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 07/18/2024

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/15/24 through 7/18/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # RTPS11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/15/24 through 7/18/24. Event ID# RTPS11. The following intakes were investigated: NC00208648, NC00210624, NC00212721, NC00213027, NC00215332, NC00219189, NC00219211, and NC00219218 . 9 of the 24 complaint allegations did result in deficiency.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		8/23/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/09/2024

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 07/18/2024

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 657	Continued From page 1 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to revise the care plan in the areas of behaviors (Resident #13) and hospice services (Resident #14) for 2 of 21 residents reviewed for care plan revision. The findings included: 1. Resident #13 was admitted to the facility on 6/24/21 with diagnoses which included Alzheimer's Disease, dementia, delusional disorder, and iron deficiency anemia. The Minimum Data Set (MDS) quarterly assessment dated 2/01/24 revealed Resident #13 had adequate vision without corrective lenses, had severe cognitive impairment, and required supervision for eating. Resident #13 was not coded for behaviors. The care plan last revised on 3/20/24 revealed no care plan for Resident #13's behavior related to the ingestion of non-edible substances and to keep bath items out of Resident #13's reach. The nursing progress note dated 4/04/24 at 12:01 am by Nurse #1 revealed Resident #13's vital	F 657	F657 Care Plan Timing and Revision The care plan for the identified resident # 13_ # _14 was modified on_07/17/2024. Care plans are to be reviewed and updated with any changes and within the 7 day look back from the Assessment Reference Date for each Omnibus Budget Reconciliation Act (OBRA) assessment. Therefore, it is critical that the care plans be reviewed quarterly, updated and revised as a resident's condition changes in regards to hospice and behaviors to keep bath items out of reach. Care plan updates and revisions is an on-going process. All Residents have the potential to be affected by this Regional MDS and/or Administrator will provide education to the MDS Nurses on timeliness of care plan submission, their revisions, and how it can affect the residents Care The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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 07/18/2024

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 657	Continued From page 2 signs were obtained, and Nurse Practitioner #1 was notified of Resident #13's incident. Nurse #1 called Poison Control and was notified by Poison Control that the cleanser was nontoxic and possible side effects included nausea and vomiting. Nurse #1 noted that all bathing items were removed from Resident #13's room. A telephone interview on 7/16/24 at 12:50 pm with Nurse #1 revealed she was notified by NA #1 that Resident #13 had the open bottle of liquid perineal and skin cleanser and she drank some of the liquid. Nurse #1 stated she removed all bath items from Resident #13's room and she notified the Nurse Practitioner and the Director of Nursing of the incident. An interview with MDS Nurse #2 on 7/18/24 at 11:06 am revealed she was present at the meeting when Resident #13's incident was reviewed but somehow just missed updating the care plan. MDS Nurse #2 stated she updated Resident #13's care plan on 7/17/24 to reflect to remove all bathing items from Resident #13's reach. An interview was conducted on 7/18/23 at 11:13 am with the Director of Nursing (DON) who revealed the MDS Nurse was required to update Resident #13's care plan when the incident was discussed in the clinical meeting. During an interview on 7/17/24 at 3:32 pm with the Administrator he revealed the MDS Nurse was responsible to update Resident #13's care plan to reflect to not leave bath items within reach of Resident #13 as discussed in the clinical meeting after the incident.	F 657	and/or in compliance with the regulatory requirements; The Director of Nursing or Administrator will monitor and audit up to 5 current residents in order to validate whether or not the care plans have been revised timely with the Assessment Reference Date (ARD) for hospice and behaviors related to keeping bath items out of reach. This will be done on weekly basis x 4 weeks then monthly x 2 months. Reports will be presented to the weekly QA committee by the Director of Nursing or Administrator to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 08 / 23 /24	

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 07/18/2024

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 657	Continued From page 3	F 657		

2. Resident #14 was admitted to the facility on 5/07/24 with diagnoses which included Alzheimer's Disease and dementia.

Resident #14 had an active physician order dated 6/11/24 for hospice services.

The Minimum Data Set (MDS) significant change assessment dated 6/12/24 revealed Resident #14 was coded for hospice services.

Review of Resident #14's active care plan revealed no care plan for hospice services.

An interview was conducted on 7/16/24 at 11:20 am with Nurse #3 who revealed Resident #14 was on hospice services. Nurse #3 stated the MDS Nurse was responsible to update Resident #14's care plan for hospice services.

An interview was conducted on 7/16/24 at 3:35 pm with MDS Nurse #2 who revealed she was responsible for updating Resident #14's care plan when she admitted to hospice services. MDS Nurse #2 stated she was aware of Resident #14's hospice admission, but she just missed updating the care plan.

