will need staff to assist with my incontinence care. Keeping me clean and reduce my risk for skin breakdown. " " I am at risk for falls related to impaired ability to transfer on my own. " Interventions included: assist with transfer with [name of lift] mechanical lift. I will need staff to assist me with my incontinent care. I usually tell staff when I need to void. An observation and interview with resident # 23 on 11/4/11 at 1:20 PM while sitting in her room. She stated with a deep sigh, " I am wet and need to be changed. I told the Nurse # 5 30 minutes ago. I know it is 30 minutes from the time on my watch. " Resident # 23 activated the called. At 1:30 PM Nurse #5 came to the resident ' s room, resident # 23 stated" I am still wet and need to be changed." Nurse # 5 stated "OK, that ' s right" and left the room. Nurse # 5 returned 15 minutes	F 241		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	Continued From page 4 later at 1:45 PM later and stated "She (NA #10) (nursing assistant) is feeding in the dining room, she is on her way, and you need the [name of lift] lift too". Resident # 23 dropped her head down and shook her head in frustration and stated " this happens often and I have to wait, I will not go back out of my room until I am changed, I am just going to go back to bed". At 1:50 PM NA #10 and NA # 3 came to room with the mechanical lift. During an interview with NA #10 on 11/4/11 at 1:55 PM she revealed there are two NAs left on the floor and a nurse on floor when she is in the dining room feeding other residents to be able to answer call bells and watch over my residents. She indicated she was in the dining room feeding some residents and Nurse #5 told her the resident needed to be changed. She came as soon as she was finished in the dining room. NA #3 went and got the mechanical lift to help me. During an interview on 11/4/11 at 2:10 PM Nurse # 5 stated "the NA was feeding, she (resident) thinks she waited a long time, but it wasn't that long. I looked for the NA on the hall but she was feeding a resident so I had to go and get the NA assigned to the resident to care for her and she was in the dining room. I could have changed her, but she needed to use the [name of lift] mechanical lift and that requires two people. " During an interview with the DON (director of nursing) on 11/4/11 at 2:00 PM revealed any staff member can assist with changing a resident's wet brief. The DON stated " my expectation would be that the nurse would have gotten another staff member to help her change this resident ' s brief when the resident asked and not make a resident wait for the NA to finished feeding residents in the dining room. "	F 241		
F 252	483.15(h)(1)	F 252		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 252 SS=E	Continued From page 5 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, family interview and staff interviews the facility failed to keep the resident care areas free from offensive lingering odor that resembled urine and stool. This was evident in 4 of 4 nursing units (Units 100, 200, 300 and 400). Findings included: Observations on 10/31/11 at 3:20 PM revealed a strong offensive odor resembling urine from an overflowing basket of resident clothes in room 212. Observations on 11/2/11 at 9:45 AM revealed an offensive odor resembling urine in room 212. The clothing bin was overflowing with clothes. Observations on 11/1/11 at 7:50 AM revealed foul smelling lingering offensive odor resembling urine and stool in the hallways of the 300 unit. Observations on 11/2/11 at 8:15 AM revealed offensive odor resembling urine in the hallways of unit 300. An interview was conducted on 11/1/11 at 8:45 am with the director of housekeeping revealed he was employed at the facility just 2 weeks ago (from the survey date) and knew he had inherited the problem with offensive odors . The director of housekeeping indicated he planned to deep	F 252	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. **Corrective Action for Resident Affected** The rooms identified during the annual survey that had odors that resembled urine and stool were immediately cleaned by the housekeeping department. The rooms immediately cleaned were the following: 212, 411, 303, 304, 301, and 302. **Corrective Action for Resident Potentially Affected** All resident rooms within the facility were examined to ensure there were no lingering or offensive odors. All mattresses were examined and replaced if necessary. **Systemic Changes** An in-service was conducted on November 29, 2011 by Housekeeping Supervisor. Any housekeeper who did not receive in-service training by December 1st 2011 will not be allowed to work until training has been completed. Also CNAs, FT, PT and PRN were in-serviced on November 25, 28 and 29, 2011. The in-service topics included to the housekeeping staff that if you are cleaning a mattress and you notice any tears, rips, or any strong urine smells (after cleaning), or any deep indentations showing excessive wear. Please notify supervisor to get it replaced if needed.	

