Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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	02/13/2026

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview and record review, the facility's staff failed to ensure a resident's packages were not open by staff before delivery for one (1) of 65 sampled residents. (Resident #10) The findings included: Resident #10 was admitted to the facility on [DATE] with multiple diagnoses including Obesity, [NAME] 2 Diabetes, and Congestive Heart Failure. A quarterly Minimum Data Set assessment dated [DATE] indicated that the resident had a Brief Interview for Mental Status summary score of 15 which means the resident had an intact cognitive response, indicating normal thinking and memory. A review of the Resident Rights documented that the resident has the right to have privacy in.getting mail.During the task of Resident Council meeting on 01/14/26 starting at 2:43 PM Resident #10 stated that staff opened 2 amazon packages he had delivered to the facility. The resident said that staff informed him that they opened the packages because they thought the packages belonged to the facility. The resident could not remember who the employee was or the date the packages were delivered. During a face-to-face interview on 01/15/26 at approximately 10AM, Employee #8 (Recreation aide) stated that she delivers mail to resident. The employee also said that she had an incident when a resident's package was opened and she refused to deliver it. She informed the person who had the package that they had to deliver it to the resident because it was open. The employee could not remember the employee or resident related to that incident.

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Number of residents sampled: Number of residents cited: Based on an observation and a staff interview the facility failed to ensure survey results were placed in a readily accessible area where individuals wishing to examine the results do not have to ask to see them for 65 of 65 sampled residents/resident's family.The findings included: An observation of the lobby on 01/23/26 at approximately 3:30PM revealed a binder label Survey Results behind the receptionist desk. During a face-to-face interview on 01/23/26 at 4PM, Employee #9(Receptionist) stated that the Survey Result Binder is always stored behind the receptionist desk. The receptionist will give the binder to anyone if they request to view it.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations and interviews, the facility staff failed to provide a safe, clean, and sanitary environment for residents.The findings include:During an environmental walkthrough of the facility conducted on January 21, 2026, between 10:30 AM and 2:00 PM, the following concerns were identified in 22 of 52 resident rooms and kitchen areas:1. room [ROOM NUMBER]: Resident's nightstand surfaces were soiled; baseboard was missing.2. room [ROOM NUMBER]: Moisture-damaged ceiling tiles; broken hand-washing soap dispensers at the toilet room and hand-washing sink; loose toilet handrail; broken toilet seat; counter surface for hand-washing sink was in poor repair.3. room [ROOM NUMBER]: Loose toilet handrail; missing baseboard under the air-conditioning unit.4. room [ROOM NUMBER]-B: Missing pillowcase; stained blanket; stained bedrail.5. room [ROOM NUMBER]: No hand-washing soap provided.6. room [ROOM NUMBER]: Resident wardrobe cabinet door was broken.7. room [ROOM NUMBER]: Loose toilet handrail.8. room [ROOM NUMBER]: Loosely attached hand-washing soap dispenser in restroom; wardrobe cabinet door was in poor repair.9. room [ROOM NUMBER]: Sticky floor in restroom.10. room [ROOM NUMBER]: Electrical outlet missing faceplate; hand-washing sink was clogged.11. room [ROOM NUMBER]: No hand-washing soap provided.12. room [ROOM NUMBER]: Broken hand-washing soap dispenser.13. room [ROOM NUMBER]: Broken hand-washing soap dispenser.14. room [ROOM NUMBER]: Detached baseboard.15. room [ROOM NUMBER]: Missing trash can in restroom.16. rooms [ROOM NUMBERS] (shared restroom): Toilet handrail was loose; hand-washing sink hot water faucet valve was broken; slow drainage observed at the hand-washing sink in the tub room.17. rooms [ROOM NUMBERS]: Clogged hand-washing sink drain.Kitchen observations:18. Damaged drywall at the delivery receiving area.19. Dust build-up on ceiling tiles and metal grids above the rack for clean utensils.20. Three-compartment dish sink area had an unclean backsplash stainless steel wall cover.21. Significant grease buildup on cooking equipment.22. Missing ceiling tile above the dishwashing area.These observations were acknowledged by Employee #20, Food Service Director, on January 6, 2026, at approximately 10:00 AM, and by Employee #19, Maintenance Director, and Employee #23, Environmental Services Director, on January 21, 2026, at approximately 2:00 PM.Facility leadership was made aware of these findings during the survey and stated they would implement measures to address the identified concerns.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and staff interviews for two (2) of 65 sampled residents, it was determined that the facility's staff failed to provide written notice of a resident's discharge from the facility, including bed hold policy with number of bed hold days, notification to the Long Term Care Ombudsman and State Agency to the resident or their representative upon transfer to the emergency room. Residents' #95 and #301. The findings included: 1.Resident #95 was admitted to the facility on [DATE] with multiple diagnoses that included: Difficulty Walking, Muscle Weakness, Severe Anemia and Fibromyalgia. A Discharge Return Anticipated Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 'Severely Impaired'. A nursing progress note dated 02/04/25 at 23:15 [11:15 PM] documented, in part: Writer was called to [resident's room number] that [the] resident had a fall. On entering the room, [the] resident was observed on the floor in a supine position between bed-A and Bed-B. Resident was observed with a swelling on her right forehead with a superficial open area. [Nurse Practitioner's name] [was] notified and order given to transfer resident to the ER (emergency room) for further evaluation and treatment. resident was transfer[ed] from the facility to [hospital name] at 12:35AM. A care plan dated 02/04/25 documented, in part: Focus: [Resident #95's name] had a fall in her room sustaining a swelling with open area on her right forehead on 02/04/25 . Interventions: Transfer resident to ER for further evaluation/treatment. A review of Resident #95's medical record on 01/28/26 at approximately 3:30 PM, revealed that there was no documented evidence that facility staff provided written notification of the resident's discharge from the facility. 2. Resident #301 was admitted to the facility on [DATE] with multiple diagnoses that included: Stroke w/ hemiplegia affecting left side, Hypertension, Diabetes Mellitus and Deep Vein Thrombosis. An admission Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '15,' indicating the resident was cognitively intact. A Social Worker progress note dated 02/20/25 at 14:04 [2:04 PM] documented, in part: Family contacted writer requesting transfer to the hospital.Writer informed family that resident doesn't have medical reason to be transferred, but if the family believes the resident should be transferred it is within their rights to proceed with the request. Writer informed clinical team of request. Facility completed transfer per family's request. Non-emergency transport was arranged to [hospital name]. A physician order dated 02/20/25 at 14:45 [2:45 PM] documented, Per resident's request: Transfer resident to the nearest hospital via non-emergency transportation. A review of Resident #301's medical record on 02/09/26 at approximately 2:20 PM, revealed that there was no documented evidence that facility staff provided written notification of the resident's discharge from the facility. During a face-to-face interview conducted on 02/09/26 at approximately 2:45 PM, Employee #10 (Director of Social Work) acknowledged the findings and stated, I don't know of any reason why the 6-108 (Notice of Discharge, Transfer or Relocation Form) wouldn't be filed in the record if it was done. Cross reference: DCMR S 3270.1

