TXX         AEGULATORY OR LISC DENTIFYING INFORMATION)         TXX         CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         DATE           F 000         INITIAL COMMENTS         F 000         F 000         A complaint investigation was conducted from 8/31/21 to 9/1/21. Event ID Q6SQ11.         F 000         F 000         F 000         Second		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
NUMBE OF PROVIDER OF SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           CAPITAL NURSING AND REHABILITATION CENTER         SIMMARY STATEMENT OF DEPICIENCES         SIMMARY STATEMENT OF DEPICIENCES         PROVIDER SPLAN OF CORRECTION         0000           IVALUE (CAN DEPICIENCES)         SUMMARY STATEMENT OF DEPICIENCES         PROVIDER SPLAN OF CORRECTION         0000           IVALUE (CAN DEPICIENCES)         FOOD         PREVIDENCE TO THE APPROPRIATE         0000           IVALUE (CAN DEPICIENCES)         FOOD         PREVIDENCE TO THE APPROPRIATE         0000           FOOD         INITIAL COMMENTS         FOOD         PROVIDER SPLAN OF CORRECTION         00000           A complaint investigation was conducted from 8/31/21 to 91/12/1 to 91/12	345202		B. WING	B. WING			
CAPITAL NURSING AND REHABILITATION CENTER         RALEIGH, NC 27510           (Wa) D PRETRY TAS         SUMMARY STATEMENT OF DEFICIENCIES (EACH BECINEWOY MIST BE PRECISED BY FULL RECOULDENT ON LISC DEMTIFYING INFORMATION)         ID PRETRY TAS         PROVICERS PLAN OF CORRECTION (EACH DEPRICIPATION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY         (D) PROVICERS PLAN OF CORRECTION (EACH DEPRICIPATION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY         (D) PRETRY (EACH DEPRICIPATION SHOULD BE CROSS-REFERENCE)         (D) PRETRY (EACH DEPRICIPATION SHOULD BE PRESRY (EACH DEPRICIPATION SHOU	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
My ID Trac         SUMMARY STATEMENT OF DEFICIENCY (EXC) IDENCES MART BE PERCEDEND YOUL BESULTION OF LOCATION ON LOCATION (EXC) IDENCES MART BE PERCEDEND YOUL (EXC) IDENCES MART BE PERCEDEND YOUL (EXC) IDENCES MART BE PERCEDEND YOUL (EXC) IDENCES MART PERCENDENT YOUR (EXC) IDENCES MART PERCENDENT (EXC) IDENCES MART PERCENDENT YOUR (EXC) IDENCES MART PERCENDENT (EXC) IDENCES MART PE	CAPITAL I	NURSING AND REHABI	LITATION CENTER				
Prefix Txo     IEACH DEFICIENCY MORTER PRECEDED BY FULL     PREFX     IEACH CORRECTIVE ACTION ADDUDUE     COMPARING       F 000     INITIAL COMMENTS     F 000       A complaint investigation was conducted from 8/31/21 to 91/121. Event ID Q65011.     F 000       Y of the 7 complaint allegations were not substantiated.     F 686       F 686     Treatment/Sves to Prevent/Heal Pressure Ulcer     F 686       S S=D     CFR(s): 483.25(b)(1)(0)(0)       S 483.25(b)(1) Pressure ulcers.     Based on the comprehensive assessment of a resident, the facility must ensure that-       (i) A resident with pressure ulcers in the event interserve to a substantiated.     F 686       The REQUIREMENT Is not metal as evidenced by:     Based on observation, record review and staff interview, facility staff failed to notify the treatment nurse to a sees and apply a dressing to a stage 3 pressure ulcer (Resident #67).       The findings included:     The findings included:       Resident #67 Was admitted to the facility on 77/29/21 and had a diagnosis of dementia and sepsis.     The Admission discond the resident had       The Admission Minimum Data Set (MDS)     Assessment dated 2/5/21 noted the resident had     Beginning on 9/10/2021 the Director of							
A complaint investigation was conducted from 8/31/21 to 9/1/21. Event ID Q65Q11. 7 of the 7 complaint allegations were not substantiated.F 686F 686Treatment/Svos to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(0)(ii)F 686§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers ulcers and does not develop pressure ulcers rom developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to notify the treatment nurse to assess and apply a dressing to a stage 3 pressure ulcer (Resident #67).For the affected resident, Resident #67, the resident's wound dressing was only attached on one side, and was wisibly soiled with serosanguineous drainage. NA #2 re-covered the wound, with the soiled dressing, instead of getting assistance from the wound, with the soiled dressing, instead of getting assistance for the wound, with the soiled dressing, instead of getting assistance for the solenge. NA #2 re-covered the wound, with the soiled dressing, instead of getting assistance for the wound, with the soiled dressing. The findings included: The Admission Minimum Data Set (MDS) Assessment dated 8/5/21 noted the resident hadFor the affected by the alleged deficient practice. Beginning on 9/10/2021 the Director of	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIATE				OULD BE	COMPLETION
