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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 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 [DATE] with diagnoses which included Alzheimer's Disease, dementia, delusional disorder, and iron deficiency anemia. The Minimum Data Set (MDS) quarterly assessment dated [DATE] 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 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. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 2. Resident #14 was admitted to the facility on [DATE] 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 [DATE] 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 update Resident #14's care plan to reflect hospice services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 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 [DATE] 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. Resident #251 was admitted to the facility on [DATE] 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 [DATE] with right lower extremity cellulitis and had two open areas to the right lower leg. The weekly skin assessment dated [DATE] 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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE] 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 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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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 regarding entering all wound treatment orders when they were obtained. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20710 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 pressure ulcers. The findings included: Resident #38 was admitted to the facility on [DATE] with diagnoses that included stroke with hemiplegia, chronic atrial fibrillation, diabetes mellitus, hypothyroidism, and epilepsy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] 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 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45045

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 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 [DATE] 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 [DATE] 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 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 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 [DATE] with a diagnosis of cellulitis (infection) of the right lower extremity. The nursing admission review note completed on 6/28/24 by Nurse #5 revealed Resident #251 was admitted to the facility on [DATE] with right lower extremity cellulitis and had two open areas to the right lower leg. The weekly skin assessment dated [DATE] 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 [DATE] 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 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.