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and staff interviews, the facility failed to complete a Significant Change in Status Assessment (SCSA) in the Minimum Data Set (MDS) within 14 days after the facility determined or should have determined that a significant change had occurred for Resident #313. The resident experienced a non-self-limiting weight loss of 5.8% in 30 days (117.4 lbs on [DATE] to 110.6 lbs on [DATE]) and was not on a physician-prescribed weight-loss regimen. This deficient practice affected 1 of 65 sampled residents.Resident #313 was admitted on [DATE] with diagnoses including neurocognitive disorder with Lewy bodies, Parkinson's disease without dyskinesia and without fluctuations, adjustment disorder with anxiety, adult failure to thrive, dysphagia (oropharyngeal phase), anorexia, and cognitive communication deficit.The resident required extensive to total assistance for Activities of Daily Living (ADLs), was always incontinent of bladder and bowel, exhibited coughing or choking during meals and medication administration, and had one unhealed Stage 4 pressure ulcer on admission. Care Area Assessments were triggered for cognition/dementia, communication, incontinence, falls, nutritional status, pressure ulcer, and return to community referral.The admission MDS dated [DATE] documented the resident was unable to complete the Brief Interview for Mental Status (BIMS) and had severely impaired cognitive skills for daily decision-making.A quarterly MDS dated [DATE] documented, in part, the resident had short-term memory problems, severely impaired decision-making, total dependence for self-care and mobility, frequent bladder and bowel incontinence, unhealed pressure ulcers (two Stage 3 and two Stage 4, one present on admission), and weight loss of 5% or more in one month or 10% in six months (coded Yes) while not on a physician-prescribed weight-loss regimen. The resident was receiving a mechanically altered diet and an antidepressant (high-risk medication).A Medical Orders for Scope of Treatment (MOST) dated [DATE] indicated CPR - Attempt Resuscitation; Medical Interventions - Full Treatment.Significant Weight LossFacility weight records revealed: 117.4 lbs on [DATE] 110.6 lbs on [DATE]This represented a 5.8% weight loss in 30 days, meeting the facility's and RAI criteria for significant, unplanned weight loss requiring comprehensive reassessment and an SCSA.There was no evidence the facility completed an SCSA within 14 days of identifying or when it should have identified the significant weight loss.During a face-to-face interview on [DATE] at approximately 1:35 PM, Employee #27 (RN, 2-South Unit Manager) stated the resident had poor oral intake and multiple pressure ulcers. The RN stated that when significant weight loss is identified, nursing notifies the dietitian and physician and documents in progress notes; however, the RN did not recall that Resident #313 had significant weight loss.During a face-to-face interview on [DATE] at approximately 2:58 PM, Employee #28 (LPN) stated the resident was non-verbal, a feeder, had poor oral intake, required encouragement to eat, had an unhealed sacral wound on admission, was repositioned every two hours, later developed an ear wound, and was eventually transferred to the hospital for poor oral intake.During a face-to-face interview on [DATE] at approximately 3:43 PM, Employee #29 (Wound Nurse) stated the resident had poor nutritional intake, multiple pressure ulcers, bladder and bowel incontinence, and impaired mobility, all of which could negatively impact wound healing.During a face-to-face interview on [DATE] at approximately 11:25 AM, Employee #21 (Dietitian) stated the resident was on a mechanical soft diet, later changed to puree at family request, and received MedPass three times daily and ProSource [both nutrition supplements] twice daily since admission. The dietitian stated she was not consulted regarding the possibility of a feeding tube, which would require a physician order, and indicated the resident's weight loss had been gradual. The dietitian further stated that if speech therapy had recommended puree earlier, the diet could have been changed prior to the (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family request.During a face-to-face interview on [DATE] at approximately 2:10 PM, Employee #30 (Wound Nurse Practitioner, Healing Partners) stated the resident was frail, thin, underweight, with prominent bony areas, and recommended the dietitian increase protein intake to support wound healing.During a face-to-face interview on [DATE] at approximately 3:10 PM, Employee #21 (Dietitian) stated that unplanned weight loss of 5% or more in 30 days is significant and requires intervention. The dietitian stated she was not aware of the resident's 5.8% weight loss between [DATE] and [DATE] and was not employed at the facility at that time.During a face-to-face interview on [DATE] at approximately 4:00 PM, Employee #3 (Director of Nursing) stated that monitoring weight is the responsibility of all disciplines and that unplanned weight loss should be reported to the responsible nurse, dietitian and physician. When asked whether a 5% weight loss constituted a significant change requiring assessment, the DON deferred to the dietitian as the most appropriate person to address that determination.Despite documented significant, unplanned weight loss, clinical indicators of poor oral intake, dysphagia, multiple non-healing pressure ulcers, total dependence for feeding, and failure to thrive, and staff acknowledgment that such weight loss is significant and requires intervention, the facility failed to initiate and complete an SCSA within 14 days as required.The facility failed to ensure a Significant Change in Status Assessment was completed within the required timeframe for Resident #313 following a 5.8% unplanned weight loss in 30 days, in accordance with S483.20(b)(2)(ii). This failure had the potential to delay identification and implementation of necessary interventions to address the resident's declining nutritional status and wound healing needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 65 sampled residents, the facility staff failed to develop and implement a comprehensive person-centered care plan with measurable objectives and individualized interventions to address the resident's allergy to eggs and preference for double portions at each meal. Residents #316 and #89. Resident #89 was admitted to the facility on [DATE] with diagnoses that included Spinal Stenosis, Type 2 Diabetes with Hyperglycemia, Discitis, End Stage Renal Disease, and Weakness. A review of Resident #89's medical record revealed the following: A physician's order dated 02/21/25 that stated: LCS/NAS (low concentrated sweets/no added salt) diet, regular texture, thin liquids consistency. A History and Physical assessment dated [DATE] at 12:00 AM that documented: .C . 2.Meds .Allergies: aspirin, codeine, and eggs. A comprehensive Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) Summary Score of 14, indicating that the resident had intact cognition and the resident had a therapeutic diet (e.g., low salt, diabetic, low cholesterol). A comprehensive care plan revised on 01/13/26 lacked documented evidence that the resident's preference for double portions and his egg allergy were addressed. During a face-to-face interview on 02/09/26 at approximately 10:15 AM, Resident #89 asked, Who do I talk to about my meals from this past weekend? I don't know why they (facility staff) can't get my food right. They keep sending me eggs at meals, and I have an allergy to eggs, and they are not sending me double portions. I am supposed to get double portions. The resident then stated I have taken pictures as evidence, and I have called down to the kitchen and spoken with [Director of Kitchen Services] myself on several occasions. The Resident then provided the following: 1. A photo dated 02/07/26 of Resident #89's breakfast meal ticket that showed: Diet order: Regular, No Added Salt, No Concentrated Sweets, Thin Liquids. Allergies: Eggs. Notes: 2x meat/protein/Double Portions. Dislikes: seafood, eggs, fish. Standing Orders: 1/2 cup grits (x3 butter); 4 x turkey sausage or bacon, 1 slice whole wheat toast (2x grape jam). 2. A photo dated 02/07/26 of Resident #89's breakfast tray that showed a slice of whole wheat toast cut in half and one slice of breakfast ham. 3. A photo dated 02/07/26 of Resident #89's lunch meal ticket that showed: Diet order: Regular, No Added Salt, No Concentrated Sweets, Thin Liquids. Allergies: Eggs. Notes: 2x meat/protein/Double Portions. Dislikes: seafood, eggs, fish. 4. A photo dated 02/07/26 of Resident #89's lunch meal that showed a chef's salad with chopped boiled egg. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a face-to-face interview on 02/10/26, the Director of Nursing/DON stated that the Residents' comprehensive care plans are implemented by the unit managers, nursing supervisors, DON, or other staff (Physical, occupational, or speech therapist, Social Work, Dietician) based on the focus area identified on the care plan. During a face-to-face interview on 02/10/26 at 2:15 PM, Employee #38 (Registered Nurse/ 3 South Unit Manager) stated that she was familiar with Resident #89, although the Resident was not on her unit. She explained that she was covering the unit where Resident #89 resided. When asked if a resident's comprehensive care plan should include the resident's food allergies and preferences, the Employee stated, Yes, and provided no further comment.

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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 review and staff interview for two (2) of 65 sampled residents, facility failed to update one resident's care plan to include ophthalmology visits and update another resident's care plan with new goals and interventions status post unwitnessed fall with injury. (Residents #11 and #309)Findings Include .

Resident #11 was admitted to facility on 08/25/2017 with diagnosis anemia, Polyneuropathy, Atherosclerotic Heart Disease, Peripheral Vascular Disease, HIV Presbyopia and Dry eye Syndrome of Bilateral Lacrimal Gland.

The resident#11 during interview reported to the surveyor I want to see the ophthalmologist.

Review of the resident medical record on 2/6/2026 showed the resident was last seen by the Ophthalmologist on 12/31/2021.

Review of the ophthalmologist report dated 12/31/2021 showed recommended follow up visit for the patient in 1year

Review of care plan showed resident was seen by the ophthalmologist three times since admission [DATE], 12/29/2021 and 12/31/2021, the Ophthalmologist recommended two times the F/u (follow up) visit. There was no mention on updated care plan documentation that the patient had follow up visit with his ophthalmologist.

Further review of the Resident Progress Note showed no documented evidence that the ophthalmologist visit was followed up indicating not Done.

Interview with Employee#7 [1North Unit Nurse Manager] on 02/04/2026 at 10:15 am concerning patient wanting to visit the ophthalmologist She made an appointment for the resident to see the in-house doctor on 2/6/2026.

A face-to-face interview was conducted on 02/13/2026 at approximately 10am with Employee#3 [Director of nursing] who was made aware of concern that the care plans were not being updated

2. A review of Resident #309's medical record revealed:

Resident #309 was admitted to the facility on [DATE] with multiple diagnoses that included: Leukemia, Dementia, Asthma, and Respiratory Failure.

An admission Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '02,' indicating the resident was cognitively impaired. Functional abilities that documented: the resident required substantial to maximal assistance from staff for standing and walking; partial to moderate assistance from staff for transfers; and used a wheelchair for locomotion.