During an interview on 7/18/24 at 11:26 am with the Director of Nursing (DON) she revealed hospice admissions were discussed in the daily clinical meetings and she stated the MDS Nurse was present at the meetings. The DON stated the MDS Nurse was responsible for updating Resident #14's care plan for hospice services.

An interview was conducted with the Administrator on 7/18/24 at 11:46 am who revealed the MDS Nurse was responsible to

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 07/18/2024

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 657	Continued From page 4 update Resident #14's care plan to reflect hospice services.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Wound Provider interview, Nurse Practitioner interview, and Medical Director interview, the facility failed to obtain a treatment order prior to treating a wound for 1 of 4 residents reviewed for professional standards of practice (Resident #251). The findings included: Review of the hospital medication administration record dated 6/28/24 revealed Resident #251 received honey 80% gel treatment to the right lower extremity prior to discharge to the facility. Review of the hospital discharge summary revealed Resident #251 was discharged to the facility on 6/28/24 with diagnoses which included cellulitis of the right lower extremity. The hospital discharge summary did not include wound treatment orders for the right lower extremity cellulitis.	F 684	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. F684 The facility failed to obtain a treatment order prior to treating a wound for 1 of 4 residents reviewed. 1. Plan for correcting specific deficiency. The process that led to deficiency cited. Resident #251 was discharged from the facility on 7/ 03/2024. On 07 / 03 /2024 the Director of Nurses educated the wound nurse on the wound	8/23/24

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 07/18/2024

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 684	Continued From page 5 Resident #251 was admitted to the facility on 6/28/24 with diagnoses which included cellulitis (infection) of the right lower extremity and diabetes. The nursing admission review note completed on 6/28/24 by Nurse #5 revealed Resident #251 was admitted to the facility on 6/28/24 with right lower extremity cellulitis and had two open areas to the right lower leg. The weekly skin assessment dated 6/28/24 completed by Nurse #5 revealed Resident #251 had existing skin concerns upon admission which included an open area to the right lower leg. Nurse #5 noted that treatment was in place for the right lower leg open areas. An attempt to interview Nurse #5 via telephone on 7/17/24 at 9:30 am was unsuccessful. Resident #251's care plan initiated on 6/28/24 revealed a care plan for antibiotic therapy related to cellulitis with interventions which included administering medications as ordered. A weekly pressure ulcer report (a report the facility utilizes to document all wounds) dated 6/29/24 completed by the Wound Treatment Nurse noted Resident #251 had a wound to the right lower leg with measurements of 2 centimeter (cm) x 2 cm x 0.1 cm noted as a stage 2 (shallow open wound with red or pink wound bed) pressure ulcer with 50% eschar (dry, dead tissue within a wound) and 50% granulation tissue (new connective tissues that forms during the wound healing process). The Wound Treatment Nurse further noted the wound was dry	F 684	care process to include the need to contact the physician for all treatment orders, documentation of the order on the treatment administration record and never to initiate a treatment without a physician order, the potential risks to the resident of failing to obtain /initiate orders timely. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with wound have the potential to be affected by the alleged deficient practice. On 8/03/2024 the Director of Nursing/Nurse Managers reviewed all current residents with wound to assure a treatment order was in place. This was completed on 08/03/2024. The results included: 2 residents that needed corrections and were corrected On 07/29/2024 the Director of Nurses/RN Manager reviewed the last 14 days of ordered wound treatments for documentation of completion on the treatment administration record. This was completed on 07/29/2024. The results included: The results included: No corrections needed 3. Systemic changes: On 08/06/2024 the Director of Nurses/Staff Development Coordinator began education with all licensed nurses (Full time, Part Time, As Needed, to include agency. Topics included: Treatment/Order Process • Treatments are never to be	

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 07/18/2024

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 684	Continued From page 6 with patches of necrotic tissue (dead or dying tissue). No treatment was noted by the Wound Treatment Nurse. Review of the Treatment Administration Record (TAR) for June 2024 revealed no documentation that treatments were ordered or completed for Resident #251's right lower extremity wound. Nurse Practitioner (NP) #2 visit note dated 7/01/24 at 3:23 pm revealed Resident #251 had a right lower extremity dressing in place for the right leg cellulitis. NP #2 further noted that Resident #251's antibiotics would continue for the right leg cellulitis. During a telephone interview on 7/17/24 at 4:08 pm with NP #2 she revealed she was unable to recall about Resident #251's right lower extremity cellulitis, but she stated if she documented in the visit note that a dressing was in place that would have been what she observed. The Medical Director visit note dated 7/02/24 at 9:17 am revealed Resident #251 had a right anterior (front) lower leg wound which was clean with granulation tissue. The Medical Director noted that Resident #251 would continue with the full course of antibiotics for the right lower leg cellulitis. The weekly skin assessment dated 7/02/24 by Nurse #4 revealed Resident #251 had existing skin concerns present upon admission which included an open area to the right lower leg. Nurse #4 reported treatment was in place. An interview was conducted with Nurse #4 who was assigned to Resident #251 on 7/02/24	F 684	administered without an active treatment order from the physician. • If a resident is admitted or readmitted with a wound and has no wound treatment orders the physician is to be contacted for orders for the care of the wound(s) so that care can be started timely. • Orders are to be transcribed timely and accurately to the Treatment Administration Record. • A second nurse reviews that the new wound care orders are transcribed correctly. • Administered treatments are to be documented following completion of the ordered treatment. • If a treatment is missed the MD/Responsible Party are to be notified and a treatment error report completed. • In the event that the wound/treatment nurse is absent the assigned nurse is responsible for the administration of the ordered wound care/treatment. • Daily clinical review of all New Wound Care orders to ensure they are in place, transcribed correctly and administered as ordered on the Treatment Administration Record / Medication Administration Record will be done by the clinical team. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and management nurses as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any applicable staff who does not receive in-service education by 8/22/2024, will not be allowed to work until training been	

