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 04/30/2015

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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code residents with a level II Preadmission Screening and Resident Review (PASRR) on the Minimum Data Set (MDS) assessments for 3 of 3 sampled residents reviewed, Residents #2, #52 & # 96). Findings	F 278	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alledged deficiencies To remain in compliance with all federal	5/13/15

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

Electronically Signed | 05/11/2015

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F 278	Continued From page 1 included: 1. Resident #96 was admitted to the facility on 3/30/15 with multiple diagnoses including dementia. Review of the records revealed that Resident #96 was assessed by the state as level II PASRR with a number ending in an " F " . The admission MDS assessment dated 4/6/15 indicated that Resident #96 was not a level II PASRR. On 4/30/15 at 10:25 AM, the MDS Nurse was interviewed. She acknowledged that Resident #96 was a level II PASRR. She reviewed the admission MDS dated 4/6/15 and stated that it was coded incorrectly, it should have been coded as level II PASRR but it was not. She added that she will correct the MDS. 2. Resident #52 was admitted to the facility on 4/2/10 with multiple diagnoses including bipolar disorder. Review of the records revealed that Resident #52 was assessed by the state as level II PASRR with a number ending in a " B " . The annual MDS assessment dated 11/6/14 indicated that Resident #52 was not a level II PASRR. On 4/30/15 at 10:2 AM, the MDS Nurse was interviewed. She acknowledged that Resident #52 was a level II PASRR. She reviewed the annual MDS dated 11/6/14 and stated that it was coded incorrectly, it should have been coded as level II PASRR but it was not. She added that she will correct the MDS. 3. Resident #2 was admitted to the facility on 6/1/14 with multiple diagnoses including cerebral palsy and intellectual disability. Review of the records revealed that Resident #2 was assessed by the state as level II PASRR with a number	F 278	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 1.Corrective action taken for the residents affected: All MDS□s were corrected on 4.30.15 for the three residents that were identified during the annual survey by the RN MDS Coordinator 2. Corrective action for those residents with the potential of being affected: RN MDS coordinator did 100% review of PASRR level2 to ensure coding accuracy this was done on 4.30.15 by the MDS Coordinator and all corrections were completed by 5.8.15 and transmitted to the state. 3. Systemic changes: Documented education was done for the MDS coordinator by the RN MDS Consultant to prevent future coding inaccuracies related to the PASRR this was done on 4.30.15.The inservice included PASRR-alpha descriptions and their meanings. The Admissions Coordinator enters PASRR level2 information into Point Click Care (facility software) on every admission. The MDS Coordinator checks PASRR level 2 information in Point click care before submitting MDS to ensure accurate coding of the level 2 PASRR. The	

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F 278	Continued From page 2 ending in a " B " . The annual MDS assessment dated 7/2/14 indicated that Resident #2 was not a level II PASRR. On 4/30/15 at 10:25 AM, the MDS Nurse was interviewed. She acknowledged that Resident #2 was a level II PASRR. She reviewed the annual MDS dated 7/2/14 and stated that it was coded incorrectly, it should have been coded as level II PASRR but it was not. She added that she will correct the MDS.	F 278	Admissions Coordinator also communicates the information to the MDS Coordinator internally to ensure she receives the level 2 information on admission or if there are any changes with the resident PASRR level. 4.Quality Assurance: The facility has developed a QA tool to do audit related to PASRR section of MDS. The audit will be done weekly by the DON/or RN Staff Development Coordinator for 4 weeks, then monthly x 8 weeks. This will be part of the facility QA to ensure continued accuracy. The DON will take the audit information to the facility QA team for the quarterly QA meeting. 5. Date of completion: This will be completed by 5.13.15	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		5/13/15

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F 431	Continued From page 3 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to date a protein supplement and a pain reliever when opened on 1 of 4 medication carts observed (300 hall cart). The findings included: On 4/30/15 at 11:29 PN the cart on 300 hall was observed. An open bottle of Prostat (protein supplement), and an open bottle of Uristat (for urinary pain management) were observed with no date of opening. The instruction on the bottle of the Prostat and Uristat read " discard 3 months after opening." On 4/30/15 at 11:32 PM Nurse #1 was interviewed. She acknowledged that the bottles did not have a date of opening and were almost	F 431	The statement 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. 1. Corrective action for resident affected The bottles of Prostat and Uristat were removed immediately.	

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F 431	Continued From page 4 empty. She also stated that she was unaware the bottles required dating upon opening. On 4/30/15 at 4 PM Administrative Staff #1 was interviewed. She indicated that it was her expectation that staff date bottles of Prostat and Uristat upon opening.	F 431	2. Corrective action for potential residents to be affected The three other medication carts were checked by the DON on 4.30.15 to ensure medication properly dated after being opened and bottles discarded if no date on bottle. The 4th cart was also rechecked by the DON on 4.30.15 3. Systemic changes All Licensed Nurses were educated on Prostat and Uristat by the SDC (staff development coordiantor) and the facility policy to date these bottles when opened. The education was done on 4.30.15 4. QA The facility has developed a QA tool to do audits of the medication carts to ensure all Prostat and Uristat properly dated This will be done daily (Monday-Friday)by the DON or SDC x 4 weeks, then weekly x 4 weeks, then monthly x 1 month to ensure compliance. This will be part of the facility QA to ensure continued compliance.The DON will take the results of the QA to the facility quarterly QA meeting to report results. This will also be added to the nurse general orientation. 5. Date of completion is 05.13.15	