A nursing progress note dated 05/25/25 at 09:45 [9:45 AM] documented, in part: Around 7:40am writer heard someone call for help and writer went in room. Resident was found leaning on her right side next to closet. Upon assessment resident noted with skin tear on her RT (right) elbow.[Nurse

(continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practitioner's name] [was] notified and order [was] given to do X-ray of the RT (right) side for evaluation due to resident complaint of pain after fall . [Nurse Practitioner's name] call[ed] back and gave order to transfer resident to the nearest ER (emergency room) for further evaluation due to resident complaint of RT (right) side pain after fall. [Nurse Practitioner's name] gave order to clean the RT elbow skin tear with NSS, apply bacitracin and cover with dry dressing daily. A physician's order dated 05/25/25 documented, X-ray of the RT (right) side to evaluate due to resident complain of pain after fall and Transfer resident to the nearest ER (emergency room) due to resident complain of RT (right) side pain after fall for further evaluation. A hospital clinical summary dated 05/25/25 documented, in part: . seen as a trauma consult after being found down with likely fall, with right femoral neck fracture, right ulnar fracture. Underwent CMN (Cephalmedullary Nail) on 5/26[/25] and R (right) olecranon ORIF (Open Reduction and Internal Fixation) on 5/27[/25] A care plan dated 05/25/25 documented, in part: Focus: Skin Tear to right dorsal elbow. Interventions: Encourage good nutrition and hydration in order to promote healthier skin. Monitor/document location, size and treatment of skin tear. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (medical doctor). Treatment as ordered . A care plan dated 06/04/25 documented, in part: Focus: [Resident #309's name] has diagnosis of displaced fracture of greater of trochanter of right femur initial encounter for closed fracture with surgical site and staples . Interventions: Orthopedic consult. It should be noted that Resident #309's care plan was not updated to include the fact that she had an unwitnessed fall in her room on 05/25/25. A facility policy titled 'Documentation in Medical Record' with a review date of 08/14/2025 documented, in part: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. During a face-to-face interview conducted on 02/11/26 at 10:40 AM Employee #3 (Director Of Nursing) Acknowledged the findings and stated, When residents are admitted the care plan is initiated then updated every month or when needed by the unit manager; like with incidents such as a fall, it should be updated. Cross Reference: DCMR 3210.4 (c)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and staff interviews, the facility failed to ensure the necessary services of activities of daily living such as personal hygiene, mobility, toileting and hydration were provided for one (1) of sixty-five (65) sampled residents (Resident #302), who was dependent on staff for activities of daily living.Findings include:Resident #302 was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus, Diffuse Traumatic Brain Injury, Chronic Idiopathic Constipation, Schizoaffective Disorder (Depressive Type), Need for Assistance With Personal Care, Flaccid Hemiplegia Affecting Left Dominant Side, Contracture of Muscle Left, and Aphasia.An admission Comprehensive Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 07, indicating severe cognitive impairment. The MDS coded the resident as dependent on staff for toileting and personal hygiene, dependent for bed mobility (rolling left and right and sit to lying), using a manual wheelchair, and frequently incontinent of bowel and bladder.A review of the current care plan dated 08/21/2025 documented in part:Focus: Resident has bowel incontinence.Goal: Resident will not have complications related to incontinence through next review date.Interventions: Check resident every two hours and assist with toileting as needed; observe pattern of incontinence and initiate toileting schedule if indicated; provide bedpan/bedside commode; provide loose fitting, easy-to-remove clothing; provide pericare after each incontinent episode.A review of the Certified Nursing Assistant (CNA) task documentation for 06/30/2025 (night shift) revealed no documentation that Resident #302 received the necessary nursing care services. Furthermore, the CNA task documentation report for that date and shift showed the following tasks left blank or undocumented for Resident #302: Additional fluids, bed mobility, bowel incontinence, bowel movements, new skin observation, personal hygiene, toileting hygiene, and turning and repositioning.A review of the facility resident care assignment sheet for 06/30/2025 (Unit 2-South, night shift) revealed one (1) nursing supervisor, two (2) charge nurses, and five (5) CNAs were assigned.During a phone interview on 02/12/2026 at approximately 12:50 PM, Employee #31 (LPN), who worked the night shift (11:00 PM-7:00 AM) on 06/30/2025 as a charge nurse on Unit 2-South, stated Resident #302 was a total care resident dependent on staff for bowel care. She stated she was not aware of any complaints regarding care not being provided on that date and that CNAs are responsible for documenting the care they provide.During a phone interview on 02/12/2026 at approximately 4:00 PM, Employee #32 (CNA), who no longer works at the facility, stated she worked only day shift, never night shift, and provided good care to her residents.During a phone interview on 02/13/2026 at approximately 9:30 AM, Employee #33 (CNA) stated she documents all care on the kiosk. She stated that on 06/30/2025 the unit was short staffed and there were only three (3) CNAs on the floor. She reported that Resident #302 urinated twice and was already soaked at the beginning of her shift, that she changed the bed and provided care, and that the resident later had a bowel movement which she addressed before leaving. She stated, It is my fault that I didn't document the care I provided for the resident, but I provided the care.During a phone interview on 02/13/2026 at approximately 10:00 AM, Employee #31 (LPN) stated it is the responsibility of the nursing supervisor to ensure CNA documentation is complete and that when CNA documentation is missing for an entire shift for multiple tasks, she would agree the tasks were not done.During a phone interview on 02/13/2026 at approximately 11:25 AM, Employee #34 (LPN) stated CNAs have access to three computers on the unit to document care immediately after providing it. She stated if tasks are not documented the system flags them, and if a resident refuses care, staff document the refusal in a progress note. She stated she did not know why (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was no documentation for Resident #302 on 06/30/2025.During a phone interview on 02/13/2026 at approximately 11:40 AM, Employee #35 (RN Supervisor), who worked as the nursing supervisor on 2-South on 06/30/2025, stated she oversees CNA task documentation and ensures tasks turn green in the facility electronic medical record, PointClickCare, system before staff leave. She stated CNAs often do not complete documentation due to short staffing and that 2-South has many total care residents. She stated she could not recall the specific events of 06/30/2025 and that if a resident refuses care, nursing documents the refusal.There was no documentation in the medical record to indicate Resident #302 refused care on 06/30/2025. There was no documentation to show the resident received toileting assistance, incontinence care, turning and repositioning, or personal hygiene during the night shift on 06/30/2025, as required by the care plan.The facility failed to ensure the resident #302 received necessary care services for the activities of daily living.