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 07/18/2024

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 684	Continued From page 7	F 684		

revealed she recalled Resident #251 had a wound to her right lower leg, but she stated she did not know what the treatment was because she did not do the treatments. Nurse #4 stated the Wound Treatment Nurse did the treatments to Resident #251's right lower leg.

An interview was conducted on 7/16/24 at 2:24 pm with the Wound Treatment Nurse who revealed he had been at the facility since February 2024, his normal work schedule was Monday through Friday, and he was responsible to complete resident wound care for during his shift. The Wound Treatment Nurse stated the normal process for new admissions was the medication cart nurse completed the initial assessment and if wounds were identified, he would then complete his assessment. He reported that the facility had a Wound Provider that did resident rounds at the facility every Monday. The Wound Treatment Nurse reported that he recalled Resident #251 had a wound to the right lower leg that he evaluated and completed an in-depth assessment on 6/29/24, and he determined the wound was a pressure ulcer. He stated he determined xeroform dressing every two days was the appropriate treatment for Resident #251's lower extremity pressure ulcers. The Wound Treatment Nurse stated that he chose the initial treatment based on his assessment of the wound, but he stated when the Wound Provider did the weekly facility wound rounds she would make changes to the treatment if needed. He stated he completed Resident #251's right lower leg treatment on 6/29/24 when he evaluated the wound, but he did not enter the order because "he knew he would be taking care of it himself since it was every 2 days". The Wound Treatment Nurse stated he

completed.
4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nursing or designee will monitor that wound care orders are obtained and initiated timely during the daily clinical meeting to ensure compliance with the wound care process.
The F 684 Quality Assurance tool will be completed daily(Monday through Friday) for 2 weeks then monthly for 3 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting.
The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager.

Date of compliance: 08/23/2024

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 07/18/2024

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 684	Continued From page 8	F 684		

"typically at times" he would take every other day treatments on personally and he would not always enter wound treatment orders for something "he knew he was handling." He stated he kept a list of residents that had wounds and if the treatment orders were not in the computer it was because he "just knew" when the treatments were due and did them.

A follow-up interview was conducted on 7/18/24 at 10:46 am with the Wound Treatment Nurse who stated he now recalled the wound to Resident #251's right lower extremity was cellulitis and not a pressure ulcer. He stated he was not aware Resident #251 had a diagnosis of right lower leg cellulitis prior to his evaluation of the wound so he initially documented it as a pressure ulcer due to the eschar that was present. He stated he later reviewed Resident #251's record and saw the wound was cellulitis. The Wound Treatment Nurse stated he must have just forgotten to strike out the pressure ulcer report. The Wound Treatment Nurse stated he was confused when he was first interviewed, and he should have reviewed Resident #251's record before giving the information.

A physician order dated 6/29/24 and created on 7/02/24 at 3:10 pm by the Wound Treatment Nurse indicated to cleanse open areas on lower right leg with wound cleanser or normal saline, pat dry. Apply layer of xeroform and cover with bandage one time a day every 2 days.

A physician order was created on 7/02/24 by the Wound Treatment Nurse, with a start date of 7/03/24, to cleanse open areas on lower right leg with wound cleanser or normal saline, pat dry. Apply a thin layer of medihoney gel and cover

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 07/18/2024

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 684	Continued From page 9	F 684		

with dry dressing one time a day every 2 days.

Resident #251 was transferred to the hospital on 7/02/24.

Review of the TAR record for July 2024 revealed no treatments to the right lower extremity were documented as completed.

A telephone interview was conducted on 7/18/24 at 10:33 am with the Wound Provider who revealed she did not recall receiving a referral from the Wound Treatment Nurse to evaluate and treat Resident #251. The Wound Provider stated she was unable to comment on treatments because she did not evaluate Resident #251.

