

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Capitol Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4000 Linglestown Road Harrisburg, PA 17112	
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)		
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on review of facility policy, document review, and resident and staff interviews, it was determined that the facility failed to provide a resident the right to voice a grievance to the facility and make prompt efforts by the facility to resolve the grievance for one of four residents reviewed (Resident 4). Findings include: Review of the facility policy, titled Grievances/Complaints, Filing with a last revised date of April 2027, revealed, 1. Any resident, family member, or appointed resident representative may file a grievance or complaint concerning the care, treatment, or behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. Grievances also may be voiced or filed regarding care that has not been furnished. 5. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. 10. The grievance officer and staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated. During an interview with Resident 4 on January 13, 2026, at 3:00 PM, she revealed an incident that occurred with Employee 4 (Licensed Practical Nurse) on January 8, 2026, where Employee 4 came into Resident 4's room that morning to pass medications and Resident 4 stated to Employee 4 that she had to use the restroom, but Employee 4 told Resident 4 that she was not able to assist at this time due to passing out medications. During that time, Resident 4's roommate asked Employee 4 to get their bed pan, where Employee 4 proceeded to get a bed pan from the bathroom and rolled Resident 4 over, put the bed pan under her, and walk out of the room. Resident 4 revealed that she was left sitting on the bed pan until she got tired and pulled it out from under her the best she could, with the call bell on, waiting for someone to come back and assist her. Resident 4 revealed that she uses a bed pan during the night, but is independent on using the rest room during the day and is continent with her bowel and bladder. Resident 4 revealed that she told Employee 5 (Admissions Director) and Employee 6 (Social Worker) about the incident the same day and requested to speak to Employee 1 (Nursing Home Administrator [NHA]) about the incident. Resident 4 revealed that Employee 5 told her they would file a grievance for her. During an interview with Employee 5 on January 14, 2026, at 1:42 PM, revealed that she goes into Resident 4's room daily to check in on her, and was made aware by the Resident on January 8, 2026, that the Resident wanted to speak to Employee 1 regarding an issue with another staff member, but did not mention the staff member's name. Resident 4 told Employee 5 that she was put on the bed pan and left there, and expressed that it was her roommate who had requested to use the bed pan. Employee 5 stated that she told Employee 1 that Resident 4 was requesting to speak to them; however, there was no documentation of their conversation with Resident 4 or any documentation of when they notified Employee 1 about the incident. During an interview with Employee 6 on January 14, 2026, at 12:54 PM, it was revealed that Resident 4 told Employee 6 about the incident that occurred with Employee 4, however, could not recall if she was told about it on January 8 or 9, 2026, as she had no documentation of her conversation</p> <p>(continued on next page)</p>		

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>with Resident 4 of her concern. Employee 6 revealed that Resident 4 reported a concern involving Employee 4 where the Resident expressed to Employee 4 that the Resident had to use the rest room, and her roommate needed the bed pan; however, Employee 4 gave the bed pan to Resident 4 instead of her roommate, and left her there with it underneath on the Resident and proceeded to walk out of the room and not return. Employee 6 revealed that she spoke to Employee 1 about Resident 4's concern, however, has no documentation of it. Employee 6 was unable to remember if she filed a grievance for Resident 4, but revealed that she would normally write a grievance for a resident if she was made aware of a concern involving a staff interaction. Review of the facility's grievance log from November 2025 to the present day failed to reveal a grievance was filed for Resident 4 and the incident that occurred with Employee 4 on January 8, 2026. Review of Resident 4's clinical record failed to reveal any documentation of the incident that occurred with Employee 4 on January 8, 2026. Review of the facility records failed to reveal any documentation regarding the concern reported by Resident 4 that occurred with Employee 4 on January 8, 2026. During an interview with the NHA on January 13, 2026, at approximately 10:30 AM, revealed that she was made aware of a concern Resident 4 had with an employee and was not feeling well but visited the Resident briefly on January 9, 2026, who informed the NHA that the Resident felt safe in the facility and can talk to the NHA about her concern another day. The NHA had no documentation to provide relating to Resident 4's concern at this time. Further interview with the NHA on January 14, 2025, at 9:19 AM, revealed that she spoke to Resident 4 that morning about her concern with Employee 4 and was going to file a grievance, as well as complete education with Employee 4 on customer service. 