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	08/07/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Consultant Pharmacist interviews, the facility failed to ensure a physician order for an as needed (PRN) psychotropic medication was time limited in duration for 1 of 5 residents reviewed for unnecessary medications (Resident #90).The findings included:Resident #90 was admitted to the facility on [DATE] with diagnoses which included anxiety disorder.The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #90 was cognitively intact and was coded for use of an antianxiety medication.Resident #90 had an active physician order dated 7/19/25 for lorazepam oral tablet 0.5 milligram (mg). Give 0.5 mg by mouth two times a day for anxiety; give after breakfast AND give 0.5 mg tablet by mouth every 12 hours as needed (PRN) for anxiety. The order did not have a stop date.The care plan last reviewed on 7/28/25 revealed Resident #90 used anti-anxiety medication and was at risk for adverse side effects with an intervention for the Consulting Pharmacist to review the psychotropic medications quarterly and PRN for possible changes or reductions.The Medication Administration Record (MAR) for July 2025 revealed Resident #90 received the PRN lorazepam on 7/19/25 at 5:04 pm and no further PRN doses were administered to Resident #90 for the remainder of the month.The MAR for August 2025 revealed Resident #90 was not administered the PRN lorazepam.The Consultant Pharmacist's Medication Regimen Review report dated 8/04/25 revealed the facility received notification that Resident #90 was prescribed lorazepam 0. 5 mg every 12 hours PRN for anxiety. The Consultant Pharmacist further noted that the order must have a stop date for re-assessment and requested the facility to clarify the order with a specific time/re-assessment date or discontinue.A telephone interview was conducted with the Consultant Pharmacist on 8/06/25 at 4:49 pm who revealed Resident #90's monthly medication review was conducted on 8/04/25. The Consultant Pharmacist reported she sent an email to the Director of Nursing (DON) when the review was completed and requested a stop date for Resident #90's PRN lorazepam but she was not sure if the DON had completed the request at this time.The DON was interviewed on 8/07/25 at 11:30 am and revealed medication orders were reviewed in the daily clinical meeting with the order listing report to review what medications were ordered and the stop dates would have been added during the meeting if missing. The DON stated the stop date was just missed for Resident #90's PRN lorazepam.An interview was conducted with the Administrator on 8/07/25 at 11:59 am who revealed medication orders were normally discussed in the morning clinical meeting. The Administrator stated Resident #90's PRN lorazepam order did not flag for not having a stop date by the way the order was written so it was missed.

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

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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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to consistently complete a thorough weekly pressure ulcer assessment that included the type of injury (pressure versus non pressure), pressure ulcer stage, a description of the pressure ulcer characteristics, presence of pain, and description of dressing or treatment for 1 of 2 residents observed for pressure ulcers (Resident #3). The findings included:Resident #3 was admitted to the facility on [DATE] with diagnoses which included functional quadriplegia and cerebral palsy. The Weekly Pressure Ulcer Review assessment dated [DATE], completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed pressure ulcer to the sacrum, not staged, with measurements of 1 centimeter (cm) x 1 cm x 0.1 cm (length x width x depth). The wound bed was noted to have 100% granulation (new tissue that forms on the wound during healing process) tissue, with no odor. Resident #3 had a physician order in place dated 5/08/25 to apply zinc to the right buttock every day and evening shift for wound care. The Treatment Administration Record (TAR) May 2025 through August 2025 was reviewed and revealed Resident #3's treatment order to apply zinc to the right buttock every day and evening shift was completed as ordered. Resident #3 had a care plan last reviewed on 5/11/25 for risk for pressure ulcer development, current pressure ulcer to right buttock and risk for development of additional pressure ulcers. The care plan had interventions which included administer treatments as ordered and monitor for effectiveness, low air loss mattress, and to consult wound physician as needed and/or ordered.The Weekly Pressure Ulcer Review assessment dated [DATE], completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed pressure ulcer to the sacrum; the wound was not staged. The wound measurements were 1 cm x 1 cm x 0.1 cm. The wound bed was noted to have 100% granulation tissue, light exudate (fluid that leaks out of blood vessels), with redness noted and no odor. The assessment also noted that the area was macerated (skin that softens and breaks down due to prolonged exposure to moisture) with bright red excoriation (break in the skin's surface) noted. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #3 was cognitively intact, was dependent of staff for activities of daily living (ADLs), and had an indwelling urinary catheter and colostomy related to bowel and bladder management. Resident #3 was coded for a pressure ulcer Stage 3 which was noted as present on admission or readmission. Resident # 3 was coded for pressure reducing device for the bed, pressure reducing device for the chair, and pressure ulcer care.The Weekly Pressure Ulcer Review assessment dated [DATE], completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed pressure ulcer to the left and right buttock, Stage 3 with measurements of 1 cm x 1 cm x 0.1 cm. The wound bed was noted to have 100% granulation tissue, with surrounding tissue noted for redness. The assessment further noted the area was macerated with bright red excoriation noted. The Weekly Pressure Ulcer Review assessment dated [DATE], completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed wound to the sacrum, pressure. The stage was noted as N/A (non-applicable), with measurements of 1.5 cm x 1.8 cm x 0.2 cm. The pressure ulcer was noted to have 50% granulation tissue and redness noted. Intact area of pressure due to damage of underlying soft tissue from moisture and pressure. The wound was noted as not painful, but firm as compared to adjacent tissue.The Weekly Pressure Ulcer Review assessment dated [DATE], completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed wound to the right buttock, the stage was noted as pressure/denuded (skin injury where the outermost layer of skin is lost) with measurements of 1.5 cm x 1.8 cm x 0.2 cm. The wound bed was noted to have 100% granulation tissue. Intact area of pressure due to damage of underlying soft tissue from moisture and pressure. The pressure ulcer was reported as not painful, but firm as compared to adjacent tissue with a treatment of zinc daily post every brief change and bath for all shifts.The Weekly Pressure Ulcer Review assessment dated [DATE], completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed pressure ulcer to the right buttock with measurements of 1.5 cm x 1.8 cm x 0. 2 cm, the Stage was noted as N/A pressure/denuded. Intact area of pressure due to damage of underlying soft tissue from moisture and pressure. The pressure ulcer was reported as not painful, but firm as compared to adjacent tissue. The wound bed was noted to have 100% granulation tissue with a treatment of zinc daily post every brief change and bath for all shifts. The Weekly Pressure Ulcer Review assessment dated [DATE], completed by the Wound Treatment Nurse, revealed Resident #3 had one unhealed pressure ulcer to the right buttock with measurements of 1.5 cm x 1.8 cm x 0.1 cm. The Stage was noted as N/A

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Consultant Pharmacist interviews, the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving an antipsychotic medication, which is used for medication monitoring of side effects of antipsychotic medications for 1 of 5 residents reviewed for unnecessary medications (Resident #82).The findings included:Resident #82 was admitted to the facility on [DATE] with diagnoses which included vascular dementia without behavioral disturbances.The Mental Health and Antipsychotic Review (which included the AIMS assessment) completed on 12/26/24 revealed Resident #82 had no negative findings related to the use of antipsychotic medication and was categorized as low risk for movement disorders.The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #82 had severe cognitive impairment and was coded for the use of antipsychotic medication.The care plan last reviewed on 6/27/25 revealed Resident #82 received antipsychotic medications with risk for adverse side effects with interventions which included performing an AIMS every 6 months.A current physician order dated 8/05/25 quetiapine fumarate 50 mg tablet; give 1 tablet by mouth every morning and at bedtime for dementia with psychosis. Further review of the physician orders indicated the resident was restarted on quetiapine fumarate on 5/09/25 after discontinuation of the medication in January 2025.A review of Resident #82's medical record on 8/05/25 revealed the facility had not completed an AIMS for the antipsychotic medication when the order was initiated on 5/09/25 and had not completed an AIMS to date. Review of the Consultant Pharmacist's Medication Regimen Review report dated 8/05/25 revealed the facility was notified that a Mental Health and Antipsychotic Review (formally the AIMS assessment) has been completed every 6 months since the patient was on the following therapy: quetiapine.A telephone interview was conducted on 8/06/25 at 4:49 pm with the Consultant Pharmacist who revealed that when a resident was prescribed an antipsychotic medication an AIMS assessment was required upon starting the medication for a baseline assessment and every 6 months thereafter for monitoring. The Consultant Pharmacist stated the facility was responsible for completing the AIMS assessment, but she stated she