A follow-up interview was conducted on 7/18/24 at 10:46 am with the Wound Treatment Nurse revealed he did not put in an order for a referral to the Wound Provider for Resident #251's lower extremity wound because he was going to ask the Wound Provider to look at the wound during the next rounds on 7/01/24 to see if his initial treatment order needed to be changed. The Wound Treatment Nurse stated he did not need an order to have the wound looked at by the Wound Provider if he just wanted her to look at them. He was unable to recall if the Wound Provider saw Resident #251. The Wound Treatment Nurse stated he basically takes the medication cart nurse with him "a lot of times" when he completed wound treatments, and he would communicate verbally with the medication cart nurse during the treatment changes. He stated it was typically the same nurses on the medication carts, so they knew about the treatments. The Wound Treatment Nurse stated since Resident #251's treatments orders were to

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 07/18/2024

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 684	Continued From page 10	F 684		

be completed every two days, if he did the treatment on Saturday it would have been due on Monday. The Wound Treatment Nurse stated that if the treatment was not done the exact date it was scheduled "one day was not going to hurt". The Wound Treatment Nurse confirmed he did not enter any wound treatment orders and he should not have completed treatments on Resident #251's right lower extremity without a physician order in place.

A telephone interview was conducted on 7/18/24 at 10:42 am with the Medical Director who revealed Resident #251 had cellulitis to the right lower leg, and to his knowledge, was prescribed oral antibiotics for treatment. The Medical Director stated the first and most important course of treatment for Resident #251's right lower extremity cellulitis was antibiotics. The Medical Director stated he did not think topical treatment was required for Resident #251's right leg cellulitis and was not aware of an order for topical treatments on the hospital discharge record.

An interview was conducted with the Director of Nursing (DON) on 7/18/24 at 11:29 am who revealed she did not meet Resident #251 until 7/02/24 and she did not observe her leg wound. The DON stated the Wound Treatment Nurse should have obtained and entered any treatment orders that were required for Resident #251 so that any nursing staff were able to complete the treatment as scheduled. The DON stated the Wound Treatment Nurse should not have completed treatments to Resident #251's lower extremity without a physician order in place. The DON stated she met with the Wound Treatment Nurse on 7/17/24 and provided education

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 07/18/2024

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 684	Continued From page 11 regarding entering all wound treatment orders when they were obtained. During an interview on 7/18/24 at 11:47 am with the Administrator he revealed that all treatment orders were to be obtained by the provider and entered into the record as a physician order. The Administrator stated he reviewed the hospital discharge summary and there was not an order for wound treatments for Resident #251 upon admission to the facility. The Administrator was unable to state how the Wound Treatment Nurse obtained the orders for Resident #251.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer 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 unless the individual's clinical condition demonstrates that they were unavoidable; and (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. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews, and interview with the Wound Care Physician the facility failed to transcribe Physician treatment orders and failed to implement the Wound Care Doctors orders as ordered for one (Resident #38) of three residents reviewed for	F 686	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	8/23/24

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 07/18/2024

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 686	Continued From page 12 pressure ulcers. The findings included: Resident #38 was admitted to the facility on 12/18/20 with diagnoses that included stroke with hemiplegia, chronic atrial fibrillation, diabetes mellitus, hypothyroidism, and epilepsy. The quarterly Minimum Data Set (MDS) assessment dated 4/26/24 indicated Resident #38 was cognitively impaired and was receiving treatments for a pressure ulcer. Review of Resident #38's care plan revealed she had a pressure ulcer on her coccyx and was at risk for development of additional pressure ulcers due to decreased ability to re-position and incontinence. bowel/bladder incontinence. Interventions included Apply moisture barrier with each brief change and prn, and administration of treatments as ordered by the physician and monitor effectiveness of treatments. Review of the Physician orders for 7/05/24 revealed: Cleanse sacrum with wound cleanser, pat dry, apply collagen powder and dry dressing. One time a day every 2 day(s). Review of Wound Care Progress note dated 7/15/24 revealed: Primary Dressing(s) Santyl apply once daily for 30 days. Secondary Dressing(s) Foam with border (silicone-sacrum) apply once daily for 16 days. Review of Resident #38s July 2024 eMAR (electronic Medication Administration Record) revealed the following: Cleanse sacrum with wound cleanser, pat dry, apply collagen powder	F 686	or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilitys allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 The facility failed to transcribe physician treatment orders and failed to implement the wound care orders for 1 of 3 residents reviewed. 1. For resident #38, a corrective action was obtained on 07/ 17 /2024. On 07/ 17/ 2024, the Nurse completed a wound assessment on Resident #38 to ensure there were no identified change of condition to the wounds. The results included: No changed noted On 07/17/2024 the wound nurse obtained an order to treat the wound from the physician for resident # 38. On 07/17/2024 the wound nurse transcribed the order for wound care to the treatment administration record and initiated and completed the ordered treatment for resident #38. On 07/ 17/2024 the Director of Nurses educated the wound nurse on the wound care process to include the need to contact the physician for all treatment orders timely, documentation/transcription of the order on the treatment administration record, never to initiate a treatment without a physician order, the potential risks to the resident of failing to obtain /initiate orders timely and the importance of initiating orders timely. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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 07/18/2024