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F 252	Continued From page 6 clean one resident hall a week. The interview revealed that the deep cleaning consisted of steam cleaning of wheelchairs, cleaning the bed, the floor and walls. Another interview on 11/2/11 at 10 AM with the director of housekeeping revealed he uses a deodorizer which he sprays in the halls. Observations on 11/1/11 at 9:45 AM revealed an offensive odor resembling urine noted in the hallway near rooms 209 and 210. Observation on 11/2/11 at 8:41 AM revealed a strong offensive odor resembling urine in the hallway near rooms 209 and 210. A chair (unmarked) with a blue cushion with sitting outside of rooms 209 and 210 smelled of odor resembling urine. Interview at the time of the observation revealed Nurse#7 did not know who used the chair. Observation on 11/2/2011 at 9:20 AM revealed room 411 had a strong offensive odor which resembled urine. Observations on 11/2/11 at 9:30AM revealed a strong offensive odor resembling urine in the activity room on the 300 hall. Observation on 11-2-2011 at 9:20 AM revealed a strong odor of urine from Room 411. The sensor pad on the mattress was dry and had a strong smell of urine. The mattress had numerous dried stains in the center of the mattress with several areas were the mattress cover was peeling. The mattress had an indentation and had a strong urine smell. Interview on 11/2/11 at 10:35 AM with NA#3 indicated he could smell the urine from	F 252	We have also contracted with Lee Air Conditioning that is going to complete the HVAC project. This project will begin in January 2012 and be tentatively completed by March 31, 2012. This design of this project is the result of a full building assessment by an architect and engineer. It will require the installation of additional central heat and air systems, along with a comprehensive ventilation system throughout the building. This should have the effect of taking odors in each resident room and moving the odors out of the building. Currently these odors to flow toward the hallways and lobby. While these HVAC systems are common in new construction, they were not routine at the time your building was originally constructed. The equipment order lead time is approximately six weeks, so I expect them to actually begin working onsite in mid-January **[illegible]lity Assurance** The Housekeeping Supervisor will monitor this issue using the "Survey QA Tool for Environmental Odors". The monitoring will include verifying that any lingering odors will be investigated to ensure this is resolved timely. See attached monitoring tool. This will be done daily Monday through Friday for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The date of completion will be December 1st 2011.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 252	Continued From page 7 the sensor and the mattress. NA#3 then replaced the sensor pad and mattress." Observations on 11/2/11 at 11:21 AM revealed a strong offensive odor resembling urine in the bathroom shared by rooms 303-304. Observations on 11/2/11 at 11:30 AM revealed a strong offensive odor resembling urine in the bathroom shared by rooms 301-302. Observations on 11/3/11 at 1:35 PM revealed a strong offensive odor resembling urine in the bathroom of 301. An interview on 11/3/11 at 2 PM with a family member and an alert and oriented was held. The family member indicated that the facility always smelled like urine when they visited. The resident indicated that the air smelled better today (11/3/11) in the facility then the usual smell of urine. Interview on 11/4/11 at 3:11 PM with the administrator and director of nurses was held. The administrator indicated that she identified an issue with poor ventilation and that an overhaul of the ventilation system was to be done. The administrator indicated that her expectations were to have a clean environment without odors and without paint chips on the walls. The administrator indicated that repair forms were located on each unit and should be completed whenever necessary.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 253 Continued From page 8
maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation and interviews with staff the facility failed to maintain a clean mattress for 2 resident rooms (Room #109 and Room #411). The facility failed to maintain cleanliness for 2 of 6 mechanical lifts utilized for resident transfers. The facility failed to maintain walls free from chipped /peeling paint. The facility failed to ensure bathroom floors were free of stains and accumulation of build-up in the corners. The facility failed to label resident care equipment and ensure the equipment was clean, sanitary and in an orderly manner. This was evident in 4 of 4 resident care units. (100, 200, 300, and 400).

Findings included:
Observations on 11/1/11 at 8:45 AM revealed 8 wheelchairs were stored in the staff development room. The 8 wheelchairs had a strong odor resembling urine. An interview was conducted on 11/1/11 @ 8:45 am with the director of housekeeping revealed he was employed at the facility just 2 weeks ago and knew he had inherited the problem with offensive odors . The director of housekeeping indicated he planned to deep clean one resident hall a week. The interview revealed that the deep cleaning consisted of steam cleaning of wheelchairs, cleaning the bed, the floor and walls. Another interview on 11/2/11 at 10 AM with the director of housekeeping revealed he uses a deodorizer which he sprays in the halls.

F 253

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.

To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

Corrective Action for Resident Affected
The resident rooms that were identified during the Annual Survey were immediately cleaned to ensure no buildup in corners; chipped paint in rooms, and stains on the floors and the cove base was completed by December 1, 2011. The resident equipment was also labeled/cleaned and stored properly. The rooms that this affected were the following: 411,401B, 311, 310, 303, 408, 409,315,316,207,208,306,202, 312,109, the eight wheelchairs in the Staff Development Office were also cleaned thoroughly. The switch was fixed in room 112.

Corrective Action for Resident Potentially Affected
All resident rooms were examined to ensure there were no chipped walls, resident equipment clean (mechanical lifts, bedpans, mattresses), labeled properly (bedpans, urinals, and measuring cups), no build up in corners, all bathroom floors were deep cleaned and all light switches working properly. All areas found to be deficient were corrected by December 1, 2011.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 253	Continued From page 9 Observation on 11/1/11 at 9 a.m. revealed the facility had 6 mechanical lifts. There are 4 mechanical lifts and 2 sit to stand lifts. Observations on 11/2/11 at 8:20 am in the storage area revealed 2 mechanical lifts and 2 sit to stand lifts had an accumulation of dust in the frame and bases. One mechanical lift sling was noted to have a strong foul odor resembling urine. Interview on 11/2/11 at 8:23 am with (nursing assistant) NA #5 and NA#12 Oscar revealed they had just used this lift and pad to transfer Resident #65 out of bed. Observation on 11/3/11 at 11:35 a.m. revealed one mechanical lift had dried spills on the frame of the lift. There was an accumulation of a dried and flaky substance similar to dust and dirt in the corners of this lift. Another mechanical lift had dried stains on the frame with a built up of dust and dirt on the stand. Observation on 11/3/11 at 1:30 p.m. with the maintenance director revealed the lifts continued to be soiled. Interview at this time with the maintenance director revealed he guess he was responsible for ensuring the lifts were clean because he would rather the lifts not get too wet when cleaning them. During the interview the maintenance director could not indicate the last time the lifts had been cleaned. Observation on 11/2/11 at 10 a.m. revealed a sensor pad on the mattress in room 411A was dry and had a strong smell of urine. The mattress had numerous dried stains in the center of the mattress. Several areas on the mattress were peeling with an indentation and strong urine	F 253	- **Systemic Changes** An in-service was conducted on November 29th by Housekeeping Supervisor. The in-service topics included: Cleaning the resident bathrooms properly including the floors, corners, commodes, cleaning wheelchairs monthly or as needed/mechanical lifts to be cleaned daily or as needed. The nursing staff, Nurses and CNAs were also in-serviced on proper labeling resident equipment (bedpans, urinals, and measuring cups); this was done on November 25th and November 29th 2011. Any housekeeper, nurse or CNA who did not receive in-service training will not be allowed to work until training has been completed by December 1, 2011. **Quality Assurance** The Housekeeping Supervisor and by weekend manager designee will monitor this issue using the "Survey QA Tool for Housekeeping/Environmental Issues". The monitoring will include verifying that all resident equipment and bathrooms with will be reviewed. See attached monitoring tool. This will be done weekly for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The date of completion is December 1st 2011.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345202	A. BUILDING ____ B. WING ____	C 11/04/2011

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CAPITAL NURSING AND REHABILITATION CENTER	3000 HOLSTON LANE RALEIGH, NC 27610

