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	11/13/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, facility staff failed to follow a physician order with timeliness, as evidenced by the transfer of a resident to the emergency room for a higher level of care approximately three (3) hours after receiving the order for one of three sampled residents. Resident #20 The findings included: Resident #20 was admitted to the facility on [DATE] with multiple diagnoses that included: Chronic Sacral Wound, Ambulatory Dysfunction, Diabetes Mellitus and Bipolar Disorder. An admission Minimum Data Set (MDS) assessment dated [DATE] documented that resident had a Brief Interview for Mental Status summary score of 13 indicating that the resident was cognitively intact. Additionally, the resident was coded for being dependent on staff for all activities of daily living and having an unstageable sacral pressure ulcer. A physical medicine and rehabilitation note dated 09/02/25 at 5:18 PM documented in part, Pt (patient) at bedside, alert some disorientation, asking about the location of her bed at home. A physician's order dated 09/02/25 at 7:48 PM instructed in part, CBC (Complete Blood Count) with diff (differential).stat[lab]. A nurse practitioner's note dated 09/02/25 at 11:47 PM documented in part, On 9/2/25, nursing staff requested evaluation for possible change in status. Patient was seen at bedside with family present, alert and verbal, though not at her cognitive baseline per staff report. Assessment, Leukocytosis WBC 20.8[results from CBC lab], Mild change in mental status but no overt encephalopathy. Monitoring: Continue close monitoring of vital[signs], mental status, and wound. Nursing staff notified to report any acute change promptly. A physician's order dated 09/03/25 at 12:12 AM instructed, Chest X-Ray to evaluate for pneumonia. A review of a Situation, Background, Assessment, and Recommendation report dated 09/03/25 at 10:51 AM documented in part, Resident is increasingly confused and pale, unable to verbalize name and present location. A nursing note dated 09/03/25 at 12:38 PM documented in part, Resident had chest x-ray done, laboratory work was carried out as well. NP/DNP [nurse practitioner] reviewed result with care team, new order for IV [intravenous] line placement, antibiotic Meropenem [antibiotic medication] was received Stat. A nursing progress note dated 09/03/25 at 13:42 [1:42 PM] documented in part, Resident were [was] seen by wound team provider, noted area red with smell serous drainage on old dressing and tender to touch. A review of a chest x-ray results dated 09/03/25 documented in part, Impressions: Early changes of infrahilar atelectasis or pneumonia. A nursing progress note dated 09/03/25 at 13:58 [1:58 PM] documented in part, Radiology result reviewed with NP/DNP [nurse practitioner]. Order given for ER [emergency room] transfer. According to the District of Columbia's Office of Unified Communications (OUC), emergency medical services (EMS - 911) was activated via telephone call from the nursing facility at 16:47 [4:57 PM]. The resident was subsequently transported to a local hospital. It should be noted that Employee #5 activated EMS (called 911) approximately three (3) hours after the Nurse Practitioner ordered Resident #20 to be transferred to the hospital. A Department of Health Complaint Intake #2616177 submitted on 09/12/25 documented in part, My daughter went to visit. [Resident#20] and found her unresponsive. I had been complaining to the nurses that [Resident #20] did not seem like herself. She appeared pale and almost unresponsive. Her [pressure] wound became infected . [Staff]only called an ambulance after my daughter alerted them around 4:15 PM. [on 09/03/25] that she was having a hard time [waking (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #20] up. During a telephone interview on 10/20/25 at 9:34 AM, Employee #5 (assigned LPN) stated that she coordinated the resident's transfer to the emergency room (ER). The employee said that at the time of transfer the granddaughter in the resident's room, and the resident seemed off [disoriented]. Because when she asked the resident what her name was? She was saying something that was not her name. The employee also stated that she received the order to transfer the resident to the emergency room at approximately 1:58 PM 09/03/25. However, she could not explain why she did not coordinate the residents' transport (EMS 911) to the ER until 4:57 PM (approximately three hours after receiving the order). During a telephone interview conducted on 10/20/25 at 2:00 PM with Employee #6 (Nurse Practitioner) she stated that on the evening shift around 4 to 5pm [between 4:00 PM to 5:00 PM] on 9/2/2025 the nurse called. I believe I saw her [Resident #20] at the bedside; her vital signs were fine. A family member was at the bedside, [I] ordered some stat labs.the next day [09/03/25] in the afternoon around 1 to 2-ish [between 1:00 PM and 2:00 PM] the staff called me saying she [Resident #20] had altered mental status, so I ordered for the resident to be sent out. During a face-to-face interview conducted on 10/20/25 at approximately 4:00 PM with Employee #1 (Administrator) and Employee #2 (Director of Nursing) they acknowledged the findings.