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	08/26/2025

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 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** Based on record reviews and staff interviews, for one (1) of eleven (11) sampled residents, facility staff failed to ensure that a care plan meeting was held or that a comprehensive care plan review was done at least quarterly (every 90 days) for one resident. Resident #11.The findings included:Resident #11 was admitted to the facility on [DATE] with multiple diagnoses that included: Schizophrenia, Hypertension and Major Depressive Disorder.Review of the resident's medical record revealed:A face sheet that showed the resident had a legal guardian.05/14/25 at 5:34 PM Care Plan Meeting Note: Readmission/Quarterly care plan meeting: IDT (interdisciplinary team) reviewed resident's plan of care, medication, diet, and EOL (end of life) planning. [Resident #11] is a LTC (long term care) resident. Code Status: DNR (do not resuscitate). Resident has no funeral arrangement in place. IDT will continue to monitor and assist.A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 00, indicating severe cognitive impairment.Continued review of the resident's medical record showed no documented evidence that the resident's comprehensive care plan was reviewed by the IDT; that a care plan meeting was held since 05/14/25 (102 days); or that the IDT reviewed and revised the care plan within seven (7) days of the Quarterly MDS assessment dated [DATE].During a face-to-face interview on 08/26/25 at 10:50 AM, the findings were brought to the attention of Employee #4 (Social Services Director) who acknowledged the findings and stated that the last care plan meeting for Resident #11 was on 05/14/25. When asked why a care plan meeting has not been held quarterly for the resident or within the seven days of the last MDS assessment, Employee #4 stated, I am not sure why it's been over 90 days since the last care plan meeting. I would have to check and see what happened. A care plan meeting is scheduled for later this month. When asked for the scheduled date, Employee #4 stated, One is scheduled for next Tuesday (09/02/25).Cross Reference 22B DCMR Sec. 3210.4(c)

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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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. (continued on next page)

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F 0684 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 record reviews and staff interviews, for two (2) of eleven (11) sampled residents, facility staff failed to ensure that the residents received medications as ordered by the physician. Residents #1 and #2.The findings included:Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included: Epilepsy, Cerebral Infarction, and Benign Neoplasm of Cerebral Meninges.Review of the resident's medical record revealed the following:An Annual Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 09, indicating moderately impaired cognitive status.08/17/25 at 10:55 AM Nurses Note: - Positive for COVDI-19.- Nurse Practitioner (NP) made aware; ordered to transfer resident from room [ROOM NUMBER]A to room [ROOM NUMBER]A and for the resident to be on Paxlovid (antiviral medication to treat mild-to-moderate COVID-19) twice a day for 5 days. 08/17/25 at 11:09 AM Nurse Practitioner Progress Note: - Updated Plan - COVID-19 Positive:- Initiate Paxlovid (Nirmatrelvir-Ritonavir) Therapy Pack (150/100 mg (milligrams), take 2 tablets by mouth twice a day (BID) for 5 days. - The plan of care was discussed with the nursing staff.A care plan focus area, [Resident #1] is encouraged to practice social distancing to minimize exposure to COVID-19, initiated on 08/17/25 had interventions that included: Administer medications as ordered. A physician's order dated 08/19/25 directed, Paxlovid (150/100mg) oral tablet therapy pack 10 x 150 MG & 10 x 100MG (Nirmatrelvir-Ritonavir), give 2 tablets by mouth two times a day for COVID-19 infection for 5 Days.08/19/25 at 10:27 PM Orders Administration Note: Paxlovid (150/100) Oral Tablet Therapy Pack 10 x 150 MG & 10 x 100MG, give 2 tablets by mouth two times a day for COVID-19 infection for 5 Days. pharmacy called.08/20/25 at 3:12 PM Orders Administration Note: Paxlovid (150/100) Oral Tablet Therapy Pack 10 x 150 MG & 10 x 100MG, give 2 tablets by mouth two times a day for COVID-19 infection for 5 Days. pharmacy called.08/20/25 at 10:07 PM Orders Administration Note: Paxlovid (150/100) Oral Tablet Therapy Pack 10 x 150 MG & 10 x 100MG, Give 2 tablet by mouth two times a day for COVID-19 infection for 5 Days. Pharmacy called.08/22/25 at 6:15 PM Nurse Practitioner Progress Note: - Blood culture results were reviewed.