(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 253	Continued From page 10 smell. At 10:35 a.m. on 11/2/11 NA#3 indicated he could smell the urine from the sensor and the mattress. NA#3 then replaced the sensor pad and mattress. At 10:40 a.m. on 11/2/11 the administrator observed the condition of the mattress. The administrator indicated that this resident's room had been deep cleaned 10/23/11. Interview on 11/2/11 at 3:15 p.m. with HK#3 working on the 400 hall revealed he had no worked on 10/23/11 and did not know who deep clean room 411. Review of the HK schedule revealed HK#2 worked the 400 and would have been responsible for the deep cleaning of 411. Interview with HK#2 during the survey was unsuccessful. Observations on 11/2/11 at 11:21 AM revealed missing cove molding and exposed rough plaster behind the wall in room 303 Observation on 11/3/11 at 1:15 PM revealed multiple areas of peeling paint in the bathroom area shared by rooms 310-311. Chipped paint was noted on the wall near bed A in room 311. Observations on 11/3/11 at 1:35 PM revealed multiple areas of peeling paint on the wall near bed 301-B. Observations on 11/3/11 at 1:45 PM revealed chipped paint on the wall near the entrance to the bathroom in room 401B. Observations on 11/3/11 at 1:50 PM revealed the light in the bathroom shared by rooms 408-409	F 253		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 11/04/2011

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F 253	Continued From page 11 would not illuminate when the switch was turned on. Interview at the time of this observation with NA#11 indicated the lights were blinking this morning. There were 2 plastic white pipe covers lying on the bathroom floor in the bathroom shared by rooms 408-409. Observations on 11/3/11 at 1:55 PM revealed an accumulation of dark brown substance in the corners of the floor in the bathroom shared by rooms 111-112. The floor tile located the perimeter of the commode had a red colored stain. There were dried spills on the commode seat. Inside the toilet bowel was a brown colored ring build up about 2 inches in width. There were 2 light switches in the bathroom. There was one light switch for the entrance of the bathroom from room 111 and one light switch for the entrance from room 112. The light switch for room 112 was broken and could not be used to turn the lights on or off. Interview on 11/3/11 at 2:45 PM with (housekeeper) HK#1 who was assigned to room 112 revealed she had completed cleaning the bathroom at 2:25 PM on 11/3/11. Immediately after this interview the director of housekeeping observed the condition of the bathroom shared by rooms 111-112. Observations on 11/3/11at 2:03 PM revealed a build up of a brown substance in the corners of the bathroom floor shared by room 315-316. The floor tiles located the perimeter of the commode in the bathroom shared by 315-316 had a red/brown colored stain. Observations on 11/3/11at 2:10 PM revealed an accumulation of a dark substance in the corners of the bathroom floor in the bathroom shared by	F 253		

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 253	Continued From page 12 rooms 207-208. The toilet paper holder was partially detached from the wall in the bathroom shared by rooms 207-208. Cove molding was missing in room 208. Observations on 11/3/11 at 2:15 PM revealed an electrical plate detached from the wall with telephone wires exposed in room 203. Observation on 11-3-11 at 3:23 PM in Room 202 bathroom revealed 2 bedpans that were stored in a plastic bag unlabeled. . Observation on 11-3-11 at 3:25 PM revealed one bedpan on floor unlabeled/not covered in the bathroom shared in rooms 207 and 208. Observation on 11-3-11 at 3:28 PM in 306 bathroom revealed a measuring container and an empty urinal sitting on the back of the toilet tank that was not labeled. Observation on 11-3-11 at 3:30 PM revealed a basin unlabeled in the 310 bathroom. Observation on 11-3-11 at 3:32 PM revealed an unlabeled measuring container on the floor in the bathroom shared by rooms 315 and 316. The floor tile at the base of the commode had a wet dark rust color stain. Broken floor tiles were observed. Observation on 11/3/11 at 3:40 PM with housekeeping director revealed room 312 had an offensive odor that resembled urine. The housekeeping director stated " I am going to strip this bed immediately; I am trying to keep up with things. The odor must be in the mattress. "	F 253		

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	345202	A. BUILDING ______ B. WING ______	C 11/04/2011

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F 253	Continued From page 13 Continued observations on 11/3/11 at 3:40 PM in room 312 bathroom revealed one unlabeled bedpan on floor. A toilet plunger was noted in on the floor in a bedpan labeled room 312. The plastic container from a bedside commode was located on the floor. The adaptive toilet seat had black particles, discoloration, and a curly black hair on the seat. The cover to the adaptive toilet seat was partially hanging off of the back of the toilet. The cove molding was partially detached from the wall. There was a dark colored marking along the wall. Observation on 11/4/11 at 11:15 AM revealed a mattress from room 109A smelled of a strong urine odor. Interview at this time with the director of housekeeping revealed he was in the process of removing the mattress from use. Interview on 11/4/11 at 3:11 PM with the administrator and director of nurses was held. The administrator indicated her expectations were to have clean environment and she was addressing the above issues when she recently hired a new director of housekeeping. The administrator indicated that the facility had work order slips on every unit and should be used when needed.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and physician	F 281	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 281		F 281		

F 281 Continued From page 14
interviews, the facility failed to transcribe and implement a physician ' s order to change Dilantin from a liquid form to a capsule for a resident with sub therapeutic Dilantin blood levels. This was evident for 1 of 1 residents receiving liquid Dilantin (Resident # 58)

Findings included:

Resident # 58 was admitted to the facility on 11/30/06 with cumulative diagnoses of convulsions, late effect CVA with cognitive defects and Alzheimer ' s disease. According to the quarterly minimum data set on 9/21/11 the resident was totally dependent on staff for all ADL's (activities of daily living) including, bathing, incontinent care, mobility, transfers and positioning.

Review of the November 2011 physician ' s order documented "Dilantin Suspension 125 mg/ml. Give 200 mg (8 ml) po BID (by mouth twice a day) start date: 03/31/11." This drug was used to control seizure activity.

Review of October and November 2011 physician ' s orders revealed the Dilantin level to be drawn Q 3 months (every 3 months). The schedule was March, June, September and December.

Review of the Nurses Notes from September 2011 through November 2011 revealed no documentation of the resident having any seizure activities.