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 686	Continued From page 13 and dry dressing. One time a day every 2 day(s). Observation on 7/17/24 at 11:10 AM of Resident #38's wound dressing change by the Wound Treatment Nurse. Resident #38's wound bed was cleaned with saline and gauze, slough and granulation tissue present, no active bleeding or drainage. There was no odor. The Wound Treatment Nurse stated he measured the wound in centimeters 2.5 cm x 1.5 cm (centimeters). During the interview, the Wound Treatment Nurse stated the treatment is completed every other day and will be either zinc or Santyl depending on the wound observation. With slough being present today Santyl will be used and then covered with border gauze. Santyl was applied and border gauze placed over the sacral wound. In an interview on 7/17/24 at 2:02 PM the Director of Nursing indicated the Wound Treatment Nurse should follow the Physician order and if there was a change in the order to call the Medical Doctor to verify. In a phone interview on 7/18/24 at 10:19 AM the Wound Care Physician revealed she discussed the order changes with the Wound Treatment Nurse during their rounds, he reviews her notes and would put the orders in the computer. She indicated the Wound Treatment Nurse called her on Tuesday to ask about making the Santyl as needed for when slough was present, and she gave the permission to change the order to PRN (as needed). In an interview on 7/18/24 at 10:22 AM the Administrator revealed if the Wound Treatment Nurse had a conversation with the Wound Care Physician and the order was changed. Then the	F 686	All residents have the potential to be affected by the alleged deficient practice. On 07/26/2024, the Director of Nurses/Unit Managers began identification of residents that were potentially impacted by this practice by completing total body skin assessments on all current residents. This audit was completed by reviewing 100% of current residents to identify any residents with new pressure wounds or skin integrity alterations. The results included: no new areas found On 08/03/2024 the Director of Nurses/Unit Managers audited 100% of all residents with identified pressure wounds to assure a current treatment order was correct and in place on the electronic treatment record. The results included: No corrections needed On 08/03/2024 the Director of Nurses/Unit Managers audited all identified pressure wounds for the administration of ordered treatments for compliance the last 14 days. The results included: No new additions As of 08/03/2024 all pressure wound treatments were in compliance with the pressure wound process. 3. Systemic changes: On 08/06/2024, the Director of Nurses/Staff Development Coordinator began in-service of 100% of all licensed nurses, full time, part time, as needed nurses, including agency to include: Identification/ obtaining wound care orders and timely implementation and administration of ordered treatments.	

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 07/18/2024

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 686	Continued From page 14 Wound Treatment Nurse should have documented the conversation and changed the order. The Administrator indicated the Wound Treatment Nurse should follow what the Medical Doctor ordered and if the order did not match, he should have clarified the order. In an interview on 7/18/24 at 10:59 AM the Wound Treatment Nurse indicated that he was responsible for entering the order for Resident #38's wound treatment change and the order should have been changed.	F 686	Wound/Skin/Treatment/Order Documentation Process. Documentation and notification of the physician/Responsible party/Director of Nurses if a treatment cannot be completed for any reason. As of 8/06/2024 the Director of Nurses/Staff Development Coordinator began education of all licensed nurses, including agency on the following expectations: the wound nurse or nurse assigned is to complete the weekly wound round user defined assessment after rounding with the wound doctor. Orders are to be transcribed by the nurse who receives the order. If the nurse needs clarification of the order, the nurse is to contact the physician for clarity of the order. During morning clinical meeting all orders are to be reviewed by the Nursing Team to ensure orders are in place and have been initiated timely. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and management nurses as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any applicable staff who does not receive in-service education by 8/22/2024, will not be allowed to work until training been completed. 4. Quality Assurance monitoring procedure. Utilizing the F686 Quality Assurance Audit Tool, the Director of Nurses or designee	

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 07/18/2024

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 686	Continued From page 15	F 686	will monitor the order/treatment implementation/administration and documentation process for compliance with the pressure wound process weekly x 2 weeks then monthly x 3 months or until resolved. Follow up will be monitored as part of the Daily Clinical Meeting (Monday through Friday). Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager DOC: 8/23/2024	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Nurse Practitioner interview, Medical Director interview, and Poison Control interview, the facility failed to provide a hazard free environment to prevent an	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	8/23/24

