STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol City Rehab and Healthcare Center	2425 25th Street SE Washington, DC 20020

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews for one (1) of three (3) sampled residents, the facility staff failed to notify the State Agency of an allegation of abuse/neglect or injury of unknown origin within 24 hours of an incident involving Resident #1 who was found by staff with bloodied bed linens and with cuts to his right wrist from a disposable razor on [DATE]. The findings included: A review of the facility's policy titled Abuse, Neglect and Exploitation dated revised on [DATE] documented the following: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified time frames: Immediately, but not later than 2 hours after the allegation is made, If the events that cause the allegation involve abuse or result in serious bodily injury or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Paranoid Personality Disorder, Personal History of Transient Ischemic Attack (TIA) and Cerebral Infarction Without Residual Deficits, Adult Failure to Thrive and Hereditary Ataxia. A review of a Facility Reported Incident (FRI) DC00013591, submitted to the State Agency on [DATE] at 1:19 PM documented the following: (Resident name) was observed with lacerations on his wrist. Resident sustained laceration from his disposable shaving razor. Resident was assessed by the licensed nurse. Resident expressed suicidal ideation and was transferred to the hospital for further assessment. Investigation initiated. It is noted that at the time of this investigation Resident #1 remained hospitalized . A review of Resident #1's medical record revealed the following: A nursing progress note dated [DATE] at 6:24 PM documented Late Entry Resident was noted with self-inflicted multiple laceration on the right wrist. Suicidal. When asked, resident stated that I'm depressed and suicidal Resident was found with multiple self-inflicted lacerations on right wrist using a disposable shaving razor. DNP (Doctor of Nursing Practice) (Employee Name) gave one time order wound care and to send resident via 911 for suicidal ideation. Resident was transferred to (Hospital Name) at 7:05 PM. Resident and RP (Resident Representative) made aware. (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
	095022	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol City Rehab and Healthcare Center	2425 25th Street SE Washington, DC 20020

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated [DATE] at 10:44 PM documented Hospital Transfer: 3 officers arrived first before EMS (emergency medical services) arrived at approximately 6:40 PM, lead by officer (officer name) with badge ID #4115. The following transfer documentation was sent with the resident: Face sheet, H&P (history and physical), MOST (Medical Orders for Scope of Treatment Form), Medication list, care plan goals, DNP (Doctor of Nursing Practice) order to transfer resident to hospital and transfer location. It is noted that the incident in which staff observed the resident with cuts to his wrist occurred on [DATE] sometime before 7:05 PM, however the facility staff did not report the incident to the State Agency until [DATE] at 1:19 PM. During a telephone interview conducted on [DATE] at approximately 1:00 PM with Employee #8 stated that the nurse told them there was blood on the bed and upon assessment the resident was bleeding from his wrist and the resident had a disposable razor and told the nurse he wanted to die. During a face-to-face interview conducted on [DATE] at approximately 12:40 PM, Employee #3 (Director of Nursing) acknowledged the findings and stated that the facility leadership submitted the incident when they returned on Monday ([DATE]) following the incident and the weekend staff have been receiving on-going training.

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	095022	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol City Rehab and Healthcare Center	2425 25th Street SE Washington, DC 20020

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews for one (1) of three (3) sampled residents, the facility staff failed to develop a comprehensive, person-centered care plan that documented the residents' use of a communication aid which the resident needed in order to communicate with others. The findings included: Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Paranoid Personality Disorder, Personal History of Transient Ischemic Attack (TIA) and Cerebral Infarction Without Residual Deficits, Adult Failure to Thrive and Hereditary Ataxia. A review of Resident #1's medical record revealed the following: A review of a document titled Speech Therapy SLP (speech language pathology) Discharge Summary date of service 04/25/24-07/10/24 documented the following LTG (long term goal) #1.0 Met on 06/04/24, Pt (patient) will increase communicative effectiveness from severely impaired to moderately impaired with use of trained strategies and use of aids. A review of the care plan focus area (Resident #1) presents with cognitive and/or communication deficit r/t (related to) a diagnosis of ataxia dated revised on 01/22/25 had the following interventions: Communication: Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions- turn off TV (television), radio, close door etc. (Resident name) responds best to consistent, simple, directive sentences; provide resident with necessary cues. During a face-to-face interview conducted on 04/17/25 at 11:15 AM, Employee #7 (Speech Therapist) stated that the resident has declined based on her observations, and he is less motivated to use his communication aid. Employee #7 went on to explain that the communication aid consists of laminated pages with words and letters on it so that the resident can communicate with others. The resident is cognitively intact, but he has trouble communicating verbally due to the ataxia and it takes a long time for him to get his words out. During a face-to-face interview conducted on 04/17/25 at 12:41 PM, with Employee #6 (Unit Manager 3 South) stated that they go over the resident's general well-being and care during the Interdisciplinary team meetings and acknowledged that the care plan did not include the use of a communication aid to promote the resident's ability to communicate. It is noted that there is no documented evidence in the resident's care plan of the communication aid that the speech pathologist recommends for the resident to use in order to communicate with others. Cross Reference 22B DCMR Sec. 3210.4 (a)(c)