8/31/21 to 9/1/21. Event ID Q65Q11.       7         7 of the 7 complaint allegations were not substantiated.       9/14/21         F 686       Treatment/Sves to Prevent/Heal Pressure Ulcer       F 686         SS=D       CFR(s): 483.25(b)(1)(i)(ii)         §483.25(b)(1) Pressure ulcers.       Based on the comprehensive assessment of a resident, the facility must ensure that:       (i) A resident were/ves care, consistent with professional standards of practice, to prevent ucers medices and does not develop pressure ulcers medices from developing.       For the affected resident, Resident #67, the resident feedback of practice, to promote healing, prevent infection and prevent new ulcers from developing.         This REQUIREMENT is not met as evidenced by:       Based on observation, record review and staff interview, facility staff failed to notify the treatment nurse to assess and apply a dressing to a stage 3 pressure ulcer (Resident #67).         The findings included:       Resident #67 was admitted to the facility on 7/29/21 and had a diagnosis of dementia and sepsis.         The Admission Minimum Data Set (MDS)       Assessment dated 8/5/21 noted the resident had	F 000	INITIAL COMMENTS	3	F 0	00		
SS=D       CFR(s): 483.25(b) (1)(i)(ii)         §483.25(b) Skin Integrity       §483.25(b)(1) Pressure ulcers.         Based on the comprehensive assessment of a resident, the facility must ensure that-       (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers and does not develop pressure ulcers neclessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.         This REQUIREMENT is not met as evidenced by:       Based on observation, record review and staff interview, facility staff failed to notify the treatment nurse to assess and apply a dressing to a stage 3 pressure ulcer for 1 of 1 resident observed with a pressure ulcer (Resident #67).         The findings included:       Resident #67 was admitted to the facility on 7/29/21 and had a diagnosis of dementia and sepsis.         The Admission Minimum Data Set (MDS)       Assessment dated 8/5/21 noted the resident had		8/31/21 to 9/1/21. Ev 7 of the 7 complaint	ent ID Q65Q11.				
§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (ii) A resident with pressure ulcers consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to notify the treatment nurse to assess and apply a dressing to a stage 3 pressure ulcer (Resident #67).For the affected resident, Resident #67, the resident's wound dressing was only attached on one side, and was visibly soiled with serosanguineous drainage. NA #2 re-covered the wound, with the soiled dressing, instead of getting assistance from the nurse, and dressed the resident for discharge.The findings included: Resident #67 was admitted to the facility on 7/29/21 and had a diagnosis of dementia and sepsis.1. Corrective action for residents with the potential to be affected by the alleged deficient practice.The Admission Minimum Data Set (MDS) Assessment dated 8/5/21 noted the resident hadBeginning on 9/10/2021 the Director of				F 6	36		9/14/21
Assessment dated 8/5/21 noted the resident had Beginning on 9/10/2021 the Director of		§483.25(b)(1) Press Based on the compre- resident, the facility r (i) A resident receive professional standar pressure ulcers and ulcers unless the ind demonstrates that th (ii) A resident with pr necessary treatment with professional sta promote healing, pre- new ulcers from deve This REQUIREMEN' by: Based on observation interview, facility stat nurse to assess and pressure ulcer for 1 of pressure ulcer (Resident The findings included Resident #67 was ad 7/29/21 and had a di sepsis.	ure ulcers. ehensive assessment of a must ensure that- s care, consistent with ds of practice, to prevent does not develop pressure ividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to event infection and prevent eloping. T is not met as evidenced on, record review and staff if failed to notify the treatment apply a dressing to a stage 3 of 1 resident observed with a dent #67). d: dmitted to the facility on agnosis of dementia and		<ul> <li>the resident's wound dressing waa attached on one side, and was vissoiled with serosanguineous drait NA #2 re-covered the wound, with soiled dressing, instead of getting assistance from the nurse, and d the resident for discharge.</li> <li>1. Corrective action for residents potential to be affected by the allocation of the set of</li></ul>	as only sibly nage. h the g ressed with the	
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE					Beginning on 9/10/2021 the Direc	ctor of	
	ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE

