

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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	
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/4/25 through 8/7/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D24B7-H1.		E0000				
F0000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 8/4/25 through 8/7/25. Event ID # 1D24B7-H1. The following intake was investigated: 2564144. 1 of the 1 complaint allegations did not result in deficiency.		F0000				
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,		F0605				

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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	
F0605 SS = D	<p>Continued from page 1 involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. </p> <p>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <p>(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.</p> <p>§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>(1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure</p>		F0605				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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	
F0605 SS = D	<p>Continued from page 2 that--</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, and staff and Consultant Pharmacist interviews, the facility failed to ensure a physician order for an as needed (PRN) psychotropic medication was time limited in duration for 1 of 5 residents reviewed for unnecessary medications (Resident #90).</p> <p>The findings included:</p> <p>Resident #90 was admitted to the facility on 6/24/24 with diagnoses which included anxiety disorder.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 7/10/25 revealed Resident #90 was cognitively intact and was coded for use of an antianxiety medication.</p>		F0605				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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
F0605 SS = D	<p>Continued from page 3</p> <p>Resident #90 had an active physician order dated 7/19/25 for lorazepam oral tablet 0.5 milligram (mg). Give 0.5 mg by mouth two times a day for anxiety; give after breakfast AND give 0.5 mg tablet by mouth every 12 hours as needed (PRN) for anxiety. The order did not have a stop date.</p> <p>The care plan last reviewed on 7/28/25 revealed Resident #90 used anti-anxiety medication and was at risk for adverse side effects with an intervention for the Consulting Pharmacist to review the psychotropic medications quarterly and PRN for possible changes or reductions.</p> <p>The Medication Administration Record (MAR) for July 2025 revealed Resident #90 received the PRN lorazepam on 7/19/25 at 5:04 pm and no further PRN doses were administered to Resident #90 for the remainder of the month.</p> <p>The MAR for August 2025 revealed Resident #90 was not administered the PRN lorazepam.</p> <p>The Consultant Pharmacist's Medication Regimen Review report dated 8/04/25 revealed the facility received notification that Resident #90 was prescribed lorazepam 0.5 mg every 12 hours PRN for anxiety. The Consultant Pharmacist further noted that the order must have a stop date for re-assessment and requested the facility to clarify the order with a specific time/re-assessment date or discontinue.</p> <p>A telephone interview was conducted with the Consultant Pharmacist on 8/06/25 at 4:49 pm who revealed Resident #90's monthly medication review was conducted on 8/04/25. The Consultant Pharmacist reported she sent an email to the Director of Nursing (DON) when the review was completed and requested a stop date for Resident #90's PRN lorazepam but she was not sure if the DON had completed the request at this time.</p> <p>The DON was interviewed on 8/07/25 at 11:30 am and revealed medication orders were reviewed in the daily clinical meeting with the order listing report to review what medications were ordered and the stop dates would have been added during the meeting if missing. The DON stated the stop date was just missed for Resident #90's PRN lorazepam.</p> <p>An interview was conducted with the Administrator on 8/07/25 at 11:59 am who revealed medication orders were normally discussed in the morning clinical meeting. The Administrator stated Resident #90's PRN lorazepam order</p>			F0605			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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	
F0605 SS = D	Continued from page 4 did not flag for not having a stop date by the way the order was written so it was missed.	F0605					