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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 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 observations, record review and staff interviews for two (2) of 65 sampled residents, it was determined that facility staff failed to follow physician orders for the use of floor mats while in bed to minimize fall related injuries for one (1) resident; and failed to follow physician orders when providing wound care for one (1) of three (3) sampled residents receiving wound care. Residents' #95 and #285. Resident #95 was admitted to the facility on [DATE] with multiple diagnoses that included: Difficulty Walking, Muscle Weakness, Severe Anemia and Fibromyalgia. A care plan dated 02/04/25 documented, in part: Focus: [Resident #95's name] had a fall in her room sustaining a swelling with open area on her right forehead . Interventions: Floor mats to both sides of bed when resident is in bed to minimize fall related injuries . A physician order dated 02/07/25 documented, Fall precaution every shift. A physician order dated 02/09/25 documented, Bed in lowest position when resident is in bed to minimize fall related injuries .Floor mats to both sides of the bed when resident is in bed to minimize fall related injuries every shift. A nursing progress note dated 02/09/2025 07:41 [7:41 AM] documented, in part: S/P (status post) fall day 3/3 (third day of 3 days) . floor mat on both sides of her bed. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '15,' indicating that the resident was cognitively intact. Functional mobility that included: Dependent for Sit-to-lying; Lying-to-sitting; Chair/bed-to-chair transfers and Sit-to-stand that documented: not attempted due to medical condition or safety concerns. During an observation conducted on 01/29/26 at 10:15 AM it was revealed that the resident was in bed and there were no floor mats in place on the right and left side of the bed. During a face-to-face interview conducted on 01/29/26 at 10:20 AM Employee #11 (Certified Nursing Assistant) stated, I don't know about that, you have to ask the unit manager about floor mats. During a face-to-face interview conducted on 01/29/26 at 10:23 AM Employee #12 (Registered Nurse) stated, This is my first time working with her [Resident #95], I haven't been in the room yet. During a face-to-face interview conducted on 01/29/26 at 10:25 AM Employee #7 (Unit Manager) stated, I'm not sure about the floor mats, I will check when they are done with ADL (activities of daily living) care. During a face-to-face interview conducted on 01/29/26 at 1:00 PM Employee #3 (Director of Nursing) acknowledged the findings and stated, You were right, I checked the orders and the care plan, and the floor mats should've been there [on each side of the resident's bed]. 2. Resident #285 was admitted to the facility on [DATE]. The resident has a history of Pressure Ulcer and Dysphagia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated 11/13/25 instructed, Right Heel: Cleanse with wound cleanser, pat dry, apply betadine, and leave open to air. Two times a day for wound care. A quarterly Minimum Data Set assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status summary score of 3 indicating sever cognitive impairment. The resident was also coded for being dependent on staff for activities of daily living and having one Stage 4 pressure ulcer and one unstageable pressure ulcer. A care plan with a review date of 12/12/25 documented in part, Focus- [Resident's name] has an actual pressure ulcer development of Sacrogluteal and [unstageable pressure ulcer]to right heel related to limited mobility. Interventions- Administer wound treatment as ordered by MD/NP (medical doctor/nurse practitioner). A physician order 12/25/25 instructed Sacrogluteal: Cleanse the wound with wound cleanser, pat dry, and apply Collagen, Calcium Alginate, and Zinc Oxide Paste to the periwound. Cover with a silicone-bordered superabsorbent. A wound assessment report dated 01/07/26 documented in part, Location [#1]: Right heel. Measurement- Length: 1.00 cm, Width: 1.90 cm L x W: 1.90 cm2 Depth: 0.30 cm. Observation- Etiology: Pressure Ulcer/Injury, Stage/Severity: Unstageable, 100% eschar. Location [#2]: Sacrogluteal.Measurements- Length: 4.30 cm Width: 5.00 cm L x W: 21.50 cm2 Depth: 0.30 cm.Observation- Etiology: Pressure Ulcer/Injury Stage/Severity: Stage 4. 30% epithelial,70% granulation, Periwound: Fragile, Intact, Scarring, Non-blanchable maroon discoloration. An observation on 01/16/26 at approximately 11:30 AM showed the following: Employee #4 (LPN/Wound Nurse) used normal saline to clean the resident's right heel and sacrogluteal wound. Additionally, the employee failed to apply zinc oxide to the periwound of the sacrogluteal wound. She did however apply zinc oxide to the resident's buttocks. After observation, the employee stated that she did not use wound cleanser to cleanse the resident's wounds because it was not available. The employee did not explain why she did not apply zinc oxide to the periwound of the resident's sacrogluteal wound. During a face-to-face interview on 01/16/26, Employee #3 (DON) stated that the facility did have wound cleanser and the employee should have used it to cleanse the resident's wounds. The employee also said that Employee #4 should have applied zinc oxide to the periwound of the resident's sacrogluteal wound as prescribed. It should be noted that the DON showed the surveyor a bottle of wound cleanser.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: 685Based on record review and staff interview facility staff failed to ensure residents received treatment and care in accordance with professional standard of practice for services to maintain his eye vision as evidence by Follow up visit with the Ophthalmologist in one year was not completed. Resident #11Finding includes .Resident #11 was admitted to facility on 08/25/2017with diagnosis anemia, Polyneuropathy, Atherosclerotic Heart Disease, Peripheral Vascular Disease, HIV, Presbyopia and Dry eye Syndrome of Bilateral Lacrimal Gland.Resident #11 requested by the surveyor I want to see the Ophthalmologist.A review of Ophthalmologist report dated 12/31/2021 showed residents. to follow up visit in one year.A review of Nurses progress and Ophthalmologist consult notes showed no documentation of the resident follow up visit to the ophthalmologist within one year for services for his vision care. This indicates that the resident has not been seen by an Ophthalmologist in 4 years.The evidence showed resident #11 last Ophthalmologist visit was dated 12/31/2021, indicating 4 years ago.A face-to-face interview conducted on 02/13/2026 at approximately 10am with Employee #3 [Director of nursing] who was made aware of concerns that the resident missed his 1 year follow up visit with ophthalmologist that now indicates the resident has not seen the Ophthalmologist in 4 years. Findings were acknowledged and an appointment was made for residents to see in- house Ophthalmologist. [NAME], [NAME] (11) [NAME]-Sampong, [NAME] (27513) - Comm-Sensory No NotesCANNING, [NAME] (11) [NAME]-Sampong, [NAME] (27513) - RESIDENT NOTE No Notes