would notify the facility from the medication regimen reviews when she identified that the AIMS assessment was not completed. The Consultant Pharmacist stated that she did review Resident #82's medical record during the monthly pharmacy review and she did notify the Director of Nursing (DON) and Administrator on 8/05/25 to make sure an AIMS was completed for Resident #82's quetiapine.An interview was conducted on 8/07/25 at 11:35 am with the DON who revealed the previous AIMS assessment had been changed to the new Mental Health and Antipsychotic Review and she believed that due to that change, the AIMS assessment did not trigger to be completed for Resident #82's quetiapine order and it was missed.During an interview with the Administrator of 8/07/25 at 12:02 pm he revealed that due to the new Mental Health and Antipsychotic Review being implemented recently it may have caused Resident #82's AIMS assessment not to be triggered when it was due.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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** Based on record review, observation, and staff interviews, the facility failed to accurately transcribe wound treatment orders for 1 of 2 residents reviewed for wound care (Resident #1).Findings included:Resident #1 was admitted on [DATE] with diagnoses which included hemiplegia and hemiparesis (weakness and paralysis) following cerebral infarction (stroke) and Type 2 Diabetes Mellitus.Resident #1's care plans included: I currently have a pressure ulcer to my sacrum and am at risk for development of additional pressure ulcers due to decreased ability to re-position andbowel/bladder incontinence, and immobility. This was initiated on 4/2/25 and most recently revised on 4/12/25. The Wound Physician assessed Resident #1 weekly; the dates included 5/6/25, 5/13/25, 5/20/25, 5/29/25, 6/5/25, 6/12/25, 6/19/25, 6/26/25, 7/3/25, 7/10/25, 7/17/25, 7/24/25, and 7/31/25. The Dressing Treatment Plan did not change and included: Primary Dressing alginate calcium with silver apply once daily and as needed. The Secondary Dressing included an island dressing with borders to cover the Primary Dressing. Resident #1's May 2025 Treatment Administration Record (TAR) noted orders: -Apply silver alginate, cover with dry dressing, every day shift. This was signed as administered 5/1/25 through 5/7/25 and 5/8/25 through 5/20/25. Noted as discontinued 5/21/25.-Apply calcium alginate, cover with dry dressing, every day shift. This was signed as administered 5/22/25 through 5/24/25 and 5/26/25 through 5/31/25.Resident #1's June 2025 TAR noted order: -Apply calcium alginate, cover with dry dressing, every day shift. This was noted as completed daily except for 6/9/25, 6/12/25 and 6/19/25. Resident #1's most recent quarterly Minimum Data Set assessment dated [DATE] indicated she had moderate cognitive impairment, dependent for all activities of daily living, had one stage 3 pressure ulcer, and had received pressure ulcer care.Resident #1's July 2025 Treatment Administration Record noted orders: -Apply calcium alginate, cover with dry dressing, every day shift. This was documented as administered every day. Resident #1's August 2025 Treatment Administration Record noted orders: -Apply calcium alginate, cover with dry dressing. every day shift, every Monday, Wednesday and Friday. One treatment was documented as completed on Monday 8/4/25.A wound care observation and interview was conducted on 8/5/25 at 9:10 AM with the Treatment Nurse. The sacral wound was cleaned with wound cleanser and gauze pads. A piece of alginate calcium with silver was applied to the wound and was covered with an island dressing. The wound appeared as a light pink area on the sacrum, approximately 2 centimeters (cm) long and 1 cm wide with no discernable depth. The Treatment Nurse explained Resident #1's wound had healed and then reopened. He stated she has been seen by the Wound Physician weekly since April when the wound reopened and was now nearly healed. An interview with the Treatment Nurse was conducted on 8/6/25 at 2:37 PM. When asked about the discrepancy in the treatment orders, the nurse explained it had been an oversight on his part to not transcribe the treatment orders correctly. He further explained that although he had transcribed the order incorrectly, the correct treatment had been provided to Resident #1. An interview with the Wound Physician was conducted on 8/7/25 at 12:30 PM via phone. He stated the person who had transcribed the order may have forgotten to add the silver detail. He stated the order should have been transcribed correctly but if the regular alginate calcium without silver had been used, it would not have been detrimental to the wound healing for Resident #1. He stated the silver added antimicrobial protection. He explained Resident #1 had multiple comorbidities and her sacral pressure ulcer was nearly healed. An interview with the Director of Nursing (DON) was conducted on 8/7/25 at 12:49 PM. She stated she would expect wound care orders to be transcribed correctly. During an interview with the Administrator on 8/7/25 at 1:36 PM he stated physician orders should be transcribed correctly.