- Blood culture (both bottles): Staphylococcus hominis (oxacillin-resistant coagulase-negative staphylococcus).- COVID-19 infection - Continue Paxlovid for COVID-19 as previously ordered.- The plan of care was discussed with the nursing staff.A Complaint #2598758 was received by the State Agency on 08/22/25 that documented in part: - Patients have been sick for roughly 10 days.- No one was provided with any medicine until yesterday.- Patient noted there was only one nurse on the floor and he was 'running round' trying to care for everyone.- Noted multiple medication errors both being given the wrong medicine and not being given any medicine at all.Review of Resident #1's Medication Administration Record (MAR) on 08/25/25 showed that the resident was ordered Paxlovid for 5 days BID, a total of 10 doses, but only received the medication for three 3 days (six doses) on 08/21/25, 08/22/25, with the final doses being administered on 08/23/25.2. Resident #2 was admitted to the facility on [DATE] with multiple diagnoses that included: Malignant Neoplasm of the Liver, Acute Embolism and Thrombosis and Hypertension.Review of the resident's medical record showed the following:A Quarterly MDS assessment dated [DATE] showed that facility staff coded: a BIMS summary score of 15, indicating intact cognitive response. Physician's orders dated 08/18/25 directed, Rapid COVID-19 test now; Vital signs every shift x 10 days notify MD (medical doctor)/NP of abnormal vital signs due to possible exposure to COVID-19; Resident is transfer from room [ROOM NUMBER]B to room [ROOM NUMBER]A for positive COVID-19.08/18/25 at 8:50 PM Nurse Practitioner Progress Note: - Patient reports not feeling well, experiencing muscle aches, and a cough. Denies chest pain. Notes mild shortness of breath, but no acute respiratory distress.- Assessment - COVID-19 infection.- Plan - Paxlovid (150/100 mg) PO BID x5 days as prescribed.- The plan of care was discussed with the nursing staff.A physician's orders dated 08/19/25 directed, Paxlovid (150/100) Oral Tablet Therapy Pack 10 x 150 MG & 10 x 100MG (Nirmatrelvir-Ritonavir), give 2 tablets by mouth two times a day for Covid-19 positive for 5 Days.08/19/25 at 3:37 PM Orders Administration Note: Paxlovid (150/100) Oral Tablet Therapy Pack 10 x 150 MG & 10 x 100MG, give 2 tablets by mouth two times a day for Covid Positive for 5 Days. Pharmacy called, order updated.08/19/25 at 10:26 PM Orders Administration Note: Paxlovid (150/100) Oral Tablet Therapy Pack 10 x 150 MG & 10 x 100MG, give 2 tablets by mouth two times a day for Covid Positive for 5 Days pharmacy called.A care plan focus area, the resident is positive for COVID-19, and is on isolation for droplet and contact precaution, initiated on 08/19/25 had interventions that included, Antiviral therapy as ordered by the

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, for one (1) of eleven sampled residents, facility staff failed to minimize risks to a resident receiving intravenous (IV) therapy as evidenced by failing to label and date, as appropriate, the IV infusion tubing. Resident #1.The findings included:A facility policy titled, Intravenous Therapy dated 06/25/25 documented:- All IV tubing is to be labeled with date, time and initials.Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included: Epilepsy, Cerebral Infarction, and Benign Neoplasm of Cerebral Meninges.Review of the resident's medical record revealed the following:An Annual Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 09, indicating moderately impaired cognitive status.08/22/25 at 6:15 PM Nurse Practitioner Progress Note: - Blood culture results were reviewed.- Blood culture (both bottles): Staphylococcus hominis (oxacillin-resistant coagulase-negative staphylococcus).- Plan - Start Vancomycin (type of antibiotic)1 g (gram) IV (intravenous) every 12 hours for 14 days. May obtain midline for IV administration.A physician's order dated 08/22/25 directed, May get a midline for IV administration.A physician's order dated 08/23/25 directed, Vancomycin HCl (hydrochloride) intravenous solution reconstituted 1 GM, use 1 gram intravenously two times a day for Bacteremia for 14 days.08/24/25 at 2:05 PM Nurses Note:- Resident had left upper arm single lumen midline was placed. - Resident tolerated procedure well. - Vancomycin 1gm given via midline. - No adverse reaction noted. During an observation on 08/25/25 at 9:16 AM, Resident #1 was observed in her room. The resident was noted with left upper arm midline IV site, that was connected to an infusion tubing, that was connected to IV infusion tubing, that was connected to an empty IV Vancomycin medication bag. It should be noted that the IV tubing infusion set was not labeled with date, time or initials. During a face-to-face interview at the time of the observation, Employee #5 (Licensed Practical Nurse/LPN) stated, I am not sure who hung this bag or when, so I will discard it. I was just coming in give the 8:00 AM dose now.The evidence showed that facility staff failed to minimize risks to Resident #1 who was receiving intravenous (IV) therapy by failing to label and date, as appropriate, the infusion tubing.During a face-to-face interview on 08/25/25 at 2:30 PM, the findings were brought to the attention of Employee #2 (Director of Nursing/DON). The employee acknowledged the findings and stated that education will be provided to the licensed nursing staff.