F0686 SS = D	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer</p> <p>CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity</p> <p>§483.25(b)(1) Pressure ulcers.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and resident and staff interviews, the facility failed to consistently complete a thorough weekly pressure ulcer assessment that included the type of injury (pressure versus non pressure), pressure ulcer stage, a description of the pressure ulcer characteristics, presence of pain, and description of dressing or treatment for 1 of 2 residents observed for pressure ulcers (Resident #3).</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on 12/17/20 with diagnoses which included functional quadriplegia and cerebral palsy.</p> <p>The Weekly Pressure Ulcer Review assessment dated 5/05/25, completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed pressure ulcer to the sacrum, not staged, with measurements of 1 centimeter (cm) x 1 cm x 0.1 cm (length x width x depth). The wound bed was noted to have 100% granulation (new tissue that forms on the wound during healing process) tissue, with no odor.</p> <p>Resident #3 had a physician order in place dated 5/08/25 to apply zinc to the right buttock every day and evening shift for wound care.</p>	F0686					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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	
F0686 SS = D	<p>Continued from page 5</p> <p>The Treatment Administration Record (TAR) May 2025 through August 2025 was reviewed and revealed Resident #3's treatment order to apply zinc to the right buttock every day and evening shift was completed as ordered.</p> <p>Resident #3 had a care plan last reviewed on 5/11/25 for risk for pressure ulcer development, current pressure ulcer to right buttock and risk for development of additional pressure ulcers. The care plan had interventions which included administer treatments as ordered and monitor for effectiveness, low air loss mattress, and to consult wound physician as needed and/or ordered.</p> <p>The Weekly Pressure Ulcer Review assessment dated 5/12/25, completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed pressure ulcer to the sacrum; the wound was not staged. The wound measurements were 1 cm x 1 cm x 0.1 cm. The wound bed was noted to have 100% granulation tissue, light exudate (fluid that leaks out of blood vessels), with redness noted and no odor. The assessment also noted that the area was macerated (skin that softens and breaks down due to prolonged exposure to moisture) with bright red excoriation (break in the skin's surface) noted.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 5/13/25 revealed Resident #3 was cognitively intact, was dependent of staff for activities of daily living (ADLs), and had an indwelling urinary catheter and colostomy related to bowel and bladder management. Resident #3 was coded for a pressure ulcer Stage 3 which was noted as present on admission or readmission. Resident # 3 was coded for pressure reducing device for the bed, pressure reducing device for the chair, and pressure ulcer care.</p> <p>The Weekly Pressure Ulcer Review assessment dated 5/28/25, completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed pressure ulcer to the left and right buttock, Stage 3 with measurements of 1 cm x 1 cm x 0.1 cm. The wound bed was noted to have 100% granulation tissue, with surrounding tissue noted for redness. The assessment further noted the area was macerated with bright red excoriation noted.</p> <p>The Weekly Pressure Ulcer Review assessment dated 6/02/25, completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed wound to the sacrum, pressure. The stage was noted as N/A (non-applicable), with measurements of 1.5 cm x 1.8 cm x 0.2 cm. The pressure ulcer was noted to have 50%</p>		F0686				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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	
F0686 SS = D	<p>Continued from page 6 granulation tissue and redness noted. Intact area of pressure due to damage of underlying soft tissue from moisture and pressure. The wound was noted as not painful, but firm as compared to adjacent tissue.</p> <p>The Weekly Pressure Ulcer Review assessment dated 6/09/25, completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed wound to the right buttock, the stage was noted as pressure/denuded (skin injury where the outermost layer of skin is lost) with measurements of 1.5 cm x 1.8 cm x 0.2 cm. The wound bed was noted to have 100% granulation tissue. Intact area of pressure due to damage of underlying soft tissue from moisture and pressure. The pressure ulcer was reported as not painful, but firm as compared to adjacent tissue with a treatment of zinc daily post every brief change and bath for all shifts.</p> <p>The Weekly Pressure Ulcer Review assessment dated 6/16/25, completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed pressure ulcer to the right buttock with measurements of 1.5 cm x 1.8 cm x 0.2 cm, the Stage was noted as N/A pressure/denuded. Intact area of pressure due to damage of underlying soft tissue from moisture and pressure. The pressure ulcer was reported as not painful, but firm as compared to adjacent tissue. The wound bed was noted to have 100% granulation tissue with a treatment of zinc daily post every brief change and bath for all shifts.