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.

		MEDICAID SERVICES			<u>_</u>	NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	OATE SURVEY
						С
		345202	B. WING			09/01/2021
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	NURSING AND REHABI			3000 HOLSTON LANE		
				RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 686	Continued From pag	e 1	F 68	36		
	severe cognitive imp		1.00	Nurses, and staff nurses audite	lle he	
		for bathing, personal		residents with pressure ulcer d		
		g and total assistance for		ensure there were no new con	-	
		oted the resident was		identified with leaving dressing		
		t of bowel and bladder and		when they are soiled or not atta	•	
		pressure ulcer with slough		properly. This was accomplishe		
	or eschar that was pr	resent on admission to the		looking at dressings for all five	residents	
		to a yellow/white material in		with pressure ulcers in the facil	ity. 5/5	
	the wound bed and e	eschar is dead tissue that is		residents were found with clear		
	typically tan, brown c	or black and may be crusty.		dressings, and the dressings w		
				appropriately attached. This pr	ocess was	
		care plan dated 8/4/21		completed by 9/10/2021.		
		ad an unstageable pressure				
		nd was at risk for additional		2. Measures /Systemic change		
	•	to decreased ability to		prevent reoccurrence of allege	a deficient	
	reposition and incont			practice:		
	treatment nurse.	report a loose dressing to the		On 9/8/2021, the Director of Nu	ireas and	
	ireaiment nuise.			her designees began an in-ser		
	On 9/1/21 at 9·45 ΔΜ	1, Nursing Assistant (NA) #2		education to all full time, part ti		
		vide a bath and peri-care for		needed nurses and CNA's. To		
		turned the resident onto her		included:	piee	
	right side to bathe her back and a dressing over the sacral area was noted to be attached with			•When a wound dressing need	s to be	
				changed, and how it should be		
		of the resident's sacrum and		This information has been integ		
	was not attached to	the rest of the wound and a		the standard orientation trainin	•	
	very large open wour	nd was observed on the		required in-service refresher co	ourses for	
		g was mostly saturated with		all staff identified above and wi		
		rainage. Serosanguineous		reviewed by the Quality Assura		
	drainage is pale red or pink in color. When the			process to verify that the change		
	bath was completed, the NA placed the			been sustained. The facility sp		
	-	e dressing back over the		in-service will be provided to al	• •	
	wound and proceede	-		nurses and CNA's who give re-		
		he resident, dressed the		care in the facility. Any nursing		
		he resident in a wheelchair.		does not receive scheduled in-		
	-	NA stated she was told to get and dressed and in her chair		training by September 13, 202		
	that "they" were goin			allowed to work until training ha		
		ted she did not know where		completed.		

Facility ID: 923006

If continuation sheet Page 2 of 7

		ID HUMAN SERVICES MEDICAID SERVICES			FC	ED: 10/04/2021 RM APPROVED NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	) MULTIPLE CONSTRUCTION BUILDING		ATE SURVEY
	345202					C 09/01/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE,	ZIP CODE	
CAPITAL I	NURSING AND REHABIL	ITATION CENTER		3000 HOLSTON LANE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEE	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 686	Continued From page	e 2	F 68	36		
	the resident was goin	g.		3. Monitoring Procedur plan of correction is eff	fective and that	
	On 9/1/21 at 9:55 AM an interview was conducted with NA #2. The NA stated usually she would tell the wound nurse about the dressing but since they were rushing her, she just put the same dressing back over the wound.			specific deficiency cite and/or in compliance w requirements. The Director of Nursing designee will utilize the	vith regulatory g, and/or her e QA tool for	
	interview the resident home today and her f	l, Nurse #1 stated in an t was being discharged family was on the way to the		Pressure Ulcer Dressir The Director of Nurses designee will monitor r pressure ulcers for 2 w	s, and/or her residents with veeks, then monthly	
	Nursing (DON) was p and was made aware	resident. The Director of present during the interview of the care observed and nurse to go in to assess ad		for 3 months, for dress when needed by obser changes during the au are not soiled or detact be completed as stated	rving dressing dit to ensure they hed. This tool will	
	On 9/1/21 at 12:50 Pl conducted with the re who stated the reside Medicaid and the fam	M an interview was esident's Responsible Party ent was not eligible for hily had located an assisted s able to meet her needs and ok the resident upon		such time that the QA determines the need to frequency of the audit determined that sustain been achieved). Identi concern are to be imm The DON will present to QA Committee. The m	Committee o change the (when it has been ned compliance has ified area of ediately addressed. the results to the nonthly QA Meeting	
	stated in an interview	M the Director of Nursing that the expectation was for urse so the nurse could go in d.		is attended by the Adm of Nursing, Minimum D Coordinator, Therapy N Information Manager, I Maintenance Director, and Consulting Pharma	Data Set Manager, Health Dietary Manager, Medical Director,	
F 690 SS=D	Bowel/Bladder Incont CFR(s): 483.25(e)(1)	tinence, Catheter, UTI -(3)	F 69	-		9/14/21
	resident who is contir admission receives s	nce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical				