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, for one (1) of eleven (11) sampled residents, facility staff failed to demonstrate competent nursing competencies and skills sets to provide safe nursing services as evidenced by a licensed nurse crushing resident medications that were labeled, Do not crush and without a physician's order. Resident #11. The findings included:A facility policy titled Medication Administration dated 06/11/25 documented:- Administer medication as ordered in accordance with the manufacturer specifications. Resident #11 was admitted to the facility on [DATE] with multiple diagnoses that included: Schizophrenia, Hypertension and Major Depressive Disorder. Review of the resident's medical record revealed:A physician's orders dated 05/13/25 directed, Ferrous Sulfate (iron supplement) oral tablet 325 MG (milligrams), give 1 tablet by mouth one time a day related to Anemia.A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 00, indicating severe cognitive impairment; had an active diagnosis of Anemia; had signs of swallowing disorder; and was on a mechanically altered diet. A physician's orders dated 07/31/25 directed, Potassium Chloride [NAME] ER (extended release) 20 MEQ (milliequivalent) tablet, give 1 tablet by mouth one time a day for Hypokalemia.During a medication administration observation on unit 3 south on 08/26/25 at 9:00 AM, Employee #6 (Licensed Practical Nurse/LPN) was observed crushing Resident #11's Ferrous Sulfate 325mg tablet and the Potassium Chloride 20 MEQ ER tablets and putting them in applesauce to administer to the resident. When asked why she crushed Resident #11's medications, Employee #6 stated, [Resident #11] gets all her medications crushed in applesauce because she has a swallowing issue and is on a thickened liquid diet. It should be noted that the blister packet for the Ferrous Sulfate 325mg tablets and the Potassium Chloride 20 MEQ ER tablets documented Do not crush. It should also be noted that the resident did not have a physician's order to crush any of her medications. The evidence showed that facility staff failed to demonstrate competent nursing competencies and skills sets to provide safe nursing services as evidenced by a licensed nurse crushing Resident #11's medications that were labeled Do not crush and without a physician's order.During a face-to-face interview on 08/26/25 at 9:34 AM, the findings were brought to the attention of Employee #7 (3 south Unit Manager). The employee acknowledged the findings and stated [Resident #11] used to be on liquid Potassium and had a previous order to crush crushable medications. I will call the doctor to rectify the orders. Employee #7 further stated that education would be provided to Employee #6.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation and staff interviews, facility staff failed to ensure that the medication error rate was less than 5%. The findings included: A facility policy titled Medication Administration dated 06/11/25 documented:- Administer medication as ordered in accordance with the manufacturer specifications.During a medication administration pass on unit 3 south on 08/26/25 at 9:00 AM with Employee #6 (Licensed Practical Nurse/LPN), two (2) medication errors were observed in five (5) opportunities, equaling a medication error rate of 40%. Employee #6 was observed crushing two (2) medications that had manufacturer labeled specifications to Do not crush on the blister packets. During a face-to-face interview at the time of the observation, Employee #6 was asked why she crushed the medications. Employee #6 stated, The resident gets all her medications crushed in applesauce because she has a swallowing issue and is on a thickened liquid diet. During a face-to-face interview on 08/26/25 at 9:34 AM, the findings were brought to the attention of Employee #7 (3 south Unit Manager) who acknowledged the findings and stated, I will call the doctor to rectify the orders. Employee #7 further stated that education would be provided to Employee #6.