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record reviews and staff interviews for two (2) of 65 sampled residents, it was determined that the facility's staff failed to ensure residents were provided with adequate monitoring and supervision as evidenced by one resident who sustained a fall with injury when she was left unattended in her room, in a bed that was positioned in the highest raised position and another resident who sustained a fall with injury during an assisted shower. Residents' #95 and #258. The findings included: A facility policy titled 'Fall Prevention Program' with a review date of 08/15/2025 documented, in part: Definitions: A fall refers to unintentional change in position coming to rest on the ground, floor.5. Low/Moderate Risk Protocols: a. Implement universal interventions that decrease the risk of resident falling, including, but not limited to: ii. Bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed.6. High Risk Protocols: b. Implement interventions from Low/Moderate Risk Protocols. d. Provide additional interventions as directed by the resident's assessment, including but not limited to: vi. Low bed. Resident #95 was admitted to the facility on [DATE] with multiple diagnoses that included: Difficulty Walking, Muscle Weakness, Severe Anemia and Fibromyalgia. A nursing progress note dated 02/04/25 at 23:14 [11:14 PM] documented, in part: readmission: Received resident in bed alert and verbally responsive. A nursing progress note dated 02/04/25 at 23:15 [11:15 PM] documented, in part: Writer was called to [room number] that resident had a fall. On entering the room resident was observed on the floor in a supine position between bed-A and Bed-B. Writer was informed by the assigned nurse that resident fell at 11:15pm. When writer inquired from the resident what happened? [The] resident said, I jump[ed] out the bed trying to get to my chair. On assessment resident is A/O (alert and oriented) x 2-3 (resident was not completely oriented) with her speech clear and coherent for her baseline status. Resident was observed with a swelling on her right forehead with a superficial open area . order given to transfer resident to the ER for further evaluation and treatment. A Situation, Background, Assessment, Request dated 02/04/2025 at 23:15 [11:15 PM] documented, in part: Resident had a fall and observed with a swelling on her right forehead with a superficial open area . Mental Status or Neuro Changes: 3a. Confusion. A Quarterly Falls Risk Evaluation dated 02/04/2025 at 23:15 [11:15 PM] documented that the resident was a Moderate Falls Risk, could not walk, was confined to a chair and unable to independently come to a standing position. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note dated 02/04/25 at 23:20 [11:20 PM] documented, in part: Received resident around 11:03am [sic] [11:03 PM] and writer went to room and check resident. V/S (vital signs) check[ed], and writer noted the bed was high. Writer attempted to fix the bed, but the bed will not go down . writer went to informed [sic] [inform] the supervisor about fixing the bed. Than [sic] [Then] around 11:15pm resident fell [from the bed] and [I] went to assessed [sic] [assess the] resident. She was lying on her face. She was bleeding and swelling on her right forehead. Writer apply [sic] [applied] pressure and report given to the incoming nurse for follow up. Every body [sic] [everybody] went and attempted to transfer resident [back] in[to] bed. A Facility Reported Incident [Intake Number: DC00013444] received by the State Agency on 02/05/25 at 01:03 [1:03 PM] documented the following, in part: On 2/4/2025 at about 11:15 pm [Resident #95's name] fell out of bed and sustained a superficial open area with swelling to her right forehead . The charge nurse assigned to resident was interviewed she stated that the bed was in a high position, and she was not able to lower the bed, she stepped out to get a CNA (Certified Nursing Assistant) in the room when she returned the resident was on the floor. A hospital consult note dated 02/05/25 at 6:51 AM documented, in part: Small abrasion to right forehead . Neurosurgery was consulted after CT (computerized tomography scan) head showed small subdural hematoma [trauma-induced brain injury] (2mm) (millimeter). A hospital Discharge summary dated [DATE] at 08:15 [8:15 AM] documented, in part: Hospital Course, presents via (by) EMS (Emergency Medical Services) from [Nursing facility name] after a fall. Patient indicates the bed was broken and she was trying to stand to get to her wheelchair when she fell, striking her head on the floor. During a telephone interview conducted on 01/30/26 at 2:20 PM Employee #14 (Licensed Practical Nurse) stated, I didn't witness the fall. When I did go into the room, she was on the floor and the bed looked like it was about waist height, it wasn't in the lowest position. During a telephone interview conducted on 01/30/26 at 2:30 PM Employee #13 (Nurse Supervisor) stated, She was a readmission, I was alerted by one of the nurses who said one of the patients [a resident] was on the floor. I rushed to the room and the bed was elevated. Her mentation was not that great, but I do know her bed was elevated to the max elevation, and it wouldn't go down. The protocol when a resident comes back from the hospital, the nurse should assess the resident to make sure head-to-toe assessment is done to make sure it's the same resident you're getting back from the hospital that you sent out. A fall assessment should've been done and the first thing I asked when I went in[to] the room is Why is the bed so high? because the bed should be low, everything should be in close proximity to the resident, so they don't have to reach. A lot of things were out of place; these are things you do when you get a resident back from the hospital and on admission for safety. During a face-to-face interview conducted on 02/04/26 at 1:25 PM Employee #3 (Director of Nursing) acknowledged the findings and stated, Fall evaluations are done on admission, quarterly and per fall incident. The bed should always be in the lowest position while the resident is still in it; you don't leave a resident alone in a bed that's elevated. 2. Resident #258 was admitted to the facility on [DATE] with multiple diagnoses including Muscle Weakness, Lack of Coordination, and Left side Hemiparesis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A fall risk assessment dated [DATE] documented that the resident had a fall risk score of 9 indicating the resident was a moderate risk for falls. A quarterly MDS dated [DATE] documented that the resident had a Brief Interview for Mental Status score of 8 indicating the resident cognitive status was moderately impaired. The resident was coded as being dependent on staff for showers. The resident was not coded for falls prior to admission or since admission to facility. A nursing progress note dated 01/30/25 at 3:15 PM documented, Around 1:45pm assigned CNA [certified nursing assistant] reported to writer that during shower time she and another staff assisting by trying to turn resident to the side, and resident sustained a fall. Resident stated that he fell in the shower room when he was being given a shower. Writer assessed resident and resident was noted with swelling on his right forehead. The resident was noted with no cut, no bruises, no laceration to any part of his body except for the swelling to his right forehead. On assessment, the resident denied pain and refused pain medication. V/S temp-97.9, P-78, R-18, B/P-139/80 and oxygen saturation of 97% in room air. [DNP's name] notified and an order was given to apply ice pack every 30 minutes on affected area and to transfer resident to the nearest ER [emergency room] for CT scan [diagnostic radiology test] for RT [right] forehead swelling . 911 was called and arrived around 2:17pm and resident refused to go to the ER. Writer and unit manager attempted to talk to the resident and resident refused to go.[Physician's name] was at the facility, and he was able to convince the resident to allow hospital transfer, finally resident agreed and left the unit via at 2:30 pm . The unit manager's note dated 01/30/25 at 4:39 PM documented in part, It was reported by the charge nurse that this resident sustained a fall. A physician order dated 01/30/25 instructed, ER (emergency room) transfer to due CT Scan of the forehead due to swelling. A nursing note dated 01/31/25 at 7:56 AM documented in part, Writer received report at start of shift that resident was transferred to [Name of hospital] emergency department, for evaluation status post fall. A nursing note dated 01/31/25 at 10:51 PM documented in part, Resident returned from [hospital's name] secondary to contusion and swollen to the forehead that occurred on 1/30/25. During a face-to-face interview on 01/22/26 at 4:27 PM, Employee #6 (CNA) stated that Employee #5 (CNA) called him to assist with a shower for Resident #258. Employee #5 turned the resident toward him. His hands were slippery with soap, so he couldn't stop the resident from hitting his head on the wall. The employee said that the resident had some swelling to his forehead after he hit his head. Additionally, Employee #6 stated that he was on the side of shower bed near the wall. During a telephone interview on 01/23/26 at 9:28 AM, Employee #5 (assigned CNA) stated that she turned the resident toward the wall where she was standing in the shower room. The resident then hit his head on the grab bar on the wall when he was trying to pull himself over. When asked, why was the resident so close to the wall where he could hit his head, the employee stated that the resident is a 2 person assist with showers and the room is too small for two people. Additionally, the employee said that she did not tell the nurse that the resident fell. During a face-to-face interview on 01/23/26 at 10:30 AM, Employee #7 (RN/Unit Manager) stated that (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the nurse and the resident told her that he fell in the shower room while staff was giving him a shower. The employee stated that she could not explain how the resident sustained a hematoma [to the head - localized bleeding outside blood vessels] while 2 staff members were assisting him with a shower.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews for one (1) of 65 sampled residents, it was determined that facility staff failed to ensure that extra tracheostomy supplies were available at the bedside for a resident who is tracheostomy dependent. Resident #17. The findings included:A facility policy titled 'Tracheostomy Care' with a review date of 06/26/2025 documented, in part: 3b. Maintain a suction machine, a supply of suction catheters, correctly sized cannulas, and an ambu [manual resuscitator] bag easily accessible for immediate emergency care. A review of Resident #17's medical record revealed: Resident #17 was admitted to the facility on [DATE] with multiple diagnoses that included: Respiratory Failure with Hypoxia, Tracheostomy Dependent, Aphasia and Seizure Disorder. A care plan dated 10/10/25 documented, in part: Focus: [Resident #17's name] has trach (tracheostomy) sz (size) 6 Shiley, sz 6.5 TC (tracheostomy collar) . Interventions: Keep extra trach tube and obturator at bedside. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 'Severely Impaired.' Dependent on staff for all Activities of Daily Living care; Dependent on Respiratory Treatments to include oxygen therapy, suctioning, tracheostomy care and Invasive Mechanical Ventilation. A physician's order dated 02/02/26 documented, Back-up trach (tracheostomy) at bedside. Size #6 uncuffed every shift. During an observation conducted on 02/12/26 at approximately 3:50 PM, there was not a back-up tracheostomy tube size six (6) uncuffed, or obturator at the resident's bedside. During a face-to-face interview conducted on 02/12/26 at approximately 3:52 PM Employee #39 (The assigned Licensed Practical Nurse) was asked where the back-up tracheostomy tube was kept. She proceeded to look around the resident's bedside to locate the back-up tracheostomy tube, but was unsuccessful and then stated, I've worked with her [Resident #17] a few times, but it never come to my mind to check for the extra supplies. During a face-to-face interview conducted on 02/12/26 at approximately 3:55 PM Employee #27 (Unit Manager) was asked where the back-up tracheostomy tube was kept. She also proceeded to look around the resident's bedside to locate the back-up tracheostomy tube, but was unsuccessful, then left the resident's room. Employee #27 returned to the resident's room with a clear plastic bag that contained a pack of 4 x 4 Gauze sponges, a roll of white surgical tape and a pair of green bandage scissors. When Employee #27 was asked about the back-up tracheostomy tube and the size of the tube, she had no comment. During a face-to-face interview conducted on 02/12/26 at approximately 4:05 PM Employee #3 (Director of Nursing) acknowledged the findings and stated, The extra trach supplies must always be at the bedside for emergencies and should include the trach and correct size lumen.