Review of the TAR (treatment administration record) for October 2011 and November 2011 revealed an order for Albumin and Dilantin level

F 281

Corrective Action for Resident Affected
For Resident # 58 an order was written to change the Dilantin from liquid to pill form, pharmacy notified, a med error report was completed, MD aware and family notified on November 4th 2011.

Corrective Action for Resident Potentially Affected
All residents receiving orders for Dilantin changes have the potential to be affected by this alleged deficient practice. All Residents lab sheets with Dilantin results were reviewed by the Assistant Director of Nursing on November 7th-11th 2011 to ensure that any order that was written on the lab report forms was transcribed to the individual order sheet and implemented as ordered.

Systemic Changes
An in-service was conducted on November 9, 14, 25, 28 and 29, 2011 by the Staff Development Coordinator. Those who attended all RNs and LPNs, FT, PT, and PRN. Any in-house staff member who did not receive in-service training by December 1st will not be allowed to work until training has been completed. The in-service topics included several topics including professional standards for writing telephone orders that must be carried through and only writing on the telephone order not on the lab results. The topic of Dilantin Administration was also covered and how to properly shake the bottle to ensure accurate distribution of the medication.

This information has been integrated into the standard orientation training for nurses and in the required in-service refresher courses for all nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 11/04/2011

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F 281	Continued From page 15 Q3months. The schedule was March, June, September and December. Review of the laboratory reports for September 2011 revealed Dilantin level of 10.0 ug/mL, with reference range of 10.0-20.0 ug/mL (unigrams/milliliters). Review of the physician ' s order dated 10/26/11 " repeat Dilantin level and Albumin level next lab day (10/28/11). " Review of the Laboratory results dated 11/02/11 revealed the Phenytoin (Dilantin) blood level was recorded at 9.2 ug/mL was documentation on the bottom of the laboratory report indicating " [physician ' s name] physician informed with Nurse # 6 ' s initial and next to the date is Nurse # 5 ' s initial. Additional documentation revealed [physician ' s name] physician informed new order change to pill form Dilantin 11/02/11. " During an interview with Nurse #5 on 11/01/11 at 4:30 PM Nurse #3 stated " I had documented an order for another resident on this resident ' s laboratory sheet, and did not follow up to make sure the physician ' s order for the change in Dilantin was transcribed on the MAR and faxed to the pharmacy. " During a telephone conversation with the physician on 11/4/11 at 3:45 PM the physician indicated she was concerned that the resident had not been receiving the correct dose of Dilantin in the liquid form. She stated " I had the Dilantin and Albumin levels redraw because I had concerns with the September blood levels. " She explained " The liquid suspension needs to be	F 281	**Quality Assurance** The Director of Nursing or Assistant Director of Nursing will monitor this issue using the "Survey QA Tool for New Lab Medication Orders". The monitoring will include verifying that all new medication orders received regarding lab results are transcribed and implemented as ordered. All residents with new medication orders resulting from lab results will be reviewed to ensure that those orders are transcribed and implemented as ordered. See attached monitoring tool. This will be done weekly for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly and monthly Quality of Life- QA committee and corrective action initiated as appropriate. The date of completion is December 1st 2011.	

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F 281	Continued From page 16	F 281		

shaken vigorously and thoroughly to make sure the medication is distributed in the bottle for each administration of the medication, but most of the time, it isn' t and the resident is probably not receiving the therapeutic dose of the Dilantin. That is why I had the medication changed to the pill form after receiving the sub therapeutic blood level of Dilantin. I will contact the DON to make sure this medication has been changed immediately. "

Review of the November 2011 MAR (medication administration record) revealed Resident # 58 was receiving Dilantin 200 mg (8ml) po BID (by mouth twice a day) from November 3 and 4. This was indicated by initials of the nurses who administered the medication. (11/03/11 at 8:00 AM Nurse # 3 initials, 11/03/11 at 8:00 PM Nurse # 8 and 11/04/11 at 8:00 AM Nurse # 5 ' s initials.

During an interview with Nurse # 3 on 11/04/11 revealed when a lab result is received from the lab, the nurse contacts the physician, documents the order from the physician on the lab result sheet, writes the order on the telephone order sheet. The order is written on the MAR, faxed to the pharmacy.

During an interview with Nurse # 6 on 11/4/11 at 4:30 PM stated " I clarified the order with Nurse # 5 and rewrote the order Nurse # 5 received from the doctor. She continued " I should have followed up to make sure the order was transcribed on the MAR and faxed to the pharmacy, but I did not. "

During an interview with the DON (director of nurses) on 11/4/11 at 4:14 PM she stated " I

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 281	Continued From page 17 would have expected the Nurse who took the order to follow through with the process of transcribing it on an order sheet, faxing it to the pharmacy and writing it on the MAR. The nurse who verified the order also should have made sure the process was followed. "	F 281		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility staff delayed providing proper incontinent care for 2 of 6 dependent sampled residents. (Resident # 66 and Resident#23). The facility staff failed to apply barrier cream on 1 of 3 residents who experienced an incontinence episode. The facility failed to provide nail care, mouth care and hair grooming to 3 of 6 dependent residents (Resident#66, #74, and #2.) Findings included: The facility's policy on " Incontinent Care " undated was reviewed. The policy read in part " Equipment: 1. Soap and water 2. washcloth and towel or disposable wipes. Procedure in Bed : 7. Use wipe or wash cloth to wash all soiled skin areas and dry very well, especially between skin folds. 9. Apply protective skin lubricant and rub	F 312	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. **Corrective Action for Resident Affected** The residents that were identified were immediately given incontinent care and proper nail care, mouth care and hair grooming by the nursing staff. **Corrective Action for Resident Potentially Affected** All residents were examined to ensure they received proper incontinent care and ADL care involving grooming including nails and mouth care. **Systemic Changes** An in-service was conducted on November 3rd, November 14th, and November 25th, November 29th 2011 by the Staff Development Director. Those who attended all CNAs, FT, PT, and PRN, any staff member who did not receive in-service training will not be allowed to work until training has been completed by December 1st 2011. The in-service topics included providing timely incontinent care and proper grooming, mouth and nail care. **Quality Assurance** The Director of Nursing or Nurse Manager designee will monitor this issue using the "Survey QA Tool for timely incontinent care". The monitoring will include verifying that all residents with splints will be reviewed. See attached monitoring tool. This will be done daily (Monday thru Friday/ and weekends by Nursing Manager designee for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The completion date is December 1st 2011.	