Facility ID: 923006

If continuation sheet Page 3 of 7

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/04/202 <sup>,</sup> M APPROVEE D. 0938-039 <sup>,</sup>
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345202			B. WING			C /01/2021
NAME OF PI	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
<b>CAPITAL</b>	NURSING AND REHABII	ITATION CENTER		3	000 HOLSTON LANE		
UAI HAE				R	RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	Continued From page	a 3		690			
1 000	• • • • • • • • • • • • • • • • • • •	e s nes such that continence is		090			
	not possible to mainta						
	§483.25(e)(2)For a re	esident with urinary					
	incontinence, based						
	comprehensive asses ensure that-	ssment, the facility must					
	(i) A resident who ent	ters the facility without an					
	•	not catheterized unless the					
		idition demonstrates that					
	catheterization was n						
		ters the facility with an r subsequently receives one					
		val of the catheter as soon					
		e resident's clinical condition					
		theterization is necessary;					
	(iii) A resident who is	incontinent of bladder					
	receives appropriate	treatment and services to					
	• •	infections and to restore					
	continence to the ext	ent possible.					
	§483.25(e)(3) For a r	esident with fecal					
	incontinence, based						
	comprehensive asses	ssment, the facility must					
		t who is incontinent of bowel					
		treatment and services to					
		nal bowel function as					
	possible.	Lis not mot as ovidenced					
	by:	Γ is not met as evidenced					
		on, record review and staff			The statements made on this plan of		
		ailed to use the correct			correction are not an admission to and	d do	
		iding peri-care for 1 of 2			not constitute an agreement with the		
		o receive incontinence care			alleged deficiencies.		
	(Resident #67) and fa	ailed to maintain a catheter			To remain in compliance with all feder		
		ne floor for 1 of 3 residents			and state regulations the facility has ta		
		welling urinary catheter			or will take the actions set forth in this		
	(Resident #36).				plan of correction. The plan of correct	on	

Event ID: Q65Q11

Facility ID: 923006

If continuation sheet Page 4 of 7

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/04/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED	
	345202				C 09/01/2021
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
CAPITAL I				000 HOLSTON LANE RALEIGH, NC 27610	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 690	Continued From page	e 4	F 690		
	3/31/17 and had a dia The most recent Minin Assessment (Quarter resident had severe of not ambulatory and re- toileting and extensive hygiene. The MDS no- incontinent of bowel a The resident's active had an ADL (activities performance deficit re- required staff assistan On 9/1/21 at 10:38 AI was observed to prov Resident #67. The re- lying on her back and wipes to clean the re- cleaned from front to the resident to turn or proceeded to clean the	admitted to the facility on agnosis of dementia. mum Data Set (MDS) ly) dated 6/28/21 noted the cognitive impairment, was equired total assistance with e assistance with personal oted the resident was and bladder. care plan noted the resident s of daily living) self-care elated to dementia and nee with personal hygiene. M Nursing Assistant (NA) #1 ide incontinence care for sident was observed to be the NA used pre-moistened sident's perineal area and back. The NA then assisted no the left side and ne resident's bottom from		<ul> <li>constitutes the facility □s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</li> <li>Corrective action for resident(s) affect by the alleged deficient practice:</li> <li>For the affected resident, Resident #6 NA# 1 failed to use the correct technic when providing peri-care. Additionally Resident #36, facility failed to maintai catheter drainage bag off of the floor.</li> <li>1. Corrective action for residents with potential to be affected by the alleged deficient practice.</li> <li>For affected Resident #67, surveyor stopped NA#1 before she continued t use incorrect technique for providing peri-care. For Resident #36, the DON raised her bed to a higher position to ensure the bag was completely off of floor. The DON immediately educated NA#1 on the facility □s policy regardin peri-care and foleys.</li> <li>2. Measures /Systemic changes to prevent reoccurrence of alleged deficient</li> </ul>	e ted 57, que y, n the the d g
	stool was observed of a clean wipe and aga	the urinary urethra and n the wipe. The NA obtained in cleaned the resident from times until no more stool s.		prevent reoccurrence of alleged defici practice: An audit was completed on 9.10.2021 the Administrator, of all residents with catheters to ensure catheter bags we	l, by re
	she was trained to wij incontinence care and wrong. I'm sorry."	d the NA stated: "I did it		away from the floor and devices were place to ensure they stay in place. Th audit showed 100% of residents catheter bags were away from the floo An audit was completed on 9.13.2021	ne or. I, by
	On 9/1/21 at the com	pletion of care the NA was		the Director of Nursing, or her designed	ee,