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews and staff interviews, facility staff failed to implement infection control policies and procedures as evidenced by multiple staff observed not following posted personal protective equipment (PPE) requirements throughout the facility.The findings included: Review of the facility's Infection Prevention and Control Program dated 06/27/25 documented:- Staff include all facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, and others who provide care and services to residents on behalf of the facility. - All staff are responsible for following all policies and procedures related to the infection control program.- All staff shall use PPE according to established facility policy governing the use of PPE. A facility tour was conducted on 08/22/25 starting at 4:26 PM with Employee #3 (Infection Preventionist). It should be noted that the facility was in a current outbreak with 16 residents positive for COVID-19. Employee #3 stated that unit 2 north was the designated COVID-19 unit. At the entrance of unit 2 north, there was sign posted on the doors that documented, Faceshield (eye protection) and mask (surgical mask) required at all times. At approximately 4:45 PM, two (2) nursing staff were observed on unit 2 north not wearing face shields (eye protection) by the surveyor and Employee #3. Employee #3 acknowledged that the two employees failed to follow posted PPE requirements for unit 2 north and stated that education would be provided.During a second observation on 08/25/25 at 9:09 AM, a new signage was posted at the entrance doors to unit 2 north that documented, N95 mask and face shield required only for staff. 2. On 08/25/25 at approximately 9:45 AM, a dietary staff observed on unit 2 north not wearing a N95 mask or a face shield by the surveyor and Employee #3. Employee #3 acknowledged that the dietary staff failed to follow posted PPE requirements for unit 2 north stated that education would be provided.The evidence showed that facility staff failed to ensure that infection control procedures were implemented as evidenced by facility staff not following posted PPE requirements for being on the facility's COVID-19 unit.Cross Reference 22B DCMR Sec. 3217.6

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, for one (1) of 11 sampled residents, facility staff failed to administer the COVID-19 immunization as ordered for Resident #7. The findings included:Review of the facility's Infection Prevention and Control Program dated 06/27/25 documented:- Residents and staff will be offered the COVID-19 vaccine when supplies are available to the facility.- The resident's medical record includes documentation that included each dose of COVID-19 vaccine administered, if the resident did not receive the COVID-19 vaccine, the reason(s) why. Resident #7 was admitted to the facility on [DATE] with multiple diagnoses that included: Type 2 Diabetes Mellitus, Congestive Heart Failure and Alzheimer's Disease. Review of the resident's medical record revealed the following: A face sheet that documented the resident's daughter as her responsible party (RP).An immunization record that showed that the last COVID-19 booster vaccine that Resident #7 received was on 09/14/22.A Significant Change Minimum Data Set (MDS) assessment dated [DATE] showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 04, indicating severe cognitive impairment.A physician's order dated 02/19/25 directed, Comirnaty Intramuscular Suspension Prefilled Syringe 30 MCG (micrograms)/0.3 ML (milliliters) (COVID-19 (SARS-CoV-2) mRNA Virus Vaccine), inject 0.3 ml intramuscularly every day shift for COVID-19 immunization for 1 Day.08/22/25 at 10:30 PM Nurses Note:- COVID-19 rapid test was done, and resident is positive. - Nurse Practitioner notified, order given to transfer resident to unit 2 north. - RP was notified. Review of the February 2025 Medication Administration Record (MAR) for February 2025 showed that on 02/19/25, the area marked Comirnaty Intramuscular Suspension Prefilled Syringe 30 MCG (micrograms)/0.3 ML (milliliters) (COVID-19 (SARS-CoV-2) mRNA Virus Vaccine), inject 0.3 ml intramuscularly every day shift for COVID-19 immunization for 1 Day was blank, meaning not administered by facility staff. During a face-to-face interview on 08/25/25 at 2:30 PM, Employee #3 (Infection Preventionist) stated that he has a spreadsheet where he keeps track of all resident vaccinations that gets updated every two weeks. When asked, Employee #3 stated that he was not aware that Resident #7 had an order for the COVID-19 vaccine on 02/19/25 or that there was no documented evidence it was never administered. The process is to get consent from the resident if they are alert and oriented. If not, we reach out to the family/RP to get consent. Once consent is obtained, the order is placed for the nurse to administer the vaccine, and the unit manager is to follow up.The evidence showed that facility staff failed to administer the COVID-19 immunization as ordered for Resident #7.Cross Reference 22B DCMR Sec. 3231.12(k)