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F 312	Continued From page 18 well into skin. " 1. Resident #66 has cumulative diagnoses which included diabetes, CVA (stroke) and dementia. Review of the quarterly Minimum Data Set assessment tool dated 10/17/11 revealed the resident had moderately impaired cognition and required extensive assistance for toileting of 2 or more staff. Resident #66 was coded as frequently incontinent of urine. Review of the care plan updated 10/6/11 revealed several problems which included: " I (referring to Resident #66) continent of bowel and bladder with some episodes of urinary incontinence. " The approaches included to " check for incontinence and change per P& P [referring to policy and procedure). " One of the other problems indicated the resident was at risk for pressure sore development due to a history of a pressure sore. Two of the approaches included to provide incontinence care with moisture barrier as needed and to please assist me (referring to Resident#66) to toilet. Observations on 11-2-2011at 9:20 AM revealed a strong odor of urine in Resident#66 ' s room. Resident#66 was lying in bed. NA#5 (nursing assistant) entered the room and checked Resident #66 ' s incontinent brief. NA#5 picked up the under pad that was on top of the bedspread. It was heavy, wet and smelled of urine. The bedspread was wet and smelled of urine. NA#5 asked Resident#66 who had checked on her that morning (referring to the NA assigned on 11/2/11), and the resident replied " nobody. " The NA pulled the brief away from the	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 11/04/2011

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F 312	Continued From page 19 resident ' s body. The brief was heavily saturated with urine that was strong and dark golden color. Observation on 11/2/11 at 10 a.m. revealed NA#1 was placing a brief on Resident#66. The resident's body smelled of an offensive odor similar to urine. NA#1indicated that she had just washed Resident# 66 ' s bottom using one end of a bed/bath blanket with soap and washed the soap off with the other end of the blanket. NA#1 indicated that after the first incontinent cleaning Resident#66 urinated again, but did not cleanse her because she needed to get another resident ready for _____ (an outside appointment). NA #1 stated "I m' putting a brief on her now and then " I was going to come back and give her a shower. " Continued interviewing with NA#1 indicated she had not provided care or checked on Resident#66 her since she arrived on duty today (11/2/11) until after her breakfast because she had to get certain residents out of bed for the first and second breakfast meal service. NA#1 indicated that she did not have any wipes to use to clean the urine off the resident. Observation of the bed/bath blanket (used to provide the incontinent care) at 10:10 AM on 11/2/11with MDS#2 (MDS coordinator) and NA#1revealed a corner of the bed/bath blanket had an orange colored stain and the other end of the blanket was damp. During the above interaction NA#2 provided Resident with a shower. On 11/2/11 at 10:20 a.m. NA#2 and NA#1 applied lotion to the resident legs, feet and hands. The resident's hair was dry and hair was loose from the braids. The resident's toe nails and fingernails had an accumulation of a dark brown substance under the nails. NA#2 placed socks and shoes	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 312	Continued From page 20 on the resident ' s feet and then transferred the resident to her wheelchair that that smelled of urine. The resident ' s skin was intact. No protective barrier cream was applied to the buttocks after her shower. The nails were not cleaned. Interview on 11/4/11 at 1:15 p.m. with NA#2 revealed she did not apply barrier cream to Resident #66 ' s skin because she did not have skin breakdown. I use the E-care system (computerized system) to tell me how to care for the resident and the care card posted in the room. Review of the care card posted in the resident's room revealed no information about incontinent care. Interview on 11/4/11 at 1:50 p.m. with MDS#1 and MDS#2 indicated the nursing assistance can retrieve the p/p from the home page in the computer. MDS#1 indicated the resident's mental status had declined. MDS#1 indicated that " to provide incontinent care with moisture barrier as needed " meant to apply if the skin was red or broken. Interview on 11/4/11 at 2:30 p.m. with NA#4 revealed residents should be cleaned after each incontinence episode then apply the barrier cream to prevent the skin from breaking down. Interview on 11/4/11 at 2:30 p.m. with the charge nurse Nurse#3 revealed Resident#66 and all other residents should have barrier cream applied after each incontinent episode. Interview on 11/4/11 at 2:40 p.m. with Nurse#4 revealed she was unsure of when the barrier	F 312		

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F 312	Continued From page 21 cream or what product should be used. Nurse#4 requested that the surveyor speak with the wound care nurse. On 11/4/11 at 2:48 p.m. an interview with the wound care nurse revealed every resident should have barrier cream applied after each incontinent episode as a form of prevention. Observation on 11/2/11 at 12:39 p.m. revealed her fingernails remained with an accumulation of a dark brown substance under them. Her hair was still loose and departing from the braids. Observation on 11/2/11 at 3 p.m. her fingernails remained with an accumulation of a dark brown substance under her nails. Her hair was still loose from the braiding. Interview on 11/2/11 at 3:31 p.m. with NA# 13 revealed Resident#66 required total care, complete bath, dressing and staff to assist her to get up in chair. NA# 13 indicated that when staff first arrives on duty, resident rounds should be made to check and make sure all incontinent residents were dry. We have an e-care computer chart to tell what the resident can do and cannot do or what assistance the resident requires. Further interview with NA# 13 revealed during AM care the resident ' s hair, toes, and feet are cleansed. NA#13 indicated when bathing the staff should be observing the resident ' s nails and clean when needed. Interview on 11/4/11 at 3:11 p.m. with the administrator and director of nurses (DON) was held. The director of nurses indicated that all residents were to have barrier crème applied after each incontinent episode whether or note skin breakdown existed and to follow the facility policy.	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL NURSING AND REHABILITATION CENTER	3000 HOLSTON LANE RALEIGH, NC 27610