</p> <p>The Weekly Pressure Ulcer Review assessment dated 6/23/25, completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed pressure ulcer to the right buttock with measurements of 1.5 cm x 1.8 cm x 0.1 cm. The Stage was noted as N/A pressure/denuded. Intact area of pressure due to damage of underlying soft tissue from moisture and pressure. The pressure ulcer was reported as not painful, but firm as compared to adjacent tissue with a treatment of zinc daily post every brief change and bath for all shifts.</p> <p>The Weekly Wound Non-Pressure Review assessment dated 6/30/25, completed by the Wound Treatment Nurse, revealed Resident #3 had a denuded area to right buttock. No further information was noted.</p> <p>The Weekly Wound Non-Pressure Review assessment dated 7/07/25, completed by the Wound Treatment Nurse, revealed Resident #3 had a denuded area to right buttock. No further information was noted.</p> <p>The Weekly Wound Non-Pressure Review assessment dated 7/14/25, completed by the Wound Treatment Nurse, revealed Resident #3 had a wound to the left and right</p>	F0686					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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
F0686 SS = D	<p>Continued from page 7 buttock. No further information was noted related to the wound.</p> <p>The Weekly Wound Non-Pressure Review assessment dated 7/21/25, completed by the Wound Treatment Nurse, revealed Resident #3 had a wound to the left and right buttock. No further information was noted.</p> <p>The Weekly Wound Non-Pressure Review assessment dated 7/28/25, completed by the Wound Treatment Nurse, revealed Resident #3 had a wound to the left and right buttocks which measured 2.5 cm x 3 cm with no further information noted.</p> <p>The Weekly Wound Non-Pressure Review assessment dated 8/04/25, completed by the Wound Treatment Nurse, revealed Resident #3 had a wound to the right buttock which measured 2.5 cm x 3 cm with no further information noted related to the wound.</p> <p>The Weekly Wound Non-Pressure Review assessment dated 8/06/25, completed by the Wound Treatment Nurse, revealed Resident #3 had a wound to the left buttock with no further information noted.</p> <p>An observation of Resident #3's right buttock pressure ulcer was conducted on 8/07/25 at 10:06 am. Resident #3 was noted to have one oblong shaped pressure ulcer to the right buttock which measured 3 cm x 2 cm with no depth noted. The wound was noted to have no drainage or odor present. The wound bed was red in color without slough (layer of dead tissue that impedes healing) or eschar (a dead layer of tissue that can prevent healing and increase risk of infection) present. Resident #3 had no other pressure ulcers at the time of the observation.</p> <p>An interview and observation was conducted with Resident #3 on 8/04/25 at 10:24 am who was observed sitting upright in bed watching television with an air mattress in place. Resident #3 revealed they had a pressure ulcer to her right backside, denied any pain from the pressure ulcer, and reported that the facility completed the treatment every day. Resident #3 stated there were no concerns regarding the care provided by the facility.</p> <p>Interviews were conducted with the Wound Treatment Nurse on 8/05/25 at 3:13 pm and 8/07/25 at 10:35 am. The Wound Treatment Nurse stated he had been responsible for the facility wound program for just over 2 years. He stated Resident #3 had one chronic Stage 3 pressure ulcer to her right buttock and that he documented the left buttock wound in error. The Wound</p>			F0686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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	
F0686 SS = D	<p>Continued from page 8</p> <p>Treatment Nurse reported a weekly assessment was completed for pressure ulcers and was documented in the medical record. He stated he had merged Resident #3's pressure ulcer information into the non-pressure wound assessment with a surgical wound that Resident #3 had, but he stated the pressure ulcer information should have been documented in the Weekly Pressure Ulcer Review. The Wound Treatment Nurse stated he would check the measurements of the pressure ulcer if he observed "a change" when doing wound care. The Wound Treatment Nurse stated was not getting and documenting all the information about the wounds, like size and the stage. The Wound Treatment Nurse stated the MDS Nurse had just recently educated him about the importance of the documentation of pressure ulcers.</p> <p>An interview was conducted on 8/07/25 at 11:38 am with the Director of Nursing (DON) who revealed when a resident had a pressure ulcer, a weekly pressure ulcer review assessment was to be completed. She stated the information that was required to be documented included description, staging, measurements, location, and any other pertinent information about the pressure ulcer. The DON stated the facility had a weekly meeting to discuss facility pressure ulcers and would look at the assessments to see if they were completed but she stated she did not open each assessment and make sure all the required information was documented. The DON was unable to say why the Wound Treatment Nurse did not complete a thorough wound assessment and document the required information regarding Resident #3's Stage 3 pressure ulcer.</p> <p>The Administrator and Corporate Representative were interviewed on 8/07/25 at 12:04 pm. The Corporate Clinical Specialist stated the Weekly Pressure Ulcer Review should have been reviewed at the weekly meeting to ensure that the Wound Treatment Nurse documented accurate and complete information regarding Resident #3's pressure ulcer.</p>		F0686				