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 07/18/2024

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 689	Continued From page 16 avoidable accident when a resident with severe cognitive impairment (Resident #13) ingested an unknown amount of nontoxic liquid perineal and skin cleanser that was left within the resident's reach for 1 of 4 residents reviewed for supervision to prevent accidents (Resident #13). The findings included: Resident #13 was admitted to the facility on 6/24/21 with diagnoses which included Alzheimer's Disease, dementia, delusional disorder, and iron deficiency anemia. Resident #13 had no known drug or food allergies. The Minimum Data Set (MDS) quarterly assessment dated 2/01/24 revealed Resident #13 had adequate vision without corrective lenses, had severe cognitive impairment, and was not coded for behaviors. Resident #13 had no range of motion limitation for upper or lower extremities, required supervision or cueing for bed to chair transfers, and was independent with wheelchair mobility. Resident #13's care plan last revised 3/20/24 revealed a care plan for impaired cognitive function, dementia, or impaired thought processes related to dementia with an intervention to cue, reorient, and supervise as needed. Review of the facility incident report dated 4/03/24 at 9:21 pm completed by Nurse #1 revealed Resident #13 was observed by Nurse Aide (NA) #1 drinking the liquid perineal and skin cleanser, but she was unable to state how much of the liquid Resident #13 consumed. The incident report further reported Resident #13 stated she	F 689	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. F689 The facility failed to provide a hazard free environment for a cognitively impaired resident. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 04/03/2024 the Cart Nurse competed a head to toe assessment of the resident for any potential signs of injuries or change in condition. The results included: No change noted On 04/03/2024 the Cart Nurse notified the physician, Poison Control and the responsible party of the ingestion of an unspecified amount of perineal/skin cleanser. The results included: Monitor for nausea or other gastric issues On 04/03/2024 the cart nurse assured there were no potentially hazardous items left in the resident's room or within reach of the resident and the perennial/skin cleanser was removed from the resident's room. The results included: no other hazards present On 04/03/2024 the DON verbally educated the assigned nurse/certified nursing assistant on the facility policy for securing any potentially hazardous items such as perineal/skin cleanser out of the reach of residents. 2. Corrective action for residents with the potential to be affected by the alleged	

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 07/18/2024

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 689	Continued From page 17	F 689		

"did not know why she drank it". The incident report noted that Resident #1 was sitting on the edge of the bed with the bed in low position and the bedside table within reach at the time of the incident.

The nursing progress note dated 4/04/24 at 12:01 am by Nurse #1 revealed Resident #13's vital signs were obtained, and Nurse Practitioner #1 was notified of Resident #13's incident. Nurse #1 called Poison Control and was notified by Poison Control that the cleanser was nontoxic and possible side effects from ingestion included nausea and vomiting. Nurse #1 noted that all bathing items were removed from Resident #13's room.

A telephone interview on 7/16/24 at 12:50 pm with Nurse #1 revealed she was notified on 4/03/24 by NA #1 that Resident #13 had an open bottle of liquid perineal and skin cleanser and drank some of the liquid. Nurse #1 stated the perineal and skin cleanser belonged to Resident #13's roommate and was used to clean the area around her stoma (an opening in the body) site. She stated she did not use the liquid cleanser for the roommate's stoma site that day, she did not see the bottle on Resident #13's tables, and she was not sure how Resident #13 got the bottle. Nurse #1 stated she had left multiple drinks and a snack in Resident #13's room earlier in the shift on her bedside table and Resident #13 may have thought the liquid perineal and skin cleanser was a drink because she was confused.

An interview was conducted on 7/16/24 at 3:44 pm with NA #1 who revealed she passed by Resident #13's room on 4/30/24 and saw Resident #13 sitting on her bed holding the open

deficient practice.
On 08/08/2024 the Admin Team audited all residents' rooms for the presence of any perineal/ skin cleanser or any other items such as a medication or treatment item or chemical such as cleaning supplies that were found in a resident's room or within reach of the resident. The results included: 2 residents with room cleaners, and 3 residents with inhalers
As of 08/09/2024 all residents room were in compliance.

Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 08/06/2024 the Director of Nurses and Staff Development Coordinator began education of all nurses and certified nursing assistants 's and housekeeping staff full time, part time, as needed and agency.
The topic included: Review of policy 14940613 Resident Safety and Health Program

- Examine resident rooms to see if hazardous chemicals/medications or treatment items are stored improperly.
- Razors and personal care items that may be hazardous should be stored in resident dressers.
- Potentially hazardous items should never be kept within a residents reach. This is especially important for residents who are confused/cognitively impaired.
- Medications/treatment items are to be stored in a locked medication/treatment cart.
- Chemicals used for cleaning are to kept locked per facility policy.