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

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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 record review and staff interviews, for one (1) of 65 sampled residents the facility staff failed to ensure nursing staff functioned with the appropriate competencies and skills to provide nursing and related services to assure resident safety as evidenced by the nurse's administration of a significant medication error. Resident #317 The findings included: Resident #317 was admitted to the facility on [DATE] with diagnoses that included: Metabolic Encephalopathy, Dependence on Dialysis, Type 2 Diabetes Mellitus, End-Stage Renal Disease, Cerebrovascular Accident (Stroke), Dysphonia, and Need for Assistance with Personal Care. A review of Resident #317's medical record showed: A care plan initiated on 04/30/2025 that documented: [Name of Resident #317] has vision impairment/hearing impairment r/t (related to) blindness in the right eye and deafness in the left ear. Goal: [Name of Resident #317] will maintain optimal quality of life within limitations imposed by visual function through the next 90 days. Target Date: 08/21/2025; Interventions.Review medications for side effects which affect vision. An admission minimum data set (MDS) assessment dated [DATE] that documented that Resident #317 had moderate difficulty with hearing, severely impaired vision, and had a Brief Interview for Mental Status (BIMS) Summary Score of 15, indicating that the resident had intact cognition. A physician's order with a start date of 06/10/25 at 8: 00 AM that directed: Debrox Solution 6.5% (Carbamide Peroxide) Instill 5 drops in right ear two times a day for ear impaction for 4 Days. A physician's order with a start date of 06/12/25 at 9:00AM that directed: Artificial Tears Ophthalmic Solution 0.2- 0.2-1 % (Glycerin-Hypromellose Polyethylene Glycol 400), Instill 2 drops in right eye three times a day for Redness for 1 Week. A physician's order with a start date of 06/12/25 at 9:00AM that directed: Artificial Tears Ophthalmic Solution 0.2- 0.2-1 % (Glycerin-Hypromellose Polyethylene Glycol 400), Instill 2 drops in right eye three times a day for Prophylaxis for 1 Week. A June 2025 Medication Administration Record (MAR) for Resident #316, which showed that facility staff administered Debrox Solution 6.5 % (Carbamide Peroxide) to the Resident on 06/10/25 and 06/11/25. Of note, further review of the June 2025 MAR showed that there were no eye medication or treatment orders for the Resident scheduled before 06/12/25 at 9:00 AM. A facility reported incident submitted online on 06/12/25 at 4:51 PM that documented: Initial Report: Nurse reported that she administered medication via the wrong route. Resident assessed by RN (Registered Nurse). No signs of adverse effect. [The] Physician and [the] resident [were] made aware. Investigation initiated. A review of the facility's investigation documents for the incident revealed the following: A typed statement that documented: 6/11/2025.Interviewer: [Name of Employee #16 /RN/Educator/Former Executive Clinical Director]; Statement of Employee #17/RN assigned to Resident #317]: '[Name of Resident #317] requested her medication. After giving her medication, she reported that her eye was stinging. I immediately rinsed her eye. She did not report any additional discomfort. I left the room and yelled for the supervisor. I notified the supervisor that I had mistakenly put an ear drop in [Resident #317]'s eye. 2. A written statement by Employee #15 (RN Supervisor) that documented: At about 5:00 PM, the nurse reported that she administered an ear drop to the right eye. The resident said, 'As soon as the nurse dropped the eye drop into my right eye, I felt a little bit stinging in my eye, and I told the nurse.' DON assessment. Resident [317] denied pain in the right eye. Eye flushing was done. No adverse reaction noted. [The] RMD (the resident's medical doctor) was notified, and an order was given to flush eye q (every) 2 hrs (hours) for 4 days, Artificial tears 2 drops to right eye TID (three times a day) x 1 week for prophylaxis. 3. A final report for the facility's investigation submitted to the State Agency on 06/12/25 at 11:52 AM that documented in part: Final Report: .On June (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11, 2025, [Name of Employee # 17/Registered Nurse (RN) for Resident #317] reported that she administered medication via the wrong route. As a result of the report, an investigation was initiated. [Resident #317] was assessed by the RN supervisor, and there were no signs of adverse effects. [Resident #317] did not report any discomfort to the supervisor. The physician and the Resident were also made aware. -The nurse who gave the medication was interviewed. Her medication administration competency was also reviewed. Employees #16 and #17 no longer work at the facility and were not available for interview during the survey. Employee #18 was on leave and unavailable for interview during the survey. Of note, Resident #317 left the facility AMA (against medical advice), on 06/11/25, the same day as the incident, and was unavailable for interview. During a face-to-face interview on 01/30/26 at 3:35 PM, Employee #15 (Unit Manager/Supervisor) when asked if agency nurses were checked for medication administration competency before working with residents on the unit, she stated, There is a competency checklist sheet for new and agency nurses on all units and if there was a problem they would be re-educated by [Name of Employee #16/ Educator, Clinica; We used to also do audits of nurses for med pass. The audit sheets were given to Employee #16. During a face-to-face interview on 02/08/26 at 3:03 PM, Employee #3/Director of Nursing (DON),when asked whether agency nurses receive an orientation that includes observation and competence in medication administration before working with residents, she stated, They do now- at least five random medication administration (med pass) observations are conducted weekly by either the new educator or me. When asked whether she documented the med pass observations, she stated that she did and would check whether there were any med pass observations for Employee #17 after the Employee's orientation on 11/27/24. After reviewing her records, the DON stated that she did not see med pass observations for Employee #17 and could find no other medication administration training for the Employee after her initial orientation. She further commented that Employee #17 was an agency nurse and that, after the incident with Resident #317, she was never asked to return.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, record review, and staff interviews, the facility staff failed to establish a consistent location for the pharmacist's monthly medication review recommendations for each resident, thereby ensuring that the pharmacist's findings were available for review upon request. Resident #8 The findings included: Resident #8 was admitted to the facility on [DATE] with diagnoses that included: Type 2 Diabetes Mellitus, Epilepsy, Hypertension, Bipolar Disorder, Schizoaffective Disorder, Viral Hepatitis C, and Generalized Muscle Weakness. A review of Resident #8's medical record showed: A Quarterly Minimum Data Set (MDS) assessment dated [DATE], which documented that the resident had a Brief Interview for Mental Status (BIMS) summary score of 15, indicating that Resident #8 had intact cognition. In addition, the assessment documented that the Resident had received the following medications during the last 7 days of the assessment: a hypoglycemic (including insulin), an antipsychotic (on a routine basis), an antiplatelet, and an anticonvulsant. An order dated 06/01/22 at 9:00 AM that directed: Haldol Decanoate Solution 50 mg/ml (milligrams/milliliter) (Haloperidol Decanoate) Inject 1 ml intramuscularly one time a day starting on the 1st and ending on the 1st every month for Schizoaffective Disorder.An order dated 06/01/22 at 9:00 AM that directed: Haldol Decanoate Solution 50 mg/ml (Haloperidol Decanoate) Inject 1 ml intramuscularly one time a day starting on the 19th and ending on the 19th every month for Schizoaffective Disorder. An order dated 06/17/24 at 2:09 AM that directed: Ammonia level every Friday one time a day every Fri (Friday) for high ammonia level. An order dated 12/22/24 at 8:00 AM that directed: Lantus SoloStar 100 unit/ml Solution pen-injector Inject 25 units subcutaneously two times a day for DM (Diabetes Mellitus). Hold if BS (Blood Sugar) is less than 120. An order dated 03/28/25 at 2:45 PM that directed: Obtain resident Depakote level on Wednesdays every 6 months. in the morning every 6 month(s) starting on the 16th for 1 day(s).An order dated 06/14/25 at 8:00 AM that directed: Novolog Flexpen 100 unit/ml Solution pen-injector. Inject as per sliding scale: if 0-200 = 0 units; 201-250 = 2 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 8 units, subcutaneously before meals for DM (Diabetes Mellitus). Call the MD (Medical Director) if less than 60 and greater than 400. An order dated 06/15/25 at 8:00 AM that directed: Novolog Solution 100 units/ml. (Insulin Aspart). Inject 12 units subcutaneously before meals for Diabetes Mellitus. An order dated 11/11/25 at 8:00 AM directed: Depakote Oral Tablet Delayed Release 500 mg (Divalproex Sodium) Give 1 tablet by mouth two times a day for Bipolar Disorder.A review of Resident #8's entire paper chart showed the following monthly pharmacy recommendations documents, entitled, Consultant Pharmacist Non-Physician Comment/ [Name of Consultant Pharmacy Agency] Non-Physician Report: 1. January 5, 2025.Resident: [Name of Resident #8]; Physician: [Name of Medical Director]; Comment:12/27 NH3 (Ammonia level) 62; Nurse Signature: [signed and dated by (Employee #/RN Supervisor) on 01/06/25. 2. January 5, 2025.Resident: [Name of Resident #8]; Physician: [Name of Medical Director]; Comment: No irregularities noted. Nurse Signature: [signed and dated by (Employee #/RN Supervisor) on 01/06/25. 