(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 312	Continued From page 22 The administrator and the DON indicated that their expectations were that each resident receive an excellent standard of care. 2. Resident #23 was admitted to the facility on 9/18/06 with cumulative diagnoses of status post bilateral amputation of her lower extremities, CVA (cerebral vascular accident) with late effect Hemiplegia of right side. According to the quarterly MDS (minimum data set) dated 10/12/11. Resident # 23 required extensive assistance with bed mobility and toileting. The resident was totally dependent on the staff for transfers with the assistance of a mechanical lift and toileting. She propelled herself independently around the facility. She was incontinent of bowel and bladder. Resident #23 was alert and oriented and able to make her needs known. Review of her Care Plans dated originally dated 9/12/2009 and updated 9/15/11 revealed in part: " I have risk for skin breakdown related to incontinence of B&B (bowel & bladder), and decreased mobility. Interventions included: I will need staff to assist with my incontinence care. Keeping me clean and reduce my risk for skin breakdown. " " I am at risk for falls related to impaired ability to transfer on my own. " Interventions included: assist with transfer with [name of lift] mechanical lift. I will need staff to assist me with my incontinent care. I usually tell staff when I need to void.	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ____ B. WING ____	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 23 During an observation and interview with resident # 23 on 11/4/11 at 1:20 PM while she was sitting in her wheelchair in her room. She stated with a deep sigh, " I am wet and need to be changed. I told the Nurse #5 30 minutes ago. I know it is 30 minutes from the time on my watch. " Resident #23 activated the called. At 1:30 PM Nurse #5 came to the resident ' s room. Resident #23 stated " I am still wet and need to be changed." Nurse #5 stated "OK, that ' s right" and left the room. Nurse #5 returned 15 minutes later at 1:45 PM later and stated "She (NA#10) (nursing assistant) is feeding residents in the dining room, she is on her way, and you need the [name of lift] lift too". Resident # 23 dropped her head down and shook her head in frustration and stated " this happens often and I have to wait, I will not go back out of my room until I am changed, I am just going to go back to bed". At 1:50 PM NA #10 and NA # 3 came to room with the mechanical lift. During an interview with NA #10 on 11/4/11 at 1:55 PM she revealed there are two NAs left on the floor and a nurse on floor when she was in the dining room feeding other residents to be able to answer call bells and watch over my residents. She indicated she was in the dining room feeding some residents and Nurse #5 told her the resident needed to be changed. She came as soon as she was finished in the dining room. NA #3 went and got the mechanical lift to help me. During an interview on 11/4/11 at 2:10 PM Nurse # 5 stated "the NA was feeding, she (the resident) thinks she waited a long time, but it wasn't that long. I looked for the NA # 2 on the hall but she was feeding a resident, so I had to go and get the NA (NA #10) assigned to the resident and she	F 312		

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F 312	Continued From page 24 was in the dining room. I could have changed her, but she needed to use the [name of lift] lift and that requires two people. " During an interview with the DON (director of nursing) on 11/4/11 at 2:00 PM revealed any staff member can assist with changing a resident's wet brief. The DON stated " my expectation would be that the nurse should have gotten another staff member to help her change this resident ' s brief when the resident asked and not make a resident wait for the NA #10 to finish feeding residents in the dining room. " 3. Resident # 74 was admitted to the facility on 3/1/11 with cumulative diagnoses of (cerebral vascular accident) CVA, anxiety, dysphasia and dementia. According to the quarterly 8/19/11 minimum data set (MDS) Resident # 74 was alert and able to make her needs known. The resident required extensive assistance of the staff for personal care including mouth care, bathing, transfers and mobility. According to the Care Plans dated 03/02/11 revealed in part: " I require assistance with ADLs (activities of daily living) due to my dementia and confusion. " The goals were to have the staff assist me with all my ADL care and daily needs. The interventions included the staff would assist the resident will all dressing, bathing and grooming tasks. " I cannot initiate them or do them due to my dementia. " During an interview with a family member on 11/1/11 at 9:59 AM revealed the resident was complaining of pain on the upper left side of her mouth. The family member stated, " She has	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ____ B. WING ____	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL NURSING AND REHABILITATION CENTER	3000 HOLSTON LANE RALEIGH, NC 27610

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F 312	Continued From page 25 been complaining about this pain in her mouth since yesterday (referring to 10/31/11). Her companion (friend) will be here today and she will see if she can help her. " The family member indicated he informed nursing assistant # 7 (NA) this morning when her breakfast tray was brought in that her room. The family member continued he had spoken to the NAs (did not know the specific NAs he has spoken to) stating her teeth needed to be cleaned and her dentures rinsed before and after she ate, but she (the resident) told him they do not. During an interview with Nurse # 6 on 11/011 at 11:00 AM revealed the NAs are responsible to assist or provide personal care to the residents. If the resident required total care the NA were to make sure their teeth were cleaned, hair combed and clean clothes were placed on the resident. If it was the resident ' s shower day, the NAs would give the resident a shower before they dressed the resident. Resident # 74 needed help with all her care including her teeth being cleaned. During an interview with NA # 7 on 11/01/11 at 11:15 PM revealed Resident # 74 required total care. She (NA) indicated she did her mouth care after the resident ate breakfast which was during her bath. NA # 7 indicated she told the Nurse # 6 that she was complaining of mouth pain. During an interview with Nurse # 6 on 11/01/11 at 1:50 PM revealed she was not aware resident # 74 was complaining of mouth pain today. Nurse # 6 spoke with the resident during this interview and the resident stated " my mouth feels better now after my friend cleaned my teeth. "	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 11/04/2011

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F 312	Continued From page 26 During an interview with the resident # 74 ' s companion (friend) on 11/04/11 at 11:50 AM revealed on Tuesday (referring to 11/1/11) resident # 74 was complaining her mouth hurt. She stated " I removed her dentures and found a piece of food in her denture and redness on her gums. I had her rinsed her mouth and I rinsed her dentures. She put her dentures back in her mouth and told me if felt much better. I was her companion when she lived at home. She stated " her teeth usually have food particles in them after her meals when I visit. The staff really should do a better job. " During an interview with NA # 10 on 11/4/11 at 2:30 PM revealed she brushed Resident # 74 ' s teeth this morning, but she did not remove and clean her dentures. She stated " I did not know she had dentures. " She revealed she knew how to care for the resident ' s from the care card. During an interview with the director of nursing (DON) on 11/4/11 at 3:50 PM indicated her expectation were that all residents received mouth care in the morning before they were served breakfast. She further indicated her expectations were that resident ' s with dentures would have their dentures removed at least daily. The dentures should be cleaned and their gums be cleaned before the dentures were replaced. 4. Resident # 2 was admitted to the facility on 6/1/04 with cumulative diagnoses of mental retardation, seizures and enucleation of the right eye. According to the annual minimum data set (MDS)	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 27	F 312		

dated 10/06/11 Resident # 2 was alert, and able to make her needs known. The resident required total care from the staff for all activities of daily living, including bathing, personal care, mobility and transfers with a mechanical lift. Once she was in her wheelchair, she could self propel throughout the facility.