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 07/18/2024

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 689	Continued From page 18	F 689		

bottle of liquid perineal and skin cleanser to her mouth. NA #1 stated she was not able to say how much of the liquid perineal and skin cleanser Resident #13 drank, but there was not much missing from the bottle. NA #1 stated she did not recall seeing the liquid perineal and skin cleanser in Resident #13's room prior and she was not sure where Resident #13 got the bottle from. NA #1 stated had not seen Resident #13 eat or drink non-food items in the past.

Review of the nursing progress notes dated 4/03/24 through 4/08/24 revealed no documentation that Resident #13 reported or was observed to have any nausea or vomiting.

A telephone interview was conducted on 7/17/24 at 12:07 pm with Nurse Practitioner (NP) #1 who revealed she was notified on 4/03/24 that Resident #13 was observed in the motion of drinking the liquid perineal and skin cleanser, but it was reported only a small amount of liquid was missing from the bottle. NP #1 stated that Resident #13 must have mistaken the bottle of liquid perineal and skin cleanser for one of her drinks that were left on her table by staff due to her cognitive impairment and drank it. NP #1 stated Resident #13 did not display any ill effects or symptoms of nausea or vomiting from the ingestion of the liquid perineal and skin cleanser. NP #1 stated she had not known Resident #13 to ingest any non-food items in the past.

A telephone interview was conducted on 7/17/24 at 12:45 pm with Poison Control who confirmed the liquid perineal and skin cleanser was non-toxic and if large amounts of liquid were ingested gastrointestinal irritation, such as nausea and vomiting, may occur. Poison Control

• The poison control center is to be notified of any ingestion of a potentially hazardous/toxic item. The number is located at the nurse's station.
• SDS are available for review see Accessing SDS sheets policy 14942316
• The notification process is to completed and an IR developed.
This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency, Nurses and Certified Nursing Assistants who provide residents care in the facility. As of 8/22/2024 any above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Administrator/Director of Nursing will monitor compliance utilizing the F689 Quality Assurance Tool for Resident Safety Process weekly x 2 weeks then monthly x 3 months or until resolved. A random sample of resident rooms will be audited for compliance. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored

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 07/18/2024

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 689	Continued From page 19 stated the guidance provided after ingestion of the liquid perineal and skin cleanser would include monitoring for nausea and vomiting and to increase fluid intake if nausea or vomiting occurred to prevent dehydration. A telephone interview was conducted with the Medical Director on 7/18/24 at 10:40 am who revealed Nurse #1 contacted Poison Control immediately when Resident #13 drank the liquid perineal and skin cleanser to determine if the product was toxic when ingested and to receive guidance for how to proceed. The Medical Director stated once the product was determined to be non-toxic Resident #13 was monitored and no signs or symptoms of gastrointestinal irritation were noted. The Medical Director stated he did not have cause for concern regarding Resident #13's ingestion of a small amount of the liquid perineal and skin cleanser. An interview was conducted on 7/18/24 at 11:13 am with the Director of Nursing (DON) who revealed she recalled being notified on 4/03/24 by Nurse #1 that Resident #13 drank some of the perineal and skin cleanser. The DON stated Resident #13 had not ingested any non-food items prior to this incident to her knowledge. During an interview on 7/18/24 at 11:40 am with the Administrator he revealed Resident #13's ingestion of the liquid perineal and skin cleanser was possible due to her cognitive status but was not expected because she had not shown a history of ingestion of non-food items.	F 689	and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/23/2024	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		8/23/24

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 07/18/2024

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 842	Continued From page 20 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (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. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(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- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (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.	F 842		

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 07/18/2024

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 842	Continued From page 21 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document wound treatment orders for 1 of 4 residents reviewed for medical record accuracy (Resident #251). The findings included: Resident #251 was admitted to the facility on 6/28/24 with a diagnosis of cellulitis (infection) of the right lower extremity. The nursing admission review note completed on	F 842	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.	