Facility ID: 923006

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE C	CONSTRUCTION	· · ·	E SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· · /	A. BUILDING			PLETED
	345202			С			
				B. WING			/01/2021
NAME OF PROVIDER OR SUPPLIER				300			
CAPITAL	NURSING AND REHABII	LITATION CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 690	Continued From page	a 5	F 69	00			
1 000		supposed to clean during	FOE	90	of all nurses and CNAs to ensure they	can	
		d the NA stated: "Front to			provide return demonstration of how to		
		sked why she cleaned back			correctly provide peri-care. 100% of		
		ated: "I made a mistake."			nurses and CNAs provided peri-care		
				according to the policy during the audit	t.		
	The Director of Nursi when doing peri-care			3. Systemic Changes:			
	resident front to back				On 0/9/2021 the Director of Nursee, of	nd	
					On 9/8/2021, the Director of Nurses, an her designees began an in-service	na	
					education to all full time, part time, and	las	
	2.Resident #36 was a	admitted to the facility on			needed nurses and CNA s. Topics		
		es of chronic obstructive			included:		
		liabetes mellitus, neurogenic			"How to perform peri-care for both fem	ale	
	bladder, sleep apnea	and hypertension.			and male residents		
	The most recent Mini	mum Data Set assessment			"How to situate foley bags to ensure th do not touch the floor, and they are	ley	
		1 revealed the resident was			draining freely		
		aired. Resident #36 required			This information has been integrated ir	nto	
		with activities of daily living			the standard orientation training and in		
	(ADLs) and had an ir	idwelling catheter.			required in-service refresher courses for	or	
	Deview of the subscript				all staff identified above and will be		
		ian orders dated 4/28/21 catheter care every shift.			reviewed by the Quality Assurance process to verify that the change has		
		ation device or leg strap (to			been sustained. The facility specific		
		tubing from pulling). Check			in-service will be provided to all agency	v	
		e every 7 days and as			nurses and CNA s who give residents		
	needed.				care in the facility. Any nursing staff w	'no	
					does not receive scheduled in-service		
		sident #36 was conducted			training by September 13, 2021 will no allowed to work until training has been		
		M. Resident #36 was laying ter bag was lying on the			completed.		
					4. Monitoring Procedure to ensure that	the	
		sident #36 was conducted			plan of correction is effective and that		
		M with the Director of			specific deficiency cited remains correct	cted	
		dent #36 was laying in the g was lying on the floor.			and/or in compliance with regulatory requirements.		
	bed. The calheler ba	g was lying on the lloor.			requirements.		

Event ID: Q65Q11

Facility ID: 923006

If continuation sheet Page 6 of 7

	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) I	3 NO. 0938-039 DATE SURVEY COMPLETED
345202		B. WING			C 09/01/2021	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		•	
CAPITAL	NURSING AND REHABIL	ITATION CENTER		3000 HOLSTON LANE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 690	Nursing on 9/01/21 at nurse aide was unsur the catheter bag, she nurse. The DON stat keep the catheter bag An interview was con AM with NA #2. She resident ' s bed at bre aware the catheter bag stated she had been bags off the floor and she would have picke An interview was con AM with the Administ resident ' s catheter bag	ducted with the Director of t 9:50 AM. She stated if the re about the placement of should have asked the red staff were expected to g off the floor. ducted on 9/01/21 at 10:04 stated she had raised the eakfast, and she was not ag was on the floor. She educated to keep catheter if she had seen the bag, ed it up off the floor. ducted on 9/01/21 at 10:42 rator and informed of the wag was on the floor. The staff were expected to keep	F 69	The Director of Nursing, or des monitor residents □ catheters d weeks and then weekly for 2 w monthly for 3 months for compl catheter policy. Additionally, the of Nursing, or designee will mo resident □ s receiving peri-care week for 2 weeks, and then mo months to ensure compliance w facility □ s policy regarding peri- Administrator or Director of Nur report to the Quality Assurance Performance Improvement Cor any findings, identified trends, o Any negative finding will be cor the time of discovery in accords standard. The Performance Im Committee consists of the Adm Director of Nursing, RN superv Coordinator, Dietary Manager, Maintenance Director, Social V Director, Infection Control Nurs Rehab Director.	aily for 2 eeks then iance with e Director nitor 5 once per onthly for 3 with care. The rsing will nmittee or patterns. rected at ance to the provement inistrator, isor, MDS	

Facility ID: 923006

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