Review of the Care Plans dated 12/01/09 revealed in part " I have self care deficit related to my medical condition. I will need staff to assist with my ADLs. " The approaches included " I need assist with all my bathing and grooming. Sometimes I can help but staff will need to do most of it. "

On 11/02/11 at 11:20 AM during an interview with the DON (director of nursing), Resident # 2 was observed with food debris on her face after eating her breakfast and AM care had been provided. Her teeth had a build up of brown debris on them. The DON asked the resident if her teeth were brushed today and she replied "NO". The DON stated "I will clean her face now. " She indicated her expectation was the resident's teeth were to be brushed daily and her face was to be cleaned after she ate.

Interview with the SDC (staff development coordinator) on 11/2/11 at 11:30 AM indicated the staff can refer to the " Yellow Card or it is known as the Care Guide " to know the specific care needs of the residents. She continued they are located on the inside of the resident ' s closet and are updated by anyone who knows of a change or need in the resident ' s care. They can also access the care plan for this information too.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 11/04/2011

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F 312	Continued From page 28 During an interview on 11/2/11 at 3:31 PM NA # 13 stated " there are no care plans for the NA to see what the residents needs are. There are NA mentors for the new NAs; there are 2 on each shift. " (She was unable to give the names of the other mentor NAs.) NA # 13 continued " if a NA has a question, the NAs go to the nurse or NA mentor or other NAs who know the residents, to find out what the resident needs are. We (the staff) will tell the NA how to get resident up and if they have any weaknesses. There is no where that I can think of that tells the NA how to care for resident. " She indicated she was not aware of the residents ' daily needs being written down anywhere. NA # 13 indicated she was unaware of the Yellow Cards/ Care Guides in the resident ' s closet in residents ' rooms. She stated "I just know the residents". She indicated all dependents residents (who required assistance from the staff) are left in bed until after breakfast. She stated "I make rounds with 11-7 shift to look at the residents. " NA #13 indicated some residents get bed baths others get showers on their shower days. We use the shower bed or shower chair, cover the resident with shower cape and bring to and from shower room. During showers, toes and feet especially in between toes are cleaned, dried and lotion applied. During their care you (NA) look at their finger and toe nails and clean them or cut them nails unless they are diabetic and then we tell the nurse and she does get them cut. " During an observation on 11/4/11 at 10:20 AM Resident # 2 was receiving AM care via a shower. NA # 2 and NA # 3 were transferring the resident to the shower chair and an observations of her toe nails were noted to be jagged and irregular in length. Her teeth were noted to have food debris	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ____ B. WING ____	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 29 and brown color to her teeth. NA # 2 stated " she (Resident # 2) will get her hair washed today while she is in the shower, when we shower them we do all the care needed including their hair and nails. " During an interview with NA # 2 on 11/4/11 at 2:40 PM stated " I thought she cut resident #2 ' s nails this morning. " She also indicated resident #2 needed her face cleaned after she eats. During an interview and observation with the Administrator on 11/4/11 at 1:50 PM noted the resident sitting in the TV area on the 300 hall with dried food matter on her left lip, cheek and chin. The administrator also looked at her toe nails and stated they needed to be cut and filed; She stated " my expectation would be the NA would have trimmed her toe nails this morning during her shower. " The Administrator also indicated her expectations were her (Resident # 2) mouth and face would be cleaned after she finished eating since she was unable to do this for herself.	F 312		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. **Corrective Action for Resident Affected** The food from the Activity Room was discarded immediately. The resident refrigerators were all deep cleaned and de-frosted on November 3, 2011. The refrigerator in the activity room is for staff use only.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL NURSING AND REHABILITATION CENTER	3000 HOLSTON LANE RALEIGH, NC 27610

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F 371	Continued From page 30 by: Based on observations and staff interviews, the facility failed to keep the inside of the nourishment refrigerators and freezer portions sanitary and free from spills. The facility failed to discard a meal plate that was served on 10/24/11. This was evident in 1 of 2 resident nourishment refrigerator (100 Unit) and the refrigerator located in the activity department. Findings included: Observations on 11/3/11 at 2:20 PM of the nourishment refrigerator located on Unit 100 revealed an accumulation of ice in the freezer measuring approximately 3 inches in thickness. The ice had built up on the back portion of the refrigerator section. Two (2) printed receipts and an empty container of _____ (brand name) chicken were stuck in the ice and could not be removed when pulled. The MDS# 2 (Minimum Data Set coordinator) witnessed the condition of the freezer and refrigerator. The MDS#2 indicated that the refrigerator was used for resident use. Interview at 2:35 PM on 11/3/11 with (Housekeeper) HK#1 revealed she was responsible for cleaning the refrigerator. HK#1indicated that had not cleaned the refrigerator unit and was not sure of the last time it was cleaned. The director of housekeeping joined the discussion who indicated that housekeepers rotate assignments on the units and he could not tell the last time the refrigerators were cleaned. The director indicated that HK are responsible for checking the refrigerator each day for the correct temperature and for cleanliness. The director of housekeeping indicated he was hired 2 weeks ago (from the survey).	F 371	**Corrective Action for Resident Potentially Affected** All resident refrigerators in the entire facility were examined and cleaned by November 3, 2011. **Systemic Changes** An in-service was conducted on November 29th by Housekeeping Supervisor. Any housekeeper who did not receive in-service training will not be allowed to work until training has been completed by December 1st 2011. The in-service topics included: cleaning/monitoring resident refrigerators daily and ensuring spills are cleaned up promptly as well monitoring for frost build-up in the freezer. **Quality Assurance** The Housekeeping Supervisor will monitor this issue using the "Survey QA Tool for Environmental/Housekeeping Issues". The monitoring will include verifying that resident refrigerators are kept clean. See attached monitoring tool. This will be done daily Monday thru Friday for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The date of completion is December 1st 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ____ B. WING ____	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL NURSING AND REHABILITATION CENTER	3000 HOLSTON LANE RALEIGH, NC 27610