3. May 5, 2025: Resident: [Name of Resident #8]; Physician: [Name of Medical Director]; Comment: 4/16 VPA (Valproic acid level) = 41, for mood disorder; Nurse Signature: [signed and dated by (Employee #3/DON) on 06/09/25. Further review of the Resident's paper and electronic medical records showed that there was no documented evidence of the pharmacist's recommendations or monthly medication review for Resident #8 from 01/05/25 to 05/05/25 and from 05/05/25 to 12/31/25. During a face-to-face interview on 01/29/25 3:56 AM, Employee #5 (Registered Nurse/# South Unit Manager), when asked where the pharmacist's monthly medication review recommendations (MMRs) (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident #8 were kept, she stated, while searching through the Resident's paper chart, They should be in each resident's paper chart. I know the DON (Director of Nursing) gets them via email from the pharmacist monthly, and she disperses them to the Unit Supervisors so they can be placed in the resident's chart where the physician can see/sign them. Employee #38 then showed the surveyor the three MMRs that the surveyor had previously reviewed from Resident #8's paper chart. When asked where the pharmacist's recommendations were for the other months in 2025, the Employee made no further comment.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff interviews for two (2) of 65 sampled residents, the facility staff failed to ensure that food services accommodated one (1) resident's allergy to eggs and personal preferences for two (2) residents. Residents #89 and #67). Resident #89 was admitted to the facility on [DATE] with diagnoses that included Spinal Stenosis, Type 2 Diabetes with Hyperglycemia, Discitis, End Stage Renal Disease, and Weakness. A review of Resident #89's medical record revealed the following: A physician's order dated 02/21/25 that stated: LCS/NAS (low concentrated sweets/no added salt) diet, regular texture, thin liquids consistency. A History and Physical assessment dated [DATE] at 12:00 AM that documented: .C . 2.Meds .Allergies: aspirin, codeine, and eggs. A comprehensive Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) Summary Score of 14, indicating that the resident had intact cognition and the resident had a therapeutic diet (e.g., low salt, diabetic, low cholesterol). A comprehensive care plan, revised 01/13/26, lacked documented evidence that the resident's preference for double portions and his egg allergy were addressed. During a face-to-face interview on 02/09/26 at approximately 10:15 AM, Resident #89 asked, Who do I talk to about my meals from this past weekend? I don't know why they (facility staff) can't get my food right. They keep sending me eggs at meals, and I have an allergy to eggs, and they are not sending me double portions. I am supposed to get double portions. The resident then stated I have taken pictures as evidence, and I have called down to the kitchen and spoken with [Director of Kitchen Services] myself on several occasions. During a face-to-face interview on 02/09/26 at 3:46 PM with Employee # (Food Services Manager) stated, We have 14 staff members including a supervisor or assistant who check meal trays before they go up to the residents on the floor. Before placing the meals in the meal cart the loader receives the tray, takes the cover off of each tray, double checks it, puts the cover back on the tray and places the tray in the cart. We have 70 or more residents who receive double portions of one type or another. The Employee reviewed Resident #89's photos and stated, I am not sure what happened there, and the Employee acknowledged the finding. 2. Resident #67 had diagnoses that included spinal stenosis (cervical region), quadriplegia, central cord syndrome, type 2 diabetes mellitus with diabetic peripheral angiopathy, major depressive disorder, and hypertension. The resident was assessed as alert and oriented, able to communicate needs, and required assistance with activities of daily living. The resident had a physician's order for a regular diet with regular texture and thin liquids. No known food allergies were documented. On 01/16/2026 at approximately 11:00 AM, Resident #67 was observed in his room, alert and oriented in no apparent distress; at approximately 1:45 PM, Resident #67 complained he had not yet received (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his lunch. The resident added that the previous day he had ordered a cheeseburger from the Always Available Menu but did not receive it. The resident stated, Normally my food comes with everyone else on the floor. On 01/29/2026 at approximately 1:55 PM, a nurse delivered a lunch tray to Resident #67's room. The tray contained cheeseburgers from the kitchen. A review of Food and Nutrition Services progress notes dated 11/04/2025 documented the resident remained on a regular diet and had multiple food preferences and requested access to regular diet for greater choices. A review of nursing progress notes dated 01/12/2026 documented the resident was to receive a chicken and beef dinner for the evening meal. The note indicated the resident disliked chicken being served as a standing order for baked chicken. The dietary department was contacted and offered a substitute of a grilled turkey and cheese sandwich with mayonnaise. The resident declined the substitute. A review of the facility tray line ticket for Unit 2-South, where Resident #67 resided, indicated lunch serving time was scheduled at 12:30 PM with delivery time at 12:45 PM. Observation revealed Resident #67 did not receive lunch until approximately 1:55 PM. A review of the undated Prestige Always Available menu, posted on the wall in the resident's room, listed a Prestige Prime Cheeseburger – premium handcrafted beef infused with signature flavors, topped with cheddar cheese and gourmet accompaniments, served on a toasted bun, as an item available for residents to order as an alternative to the regular menu. On 02/09/2026 at approximately 1:45 PM, Employee #27, the 2-South Unit Manager, stated that Resident #67's cheeseburger was not sent with the unit's meal trays and that a nurse had to go to the kitchen to obtain the tray after the initial meal pass. On 02/09/2026 at approximately 2:35 PM, Employee #20, the Food Service Director stated staff were not aware that the cheeseburger was unavailable for the resident on the previous day, 02/08/2026, and reported that if an item is listed on the Always Available Menu, it should be provided unless contraindicated by the resident's diet order or allergies. During a phone interview on 02/09/2026 at approximately 4:15 PM, Employee #37, CNA, stated that the employee who took the order stated that when the order was placed the previous day (02/08/2026) at approximately 10:30 AM, the kitchen staff reported cheeseburgers and hotdogs weren't available. During a phone interview on 02/10/2026 at approximately 9:30 AM, Employee# 20, the Food Service Director stated the kitchen had cheeseburgers available but did not have buns to serve the sandwich as ordered on 02/08/2026. During a phone interview on 02/10/2026 at approximately 10:00 AM, Employee #37 stated the employee who took the order reported hotdogs and cheeseburgers were not available; I was not told it was only the buns that were not available. The facility failed to ensure Resident #67 received his meal at the scheduled mealtime; ensure the availability of a menu substitute listed on the Always Available Menu. And this resulted in Resident #67 receiving his lunch tray more than one (1) hour) late after the scheduled delivery time and not (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receiving the requested menu item on the prior day.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident’s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Number of residents sampled: Number of residents cited: Based on residents' interviews, observation, and staff interviews, the facility staff failed to ensure residents received pm snacks. The findings included:A policy titled, Offering/Serving Bedtime Snacks with a review date of 08/15/25 instructed nursing staff to offer bedtime snacks to residents in accordance with resident's needs, preferences and requests on a daily basis.During the task of Resident Council meeting on 01/14/26 starting at 2:43 PM held with multiple residents from different units in the facility stated that they are not provided with pm snacks. Additionally, Resident #10 stated that they do have pm snacks for specific residents and their names are on the snack. The resident said that he can only get a pm snack if the resident who it is assigned to refuses it. During observations of kitchen on Unit 1 south and 3 south on 01/15/26 starting at 10:30 AM revealed multiple sandwiches with residents' names.During a face-to-face interview with the Administrator and Executive Director on 01/15/26 at approximately 3PM they stated that they were not aware of residents not being offered pm snacks. They have corrected the issues and now multiple pm snacks are provided for all units for all residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Number of residents sampled: Number of residents cited: Based on observations and staff interviews, facility staff failed to prepare and distribute foods under sanitary condition, as evidenced by the following observations. The findings include:During a walkthrough survey in the kitchen on 01/06/2025 approximately at 9:30AM, the following observations were made: Cleaned and sanitized food contact utensils stored on rack that had no minimum 6 inches clearance from floor to prevent potential contamination at the manual dish washing area in the kitchen. There was no proper test kit provided to monitor food contact surface sanitizing solution concentration at the 3-compartment sink manual dish washing and for the sanitizing buckets. Single use coffee cups and lids left on floor under coffee making station. Food service director, Employee #20, was immediately made aware of these findings and proceeded to implement measures to address these issues.During a face-to-face interview on 01/06/2026, approximately at 10:00 AM, the above observations were acknowledged by Employee #20, Food Service Director.During kitchen survey on 01/12/2026 approximately at 9:40 AM, it was observed that:Mashed potatoes were held at improper hot holding temperature, 134-degree F, 132-degree F on the broken steam table.Kitchen utensils were not properly washed, rinsed and finally sanitized in the 3-compartment sinkSame spatula used to handle raw and cooked hamburgers on griddle; this practice created cross contamination; affected food items were discarded at callFood service director, Employee #20, was immediately made aware of these findings and proceeded to implement measures to address these issues.During a face-to-face interview on 01/12/2026, approximately at 9:40 AM, the above observations were acknowledged by Employee #20, Food Service Director.During kitchen survey on 01/13/2026 approximately at 2:00 PM, it was observed that mashed potatoes were held at improper hot holding temperature, 123-degree F, 120-degree F.During a face-to-face interview on 01/13/2026, approximately at 2:00 PM, the above observations were acknowledged by Employee #20, Food Service Director.

