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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345202  

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING _____________________________  
B. WING _____________________________  

(X3) DATE SURVEY COMPLETED  08/18/2020  

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-REFERRED TO THE APPROPRIATE DEFICIENCY)  

(X5) COMPLETION DATE  

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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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An unannounced COVID-19 Focused Survey was conducted on 8/18/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# FQUK11.

An unannounced COVID-19 Focused Infection Control Survey was conducted on 8/18/2020. The facility was found in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# FQUK11.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  

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.

Electronically Signed