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 09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL NURSING AND REHABILITATION CENTER	3000 HOLSTON LANE RALEIGH, NC 27610

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 8/31/21 to 9/1/21. Event ID Q65Q11. 7 of the 7 complaint allegations were not substantiated.	F 000		
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 observation, record review and staff interview, facility staff failed to notify the treatment nurse to assess and apply a dressing to a stage 3 pressure ulcer for 1 of 1 resident observed with a pressure ulcer (Resident #67). The findings included: Resident #67 was admitted to the facility on 7/29/21 and had a diagnosis of dementia and sepsis. The Admission Minimum Data Set (MDS) Assessment dated 8/5/21 noted the resident had	F 686	For the affected resident, Resident #67, the resident's wound dressing was only attached on one side, and was visibly soiled with serosanguineous drainage. NA #2 re-covered the wound, with the soiled dressing, instead of getting assistance from the nurse, and dressed the resident for discharge. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 9/10/2021 the Director of	9/14/21

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

Electronically Signed | 09/13/2021

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F 686	Continued From page 1 severe cognitive impairment and required extensive assistance for bathing, personal hygiene and dressing and total assistance for toileting. The MDS noted the resident was frequently incontinent of bowel and bladder and had one unstageable pressure ulcer with slough or eschar that was present on admission to the facility. Slough refers to a yellow/white material in the wound bed and eschar is dead tissue that is typically tan, brown or black and may be crusty. The resident's active care plan dated 8/4/21 noted the resident had an unstageable pressure ulcer to the sacrum and was at risk for additional pressure ulcers due to decreased ability to reposition and incontinence. One of the interventions was to report a loose dressing to the treatment nurse. On 9/1/21 at 9:45 AM, Nursing Assistant (NA) #2 was observed to provide a bath and peri-care for the resident. The NA turned the resident onto her right side to bathe her back and a dressing over the sacral area was noted to be attached with tape on the left side of the resident's sacrum and was not attached to the rest of the wound and a very large open wound was observed on the sacrum. The dressing was mostly saturated with a serosanguineous drainage. Serosanguineous drainage is pale red or pink in color. When the bath was completed, the NA placed the unattached part of the dressing back over the wound and proceeded to place a clean incontinent brief on the resident, dressed the resident and placed the resident in a wheelchair. During the care, the NA stated she was told to get the resident bathed and dressed and in her chair that "they" were going to pick her up in 15 minutes. The NA stated she did not know where	F 686	Nurses, and staff nurses audited all residents with pressure ulcer dressings to ensure there were no new concerns identified with leaving dressings in place when they are soiled or not attached properly. This was accomplished by looking at dressings for all five residents with pressure ulcers in the facility. 5/5 residents were found with clean dressings, and the dressings were appropriately attached. This process was completed by 9/10/2021. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 9/8/2021, the Director of Nurses, and her designees began an in-service education to all full time, part time, and as needed nurses and CNA's. Topics included: •When a wound dressing needs to be changed, and how it should be changed. 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 CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training by September 13, 2021 will not be allowed to work until training has been completed.	

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F 686	Continued From page 2 the resident was going. On 9/1/21 at 9:55 AM an interview was conducted with NA #2. The NA stated usually she would tell the wound nurse about the dressing but since they were rushing her, she just put the same dressing back over the wound. On 9/1/21 at 9:58 AM, Nurse #1 stated in an interview the resident was being discharged home today and her family was on the way to the facility to pick up the resident. The Director of Nursing (DON) was present during the interview and was made aware of the care observed and the DON directed the nurse to go in to assess and redress the wound. On 9/1/21 at 12:50 PM an interview was conducted with the resident's Responsible Party who stated the resident was not eligible for Medicaid and the family had located an assisted living facility who was able to meet her needs and that is where they took the resident upon discharge from the nursing home. On 9/1/21 at 10:02 AM the Director of Nursing stated in an interview that the expectation was for the NA to notify the nurse so the nurse could go in and assess the wound.	F 686	3. 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, and/or her designee will utilize the QA tool for Pressure Ulcer Dressing Replacement. The Director of Nurses, and/or her designee will monitor residents with pressure ulcers for 2 weeks, then monthly for 3 months, for dressing changes made when needed by observing dressing changes during the audit to ensure they are not soiled or detached. This tool will be completed as stated above or until such time that the QA Committee determines the need to change the frequency of the audit (when it has been determined that sustained compliance has been achieved). Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director, and Consulting Pharmacist.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		9/14/21

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F 690	Continued From page 3 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to use the correct technique when providing peri-care for 1 of 2 residents observed to receive incontinence care (Resident #67) and failed to maintain a catheter drainage bag off of the floor for 1 of 3 residents observed with an indwelling urinary catheter (Resident #36).	F 690	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	