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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 reviews and staff interviews for two (2) of 65 sampled residents, it was determined that facility staff failed to show documented evidence that the facility's visitor logbook was retained with accuracy and documentation of gastrostomy management was lacking for one resident. (Residents #55 and #220). The findings included: Resident # 55 was admitted to facility on 04/03/2025 with diagnosis of diabetes mellitus, myocardial infarction, fluid overload, hypertension, osteoarthritis and congestive heart failure. Resident #55 reported to facility staff that on 04/07/2025, two hundred (200) dollars was missing from his room. He was residing on unit 2 South when this happened. On 02/06/2026 at 1:12 PM during an interview with Resident #55, in response to an inquiry regarding how he obtained the 200 dollars, he stated, my cousin [name] visited and gave it to me. A review of the visitor's logbook for 2south where the resident resided at the time showed that the pages were missing for the dates during the period of 04/01/2025 through 04/029/2025. Interviews were conducted on 02/12/2026 with the staff assigned to Resident #55 on 04/07/2025, Employees #26 and # 36. The staff stated that they were not aware the resident had $200 until it was reported missing. In response to an inquiry regarding the process for securing resident valuables (e.g. money), they stated it would be reported to the registered nurse who would secure it in a safe. The evidence showed that facility staff failed to ensure accuracy and retention of the visitor logbook. A face-to-face interview was conducted with Employee #3 [Director of Nursing] on 2/12/2026 at 2:00pm, she acknowledged the visitor logbook was missing pages from 04/01-04/29/2026 and she was unable to locate the missing pages. 2. A facility policy titled 'Documentation in Medical Record' with a review date of 08/14/2025 documented, in part: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medial record in accordance with sate law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3. Documentation may be performed manually or as per the facility's specific electronic medical record software program. A review of Resident #220's medical record revealed: Resident #220 was admitted to the facility on [DATE] with multiple diagnoses that included: Stroke, Dysphagia, Gastrostomy Tube, Dementia and Seizure Disorder. An Annual Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview for Mental Status (BIMS) summary score of 'Severely Impaired'; Functional Abilities: Totally Dependent on staff for all ADLs (activities of daily living) and transfers; and the resident had a Gastrostomy Tube for feedings. A physician's order with a start date of 08/09/24 documented, Dressing Change to G-(Gastrostomy) tube site every night shift in the morning. A physician's order with a start date of 08/10/24 documented, Enteral Feed Order: In the morning change flush syringe every 24 hours. A review of Resident #220's Treatment Administration Record dated 02/01/25 – 02/28/25 revealed no documented evidence that the resident's Dressing change to his G-tube site was completed on 02/10/25 at 6:00 AM as ordered by the physician. A review of Resident #220's Medication Administration Record dated 02/01/25 – 02/28/25 revealed no documented evidence that the resident's G-tube flush syringe was changed on 02/18/25 at 6:00 AM as ordered by the physician. A face-to-face interview conducted on 01/23/26 at 12:25 PM Employee #3 (Director Of Nursing) acknowledged the findings and stated, I cannot vouch for what wasn't done, I can only provide Education on proper documentation.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, record review, and staff interviews for one (1) of 65 sampled residents, the facility staff failed ensure no breaks in infection control by failing to wear proper personal protective equipment while providing incontinent care for a resident on Enhanced Barrier Precautions (EBP). Residents #3 The findings included: A facility policy entitled, Enhanced Barrier Precautions (EBP), reviewed and revised on 06/26/25, that documented: .Definitions: Enhanced Barrier Precautions (EBP): refer to an infection control intervention designed to reduce transmission of multidrug -resistant organisms that employ targeted gown and glove use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 1. Prompt recognition of need: a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions.3. Implementation of Enhanced Barrier Precautions: .b. PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room.4. High-contact care activities include a. Dressing, b. Bathing, c. Transferring, d. Providing hygiene, e. Changing linens, f. Changing briefs or assisting with toileting, g. Device care or use. h. Wound care: any skin opening requiring a dressing. Resident #3 was admitted to the facility on [DATE] with diagnoses that included:Idiopathic Aseptic Necrosis of Left Femur; Gout; Methicillin-Resistant Staphylococcus Aureus (MRSA) Infection; Bacterial Infection, Unspecified; Hidradenitis Suppurativa; Complications of Colostomy; Protein Calorie Malnutrition, and Need for Assistance with Personal Care. During an observation on 01/08/26 at 1:04 PM, Resident #3 was lying in bed watching television. The Resident stated that his brief was wet and he needed to be changed. The Resident pressed his call light for his nurse or CNA (Certified Nurse Aide). At approximately 1:10 PM, Employee #16 CNA) washed his hands and applied (donned) gloves, per the facility's EBP policy. The Employee did not apply a gown, as required by policy. The Employee removed the changed the Resident's brief and applied cream per the physician's orders. Employee #16 removed (doffed) his gloves per facility policy and washed his hands before exiting the Resident's room. Of note, hanging on the resident's room door, was a storage bag with compartments that held disposable gloves, masks, and gowns. In addition, there was a sign posted on the Resident's door indicating that the resident was on enhanced barrier precautions. The sign directed all staff performing any high-contact care activity to apply gloves, a mask, and a gown before entering the Resident's room. A review of Resident #3's medical record revealed: A physician's order dated 11/02/25 at 8:58 PM that directed: Barrier cream to buttocks for protection every shift. A physician's order dated 11/02/25 at 9:02 PM, that directed: Change Resident['s] colostomy bag q (every) shift as needed every shift related to Other Complications of Colostomy. A physician's order dated 11/02/25 at 9:02 PM that directed: Colostomy Care; Ostomy; Remove soiled appliance. Cleanse the stoma and peristomal skin with saline gauze or a moist washcloth. Do not use soap or lotions on the stoma. Place a wafer around the stoma and attach the corresponding pouch. Empty when 1/3, 1/2 full. Change every 3 days and PRN (as needed) when leaking. every day shift every 3 day(s). A physician's order dated 11/16/25 at 11:00 PM that directed: Aquaphor Advanced Therapy External Ointment (Emollient) Apply to urinary fistula topically every shift for skin protection, apply to the surrounding area. A physician's order dated 12/25/25 at 3:25 PM, that directed: Left groins: Cleanse with wound cleanser, pat dry and apply calcium alginate with silver, mesh underwear, superabsorbent qd/prn (every day as needed). One time a day for wound treatment until seen and evaluated by the wound team. A physician's order dated 01/13/26 at 12:25 AM that directed: Right groins: Cleanse with wound (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleanser, pat dry and apply calcium alginate with silver, mesh underwear, superabsorbent qd/prn, one time a day for wound treatment. During a face-to-face interview on 01/08/26, approximately 1:15 PM, Employee #16 stated that Resident #3 was on Enhanced Barrier Precautions because he had a colostomy and wounds. When asked why he had not put a disposable gown on before entering the room to provide incontinent care, he stated, I don't know, I just forgot. The Employee then acknowledged the findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Number of residents sampled: Number of residents cited: Based on observations and staff interviews, the facility staff failed to maintain essential kitchen equipment in good working condition as evidenced by the following:The findings include:During the initial walkthrough survey in the kitchen on 01/06/2026, the following observations were made: One (1) of one (1) the reach-in refrigerator in kitchen located next to the ice making machine was leaking condensate water inside its food storage chamber,The refrigerator referenced in above item #1 was missing light bulb cover inside its food storage chamber,Dish washing machine area - the spray hose storage hook was in poor repairDish washing machine area - atmospheric backflow preventer valve cover was in poor repairBroken garbage disposer attached underneath a food preparation sinkLeaking drainpipe under the food preparation sink at the cooklineThe ventilation exhaust hood in kitchen was missing grease trap pan and one grease filterFood service director, Employee #20, was immediately made aware of these findings and proceeded to implement measures to address these issues.During a face-to-face interview on 01/06/2026, approximately at 10:00 AM, the above observations were acknowledged by Employee #20, Food Service Director.During kitchen survey on 01/12/2026 approximately at 9:40 AM, it was observed that the steam table was not operational; mashed potatoes were held at improper hot holding temperature, 134-degree F, 132-degree F on then broken steam tableFood service director, Employee #20, was immediately made aware of these findings and proceeded to implement measures to address these issues.During a face-to-face interview on 01/12/2026, approximately at 9:40 AM, Employee #20, Food Service Director, stated that the steam table went out of operation yesterday (01/11/2026) approximately at 3:00 PM. He added and said, order for part to fix the table is already submitted, repair is anticipated today. During kitchen survey on 01/12/2026 approximately at 4:45 PM, the following observations were made: the steam table was still not operational, and kitchen employees were plating dinner for residents on the broken steam table.During a face-to-face interview on 01/12/2026, approximately at 4:45 PM, Employee #20, Food Service Director, acknowledged the above observations and further stated maintenance crew came and looked at the table today, and they said they will be back tomorrow to continue working on the table.During a face-to-face interview on 01/13/2026, approximately at 9:00AM, Employee #20, Food Service Director, stated that the part for the broken steam table was delivered and the crew would fix the table today.During kitchen survey on 01/13/2026 approximately at 2:00 PM, it was observed that mashed potatoes were held at improper hot holding temperature, 123-degree F, 120-degree FDuring a face-to-face interview on 01/13/2026, approximately at 2:00 PM, Employee #20, Food Service Director, said one of the steam tables is fixed and operational now but the other one is still not functional and it will be fixed tomorrow.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations and interviews, the facility staff failed to adequately equip to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside and toilet facilities.The findings include:During an environmental walkthrough of the facility on January 21, 2026, approximately between 10:30 AM and 2:00 PM, the following issues were identified out of 52 surveyed resident rooms on 1st, 2nd and 3rd floors of the facility building:Resident call lights were not functional in room [ROOM NUMBER]-A, 134-B, 132 - toilet room,152-A, 122-A and B, 106-A, 111-toilet room.Facility leadership was immediately made aware of these findings and proceeded to implement measures to address these issues.The observations were acknowledged by Employee #19, Maintenance Director, during a face-to-face interview on January 21, 2026, approximately at 2:00 PM.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations and interviews, the facility staff failed to equip corridors with firmly secured handrails.The findings include:During an environmental walkthrough of the facility on January 21, 2026, between 10:30 AM and 2:00 PM, it was observed that some of the handrails in 1-South unit corridors were not firmly secured to the adjacent wall, and the handrail near to room [ROOM NUMBER] was missing end cap.These observations were acknowledged by Employee # 19, Maintenance Director, approximately at 1:45 PM on 01/21/2026 approximately at 1:45 PM.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Number of residents sampled: Number of residents cited: Based on observations and interview, the facility staff failed to maintain an efficient pest control system as evidenced dead cockroaches were seen on floor at the cookline area in the kitchen.The findings include:1. Five (5) dead cockroaches observed under food preparation sink with leaking drainpipe at the cookline in the kitchen.Facility leadership was immediately made aware of these findings and proceeded to implement measures to address these issues.Employee # 20, Food Service Director, acknowledged the findings during a face-to-face interview on January 6th, 2026, at approximately 10:00 AM.