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 07/18/2024

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 842	Continued From page 22 6/28/24 by Nurse #5 revealed Resident #251 was admitted to the facility on 6/28/24 with right lower extremity cellulitis and had two open areas to the right lower leg. The weekly skin assessment dated 6/28/24 completed by Nurse #5 revealed Resident #251 had an open area to the right lower leg. Nurse #5 noted that treatment was in place for the right lower leg open areas. An attempt to interview Nurse #5 via telephone on 7/17/24 at 9:30 am was unsuccessful. Review of the Treatment Administration Record (TAR) for June 2024 revealed no documentation that treatments were ordered or completed for Resident #251's right lower extremity wound. Nurse Practitioner (NP) #2 visit note dated 7/01/24 at 3:23 pm revealed Resident #251 had a right lower extremity dressing in place for the right leg cellulitis. During a telephone interview on 7/17/24 at 4:08 pm with NP #2 she revealed she was unable to recall about Resident #251's right lower extremity cellulitis, but she stated if she documented in the visit note that a dressing was in place that would have been what she observed. The weekly skin assessment dated 7/02/24 by Nurse #4 revealed Resident #251 had an open area to the right lower leg. Nurse #4 reported treatment was in place Resident #251's right lower extremity. An interview was conducted on 7/16/24 at 2:24	F 842	F842 The facility failed to maintain accurate medical records for resident #251 1. Plan for correcting specific deficiency. The process that led to deficiency cited. Resident #251 was discharged from the facility on 7/03/2024. On 07/03/2024 the Director of Nurses educated the wound nurse on the wound care process to include the need to contact the physician for all treatment orders, documentation of the order on the treatment administration record and never to initiate a treatment without a physician order, the potential risks to the resident of failing to obtain /initiate orders timely. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with ordered wound treatments have the potential to be affected by the alleged deficient practice. On8/03/2024 the Director of Nursing began auditing the past 14 days of Treatment Administration Records to ensure treatments were appropriately documented as completed by the assigned nurse. This was completed on 08/03/2024. The results included: No corrections needed On 08/08/2024 the Director of Nursing/Unit Managers began assessment of current residents with missed treatment documentation to ensure there were no changes in wound status. This was completed on 08/09/2024. The results included: no corrections needed As of 08/09/2024 all residents with	

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 07/18/2024

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 842	Continued From page 23	F 842		

pm with the Wound Treatment Nurse who revealed Resident #251 had a wound to the right lower leg that he evaluated and completed an in-depth assessment on 6/29/24, and he determined the wound was a pressure ulcer. He stated he completed Resident #251's right lower leg treatment on 6/29/24 when he evaluated the wound, but he did not enter the order because "he knew he would be taking care of it himself since it was every 2 days". The Wound Treatment Nurse stated he "typically at times" would take every other day treatments on personally and he would not always enter wound treatment orders for something "he knew he was handling."

A physician order dated 6/29/24 and created on 7/02/24 at 3:10 pm by the Wound Treatment Nurse indicated to cleanse open areas on lower right leg with wound cleanser or normal saline, pat dry. Apply layer of xeroform and cover with bandage one time a day every 2 days.

A physician order was created on 7/02/24 by the Wound Treatment Nurse, with a start date of 7/03/24, to cleanse open areas on lower right leg with wound cleanser or normal saline, pat dry. Apply a thin layer of medihoney gel and cover with dry dressing one time a day every 2 days.

Review of the TAR record for July 2024 revealed no treatments to the right lower extremity were documented as completed.

A follow-up interview was conducted on 7/18/24 at 10:46 am with the Wound Treatment Nurse who stated Resident #251's right leg treatment would have been due to be changed on 7/01/24 but he completed the dressing change on

wounds were in compliance with the wound/treatment process.
3. Systemic changes:
On 08/06/2024, the Director of Nursing/Staff Development Coordinator began an in-service education to all full time, part time, and as needed RN, LPN, and wound nurse (including agency).
Topics included: Examples of Potential Treatment Errors:
- Omission of treatment
- Treatment administered without a physician's order
- Wrong treatment or medication ordered with treatment is incorrect
- Wrong Route Administered
- Wrong Time administered
- Wrong dose of medication delivered with ordered treatment
- Failure to document that the treatment was administered

The wound process to include obtaining orders timely for all treatments.
Entering orders completely and timely to assure completion of ordered treatment by the wound or assigned nurse.
Notification of the physician/Responsible Party/Director of Nurses of treatment omissions/errors.
On 08/07/2024 the Nurse Consultant educated the Director of Nurses/Nursing Team on the need for Daily clinical review of Treatment Administration Records / Medication/Treatment Administration Audit report for missed documentation to ensure timely follow up and immediate corrective actions are implemented.
This information has been integrated into the standard orientation training and in the

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 07/18/2024

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 842	Continued From page 24 7/02/24. The Wound Treatment Nurse confirmed he did not document the treatment was completed and he did not enter any wound treatment orders for Resident #251. An interview was conducted with the Director of Nursing (DON) on 7/18/24 at 11:29 am who revealed the Wound Treatment Nurse should have entered any treatment orders that were required for Resident #251 so that any nursing staff were able to complete the treatment as scheduled. The DON stated she met with the Wound Treatment Nurse on 7/17/24 and provided education regarding entering all wound treatment orders when they were obtained. During an interview on 7/18/24 at 11:47 am with the Administrator he revealed that all treatment orders were to be obtained by the provider and entered into the record as a physician order.	F 842	required in-service refresher courses for all nurses and management nurses as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any applicable staff who does not receive inservice education by 8/22/2024, will not be allowed to work until training been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the completion of Medication/Treatment documentation daily Monday – Friday during daily clinical to ensure timely corrective action and follow up is completed timely. The F 842 Quality Assurance tool will be completed weekly for 2 weeks then monthly for 3 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Date of compliance: 08/23/2024	