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and staff interviews for one (1) of 12 sampled residents, the facility staff failed to show accurate documentation for a resident who was dependent on staff for Activities of Daily Living care and ensured he was offered and provided a shower or bath on scheduled days as prescribed by the physician. Resident #1.Based on record review and staff interviews for one (1) of 12 sampled residents, the facility staff failed to show accurate documentation for a resident who was dependent on staff for Activities of Daily Living care and ensured he was offered and provided a shower or bath on scheduled days as prescribed by the physician. (Resident #1) The findings included: Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included: Diabetes Mellitus, Peripheral Neuropathy, Lumbar Spine injury s/p (status post) Laminectomy and Spinal Fusion on Thoracic 11-L (Lumbar) 3 and chronic Lower Extremity Lymphedema.A review of Resident #1's medical record revealed:A physician's order dated 10/24/24 documented, Resident to receive bath/shower two times per week and PRN (as needed) one time a day every Tue (Tuesday), Fri (Friday). A care plan dated 10/25/24 documented, in part: Focus: [Resident #1's name] has an ADL (Activities of Daily Living) self-care deficit r/t (related to) needing assistance with ADL's; Goal: [Resident #1's name] will show an improvement in ADL performance; Interventions: Bathing/Showering: [Resident #1's name] is totally dependent on (1) staff to provide bath/shower and as necessary. A Minimum Data Set (MDS) assessment dated [DATE] documented: facility coded a Brief Interview for Mental Status (BIMS) summary score of '15,' indicating the resident was cognitively intact. Functional Abilities that revealed that the resident had impairment on both sides to his lower extremities, used a manual wheelchair and was dependent on staff to complete a shower/bath. A facility policy titled ?Documentation in Medical Record' with a revised date of 08/07/25 documented, in part: Policy: each resident's medical record shall contain an accurate representation of the actual experiences of the resident and Principles of documentation include, but are not limited to: a. Documentation shall be factual b. Documentation shall be accurate. A review of a Complaint Intake [Intake # 2613672] received by the State Agency on 09/09/25 at approximately 11:34 AM documented, in part: My [relative] often goes days without bathing or proper hygiene support; The right to timely access to medical treatment and necessary supportive services. During a face-to-face interview conducted on 09/11/25 at approximately 2:30 PM, Resident #1 stated, in part: I didn't know I had scheduled days [for a shower/bath]; they [facility staff] never offered me to take a shower I was told I had to ask, but I never knew there was an option.A review of the unit staffing assignment dated 09/09/25 Evening [evening shift, 3:00 PM-11:30 PM] revealed [Unit name], [Employee #4's name] and her assignment that included the room number for Resident #1.A review of the unit's Shower Logbook dated 09/09/25 from 3:00 PM-11:30 PM revealed Resident #1's room number was listed under the heading ?Showers' indicating it was his scheduled day to be offered and provided with a shower and Employee #4's name was listed as one of the assigned nursing staff.A review of a Treatment Administration Record (TAR) for 09/09/25 revealed an electronic signature at 1600 (4:00 PM) and a check mark for Resident to receive bath/shower two times per week and PRN once a day every Tue, Fri.During a face-to-face interview conducted on 09/12/25 at approximately 3:18 PM with Employee #4 (Assigned Registered Nurse), she confirmed her electronic signature as noted on the TAR and stated, in part: Some [residents] have a schedule for showers and further acknowledged that her electronic signature for the bath/shower task was confirmation that a bath/shower was given to the resident. Then Employee #4 stated, I remember that day [09/09/25], he refused his bath, I didn't document that he refused, that was an error.During a face-to-face interview conducted on 09/15/25 at approximately 11:55 AM with Employee #1 (Director of Nursing), she acknowledged the findings.