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F 690	Continued From page 4 The findings included: 1. Resident #67 was admitted to the facility on 3/31/17 and had a diagnosis of dementia. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 6/28/21 noted the resident had severe cognitive impairment, was not ambulatory and required total assistance with toileting and extensive assistance with personal hygiene. The MDS noted the resident was incontinent of bowel and bladder. The resident's active care plan noted the resident had an ADL (activities of daily living) self-care performance deficit related to dementia and required staff assistance with personal hygiene. On 9/1/21 at 10:38 AM Nursing Assistant (NA) #1 was observed to provide incontinence care for Resident #67. The resident was observed to be lying on her back and the NA used pre-moistened wipes to clean the resident's perineal area and cleaned from front to back. The NA then assisted the resident to turn onto the left side and proceeded to clean the resident's bottom from back to front, towards the urinary urethra and stool was observed on the wipe. The NA obtained a clean wipe and again cleaned the resident from back to front several times until no more stool observed on the wipes. On 9/1/21 at 10:40 AM the NA was asked how she was trained to wipe when providing incontinence care and the NA stated: "I did it wrong. I'm sorry." On 9/1/21 at the completion of care the NA was	F 690	constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice: For the affected resident, Resident #67, NA# 1 failed to use the correct technique when providing peri-care. Additionally, Resident #36, facility failed to maintain catheter drainage bag off of the floor. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. For affected Resident #67, surveyor stopped NA#1 before she continued to use incorrect technique for providing peri-care. For Resident #36, the DON raised her bed to a higher position to ensure the bag was completely off of the floor. The DON immediately educated NA#1 on the facility□s policy regarding peri-care and foleys. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: An audit was completed on 9.10.2021, by the Administrator, of all residents with catheters to ensure catheter bags were away from the floor and devices were in place to ensure they stay in place. The audit showed 100% of residents□ catheter bags were away from the floor. An audit was completed on 9.13.2021, by the Director of Nursing, or her designee,	

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F 690	Continued From page 5 asked how she was supposed to clean during incontinence care and the NA stated: "Front to back." The NA was asked why she cleaned back to front and the NA stated: "I made a mistake." The Director of Nursing stated in an interview when doing peri-care the staff should clean the resident front to back. 2.Resident #36 was admitted to the facility on 4/28/21 with diagnoses of chronic obstructive pulmonary disease, diabetes mellitus, neurogenic bladder, sleep apnea and hypertension. The most recent Minimum Data Set assessment completed on 7/27/21 revealed the resident was mildly cognitively impaired. Resident #36 required extensive assistance with activities of daily living (ADLs) and had an indwelling catheter. Review of the physician orders dated 4/28/21 revealed an order for catheter care every shift. Provide foley stabilization device or leg strap (to prevent the catheter tubing from pulling). Check every day and change every 7 days and as needed. An observation of Resident #36 was conducted on 9/01/21 at 9:15 AM. Resident #36 was laying in the bed. The catheter bag was lying on the floor. An observation of Resident #36 was conducted on 9/01/21 at 9:48 AM with the Director of Nursing (DON). Resident #36 was laying in the bed. The catheter bag was lying on the floor.	F 690	of all nurses and CNAs to ensure they can provide return demonstration of how to correctly provide peri-care. 100% of nurses and CNAs provided peri-care according to the policy during the audit. 3. Systemic Changes: On 9/8/2021, the Director of Nurses, and her designees began an in-service education to all full time, part time, and as needed nurses and CNA□s. Topics included: "How to perform peri-care for both female and male residents "How to situate foley bags to ensure they do not touch the floor, and they are draining freely 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 CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training by September 13, 2021 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.	

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F 690	Continued From page 6 An interview was conducted with the Director of Nursing on 9/01/21 at 9:50 AM. She stated if the nurse aide was unsure about the placement of the catheter bag, she should have asked the nurse. The DON stated staff were expected to keep the catheter bag off the floor. An interview was conducted on 9/01/21 at 10:04 AM with NA #2. She stated she had raised the resident ' s bed at breakfast, and she was not aware the catheter bag was on the floor. She stated she had been educated to keep catheter bags off the floor and if she had seen the bag, she would have picked it up off the floor. An interview was conducted on 9/01/21 at 10:42 AM with the Administrator and informed of the resident ' s catheter bag was on the floor. The Administrator stated staff were expected to keep catheter bags off the floor.	F 690	The Director of Nursing, or designee will monitor residents□ catheters daily for 2 weeks and then weekly for 2 weeks then monthly for 3 months for compliance with catheter policy. Additionally, the Director of Nursing, or designee will monitor 5 resident□s receiving peri-care once per week for 2 weeks, and then monthly for 3 months to ensure compliance with facility□s policy regarding peri-care. The Administrator or Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Dietary Manager, Maintenance Director, Social Work Director, Infection Control Nurse, and Rehab Director.	