F0757 SS = D	<p>Drug Regimen is Free from Unnecessary Drugs</p> <p>CFR(s): 483.45(d)(1)-(6)</p> <p>§483.45(d) Unnecessary Drugs-General.</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p>		F0757				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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	
F0757 SS = D	<p>Continued from page 9</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, and staff and Consultant Pharmacist interviews, the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving an antipsychotic medication, which is used for medication monitoring of side effects of antipsychotic medications for 1 of 5 residents reviewed for unnecessary medications (Resident #82).</p> <p>The findings included:</p> <p>Resident #82 was admitted to the facility on 8/21/24 with diagnoses which included vascular dementia without behavioral disturbances.</p> <p>The Mental Health and Antipsychotic Review (which included the AIMS assessment) completed on 12/26/24 revealed Resident #82 had no negative findings related to the use of antipsychotic medication and was categorized as low risk for movement disorders.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 6/10/25 revealed Resident #82 had severe cognitive impairment and was coded for the use of antipsychotic medication.</p> <p>The care plan last reviewed on 6/27/25 revealed Resident #82 received antipsychotic medications with risk for adverse side effects with interventions which included performing an AIMS every 6 months.</p> <p>A current physician order dated 8/05/25 quetiapine</p>	F0757					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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	
F0757 SS = D	<p>Continued from page 10 fumarate 50 mg tablet; give 1 tablet by mouth every morning and at bedtime for dementia with psychosis. Further review of the physician orders indicated the resident was restarted on quetiapine fumarate on 5/09/25 after discontinuation of the medication in January 2025.</p> <p>A review of Resident #82's medical record on 8/05/25 revealed the facility had not completed an AIMS for the antipsychotic medication when the order was initiated on 5/09/25 and had not completed an AIMS to date.</p> <p>Review of the Consultant Pharmacist's Medication Regimen Review report dated 8/05/25 revealed the facility was notified that a Mental Health and Antipsychotic Review (formally the AIMS assessment) has been completed every 6 months since the patient was on the following therapy: quetiapine.</p> <p>A telephone interview was conducted on 8/06/25 at 4:49 pm with the Consultant Pharmacist who revealed that when a resident was prescribed an antipsychotic medication an AIMS assessment was required upon starting the medication for a baseline assessment and every 6 months thereafter for monitoring. The Consultant Pharmacist stated the facility was responsible for completing the AIMS assessment, but she stated she would notify the facility from the medication regimen reviews when she identified that the AIMS assessment was not completed. The Consultant Pharmacist stated that she did review Resident #82's medical record during the monthly pharmacy review and she did notify the Director of Nursing (DON) and Administrator on 8/05/25 to make sure an AIMS was completed for Resident #82's quetiapine.</p> <p>An interview was conducted on 8/07/25 at 11:35 am with the DON who revealed the previous AIMS assessment had been changed to the new Mental Health and Antipsychotic Review and she believed that due to that change, the AIMS assessment did not trigger to be completed for Resident #82's quetiapine order and it was missed.</p> <p>During an interview with the Administrator of 8/07/25 at 12:02 pm he revealed that due to the new Mental Health and Antipsychotic Review being implemented recently it may have caused Resident #82's AIMS assessment not to be triggered when it was due.</p>	F0757					
F0842 SS = B	<p>Resident Records - Identifiable Information</p> <p>CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information.</p>	F0842					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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