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F 371	Continued From page 31 Observations with the director of housekeeping on 11/3/11 at 3 PM of the nourishment/ patient use refrigerator located in the Activity room revealed multiple dried red and yellow colored spills in the freezer. Plastic bags were stuck to the freezer shelf. Pieces of a receipt were stuck to the floor of the freezer. The refrigerator portion had dried spills and the facility ' s food plate inserted in a base with a covered dome lid. There was no date on the lid but bear the name of resident. Observation of the food plate revealed food items of a green vegetable, a roll/biscuit which had a black colored substance on the side which resembled mold and another food item that was unidentifiable. This unidentifiable food item was observed to have a black covering resembling mold that measured 4 inches in length and 3 inches in width. There was an offensive odor when the dome was lifted. Interview on 11/3/11 at 5:52 PM with the dietary manager revealed he identified the above food items as collard greens, biscuit and chicken and pastry that were served from the menu. Review of the menu revealed these items were served last on 10/24/11. Interview on 11/4/11 at 3:11 PM with the administrator and director of nurses was held. The administrator indicated her expectations were to have clean refrigerators for use.	F 371		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345202	MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	DATE SURVEY COMPLETE: 11/4/2011
NAME OF PROVIDER OR SUPPLIER **CAPITAL NURSING AND REHABILITATION CENT**	STREET ADDRESS, CITY, STATE, ZIP CODE **3000 HOLSTON LANE RALEIGH, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345202	MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	DATE SURVEY COMPLETE: 11/4/2011
NAME OF PROVIDER OR SUPPLIER: **CAPITAL NURSING AND REHABILITATION CENT]**	STREET ADDRESS, CITY, STATE, ZIP CODE: **3000 HOLSTON LANE RALEIGH, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1 benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide at least a two days notice of Medicare Non-Coverage ending for 1of 3 notices reviewed. (Residents #14) Findings included: Record review revealed Resident#14 was still residing in the facility. Interview on 11/4/11 at 2:33 PM with the Business office manager (BOM) revealed the facility does not have a written policy and procedure for providing notification of Medicare provider non-coverage. The business office manager indicated practice in the facility included the MDS coordinator (MDS) would notify her via e-mail when a resident coverage for Medicare would be ending. Continued interview with the business office manager revealed Resident#14 ' s Medicare coverage was July 12, 2011 through August 23, 2011 for skilled nursing care. MDS#1 and MDS#2 joined the interview. The business office manager and MDS #1 indicated that the process of communicating when coverage of Medicare starts and ends was discussed every day in a stand-up meeting and weekly meetings. MDS#1 indicated she usually e-mailed the business office manager to inform them of the end of coverage date. The BOM indicated that she was not sure if she was notified or that the notice of non coverage was provided to Resident#14 or resident ' s responsible party. MDS#1 and MDS#2 indicated they would search for the e-mail regarding non coverage notification. Follow-up interview on 11/4/11 at 6:40 p.m. with MDS#1 and MDS#2 was held. MDS#1 revealed Resident #14 was covered under Medicare benefits for skilled nursing associated with antibiotic therapy from August 10, 2011 to August 23, 2011. A an immediate follow-up interview the BOM indicated that she had not provided notice to Resident#14 or Resident#14 ' s responsible party.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346202	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/22/2011

NAME OF PROVIDER OR SUPPLIER: CAPITAL NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3000 HOLSTON LANE, RALEIGH, NC 27610

(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
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19 3.6.3.6 are permitted. 19 3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: A. Based on observation on 11/22/2011 the privacy curtains when pulled prevented the doors from closing and latching in rooms 301, 311, 106, and 401. 42 CFR 483.70 (a)	K 018	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. K018 The doors in rooms 301, 311, 106 and 401 are now able to close completely. The tracts were fixed to ensure the doors to close properly. All doors were checked in the facility to ensure they could close properly. this will be done by January 6th 2012 The curtain tracts will be checked daily with the room inspection of the room to ensure all the curtains move freely and the door closes properly. The Maintenance Director will perform a QA of at least 2 rooms on each hall (total of 8 weekly) x 4 weeks, then monthly x 4 weeks to ensure compliance. The results of the rounds will be brought the weekly Quality of Life Meetings (QA) to ensure compliance times 4 weeks. The QOL Committee will make a decision to continue the weekly rounds after 4 weeks. The completion date for the items above is January 6th 2012	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from ··	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE (X6) DATE [illegible]

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 029	Continued From page 1 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by A. Based on observation on 11/22/2011 the door to the soiled linen room failed to close and latch (room also contains three (3) washing machines. 42 CFR 483.70 (a)	K 029	K029 The door at the soiled linen room was altered with a continuous hinge to ensure proper closing at all times this will be completed by January 6th 2012 All doors in the facility will be Checked by the Maintenance Director to ensure proper closure. This will be done by January 6th 2012 The Maintenance Director will perform a weekly QA to do random Checks of the facility doors. The weekly Audit will be done weekly x 4 weeks, then monthly x 4 weeks The results of the rounds will be brought the weekly Quality of Life Meetings (QA) to ensure compliance times 4 weeks. The QOL Committee will make a decision to continue the weekly rounds after 4 weeks. The completion date for the items above is January 6th 2012	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 11/22/2011 the door to the Administrator's office and one other office required more than one (1) motion of the hand to exit the room. 42 CFR 483.70 (a)	K 038	K038 The lock in the Administrator and DON office was changed to ensure only 1 motion to exit the room This is to be completed by January 6th 2012 All doors in the facility will be Checked by the Maintenance Director to ensure only one motion to exit the room. This will be done by January 6th 2012	

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