F0842 SS = B	<p>Continued from page 11</p> <p>(i) A facility may not release information that is resident-identifiable to the public.</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(h) Medical records.</p> <p>§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p>			F0842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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
F0842 SS = B	<p>Continued from page 12</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, observation, and staff interviews, the facility failed to accurately transcribe wound treatment orders for 1 of 2 residents reviewed for wound care (Resident #1).</p> <p>Findings included:</p> <p>Resident #1 was admitted on 1/24/17 with diagnoses which included hemiplegia and hemiparesis (weakness and paralysis) following cerebral infarction (stroke) and Type 2 Diabetes Mellitus.</p> <p>Resident #1's care plans included: I currently have a pressure ulcer to my sacrum and am at risk for development of additional pressure ulcers due to decreased ability to re-position and</p> <p>bowel/bladder incontinence, and immobility. This was</p>			F0842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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
F0842 SS = B	<p>Continued from page 13 initiated on 4/2/25 and most recently revised on 4/12/25.</p> <p>The Wound Physician assessed Resident #1 weekly; the dates included 5/6/25, 5/13/25, 5/20/25, 5/29/25, 6/5/25, 6/12/25, 6/19/25, 6/26/25, 7/3/25, 7/10/25, 7/17/25, 7/24/25, and 7/31/25. The Dressing Treatment Plan did not change and included: Primary Dressing alginate calcium with silver apply once daily and as needed. The Secondary Dressing included an island dressing with borders to cover the Primary Dressing.</p> <p>Resident #1's May 2025 Treatment Administration Record (TAR) noted orders:</p> <p>-Apply silver alginate, cover with dry dressing, every day shift. This was signed as administered 5/1/25 through 5/7/25 and 5/8/25 through 5/20/25. Noted as discontinued 5/21/25.</p> <p>-Apply calcium alginate, cover with dry dressing, every day shift. This was signed as administered 5/22/25 through 5/24/25 and 5/26/25 through 5/31/25.</p> <p>Resident #1's June 2025 TAR noted order:</p> <p>-Apply calcium alginate, cover with dry dressing, every day shift. This was noted as completed daily except for 6/9/25, 6/12/25 and 6/19/25.</p> <p>Resident #1's most recent quarterly Minimum Data Set assessment dated 7/16/25 indicated she had moderate cognitive impairment, dependent for all activities of daily living, had one stage 3 pressure ulcer, and had received pressure ulcer care.</p> <p>Resident #1's July 2025 Treatment Administration Record noted orders:</p> <p>-Apply calcium alginate, cover with dry dressing, every day shift. This was documented as administered every day.</p> <p>Resident #1's August 2025 Treatment Administration Record noted orders:</p> <p>-Apply calcium alginate, cover with dry dressing. every day shift, every Monday, Wednesday and Friday. One treatment was documented as completed on Monday 8/4/25.</p>			F0842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE , RALEIGH, North Carolina, 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	
F0842 SS = B	<p>Continued from page 14</p> <p>A wound care observation and interview was conducted on 8/5/25 at 9:10 AM with the Treatment Nurse. The sacral wound was cleaned with wound cleanser and gauze pads. A piece of alginate calcium with silver was applied to the wound and was covered with an island dressing. The wound appeared as a light pink area on the sacrum, approximately 2 centimeters (cm) long and 1 cm wide with no discernable depth. The Treatment Nurse explained Resident #1's wound had healed and then reopened. He stated she has been seen by the Wound Physician weekly since April when the wound reopened and was now nearly healed.</p> <p>An interview with the Treatment Nurse was conducted on 8/6/25 at 2:37 PM. When asked about the discrepancy in the treatment orders, the nurse explained it had been an oversight on his part to not transcribe the treatment orders correctly. He further explained that although he had transcribed the order incorrectly, the correct treatment had been provided to Resident #1.</p> <p>An interview with the Wound Physician was conducted on 8/7/25 at 12:30 PM via phone. He stated the person who had transcribed the order may have forgotten to add the silver detail. He stated the order should have been transcribed correctly but if the regular alginate calcium without silver had been used, it would not have been detrimental to the wound healing for Resident #1. He stated the silver added antimicrobial protection. He explained Resident #1 had multiple comorbidities and her sacral pressure ulcer was nearly healed.</p> <p>An interview with the Director of Nursing (DON) was conducted on 8/7/25 at 12:49 PM. She stated she would expect wound care orders to be transcribed correctly.</p> <p>During an interview with the Administrator on 8/7/25 at 1:36 PM he stated physician orders should be transcribed correctly.</p>		F0842				