28 Pa Code 201.18(b)(2)(3) Management 28 Pa code 201.29(a) Resident rights</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, review of facility documentation, and staff interviews, it was determined that the facility failed to provide pharmaceutical services to meet the needs of each resident for six of 24 residents reviewed (Residents 5, 6, 7, 8, 9, and 10). Findings include: Review of the facility policy, titled Administering Medications with a last revised date of April 2019, revealed 4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are to be administered within one hour of their prescribed time, unless otherwise specified. Review of Resident 5's clinical record revealed diagnoses that included hypothyroidism (when your thyroid gland does not make enough thyroid hormone to meet your body's needs) and depression (a serious mood disorder that involves persistent sadness and a loss of interest in daily activities). Review of Resident 5's physician orders revealed the following orders: Zyprexa oral tablet 2.5 milligrams (mg) (Olanzapine), give 0.5 mg by mouth at bedtime for behavioral disturbances, with a start date of January 7, 2026; Mirtazapine Oral Tablet 7.5 mg, give one tablet by mouth at bedtime for depression, with a start date of January 7, 2026. Review of Resident 5's nursing progress notes revealed Resident 5 was admitted to the facility on [DATE], at 5:40 PM from the hospital. Review of Resident 5's medication administration record (MAR) for January 2026 revealed on January 7 and 8, 2026, Resident 5's 9:00 PM doses of Zyprexa oral tablet and Mirtazapine oral tablet were blank, indicating they were not administered to the Resident; and marked 5 on January 9, 2026, which is code for Hold. Further review of Resident 5's nursing progress notes revealed a note on January 9, 2026, corresponding with the aforementioned time that the medications were waiting to be delivered by the pharmacy. Review of Resident 6's clinical record revealed diagnoses that included hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD - a progressive lung disease that causes airflow obstruction and breathing problems, including shortness of breath, chronic cough, and wheezing). Review of Resident 6's physician orders revealed an order for Meropenem Intravenous (IV) Solution Reconstituted 500 mg, use 500 mg intravenously every 6 hours for right AKA (above-the-knee amputation) wound until December 24, 2025, with a start date of December 4, 2025. Review of Resident 6's December 2025 MAR revealed on December 4, 2025, Resident 6's 6:00 PM dose of Meropenem IV salutation 500 mg was documented as 22, which is code for drug/treatment not administered. Review of Resident 6's nursing progress notes revealed a note written on December 4, 2025, corresponding with the aforementioned time that the medication was not available yet from pharmacy. Review of Resident 7's clinical record revealed diagnoses that included bipolar disorder (a mental health condition causing extreme shifts in mood, energy, and activity levels) and diabetes (a chronic metabolic disorder that causes high blood sugar levels). Review of Resident 7's physician orders revealed the following orders: Lithium Carbonate Oral Capsule 150 mg, give one capsule by mouth one time a day for Bipolar, with a start date of December 18, 2025; Tizanidine HCL oral tablet 2 mg, give three tablets by mouth at bedtime for muscle spasms, with a start date of December 17, 2025. Review of Resident 7's nursing progress notes revealed Resident 7 was admitted to the facility on [DATE], at 2:40 PM, from the hospital. Review of Resident 7's December 2025 MAR revealed on December 17, 2025, Resident 7's 8:00 PM dose of Tizanidine HCL oral tablet 2 mg, three tablets at bedtime was documented as 22, which is code for drug/treatment not administered. Further review of Resident 7's December 2025 MAR revealed on December 18, 2025, Resident 7's 8:00 AM dose of Lithium Carbonate Oral Capsule 150 mg was marked 5, which is code for Hold. Further review of Resident 7's nursing progress notes revealed a progress note written on December 17, 2025, at 8:54 PM, indicating Resident 7 was a new admit and was</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>waiting from pharmacy to deliver their Tizanidine HCL oral tablet medication. Review of progress note written on December 18, 2025, at 9:31 AM, indicated the medical director was aware that Resident 7's Lithium Carbonate Oral Capsule was not administered. Review of Resident 8's clinical record revealed diagnoses that included hypertension and diabetes. Review of Resident 8's physician orders revealed the following orders: Glipizide oral tablet 10 mg, give one tablet by mouth one time a day for diabetes, with a start date of January 4, 2026, at 9:00 AM; Dapagliflozin Propanediol oral tablet 10 mg, give one tablet by mouth two times a day for diabetes, with a start date of January 4, 2026; Dapagliflozin Propanediol oral tablet 10 mg, give one tablet by mouth one time a day for diabetes, with a start date of January 6, 2026, at 9:00 AM; Metformin HCl oral tablet 850 mg, give one tablet by mouth with meals for diabetes, with a start date of January 4, 2026; and Divalproex sodium oral tablet delayed release 500 mg, give one tablet by mouth two times a day for mood disorder, with a start date of January 3, 2026. Review of Resident 8's clinical record revealed the Resident was admitted to the facility from the hospital on January 3, 2026. Review of Resident 8's January 2026 MAR revealed on January 4, 2026, Resident 8's 9:00 AM dose of Glipizide oral tablet 10 mg, was marked 5, which is code for Hold. On January 4, 2026, Resident 8's 9:00 AM dose of Dapagliflozin Propanediol oral tablet 10 mg was marked 5 and their 5:00 PM dose was marked 22, which is code for Medication/treatment not administered. On January 6, 2026, Resident 8's 9:00 AM dose of Dapagliflozin Propanediol oral tablet 10 mg was marked 22. On January 4, 2026, Resident 8's 8:00 AM and 12:00 PM doses of Metformin HCl oral tablet 850 mg, were marked 5, and their 5:00 PM dose was marked 22. On January 4, 2026, Resident 8's 8:00 AM dose of Divalproex sodium oral tablet delayed release was marked 5. Review of Resident 8's nursing progress notes revealed corresponding documentation with the aforementioned dates and times that the medications were either on order or waiting to be delivered from the pharmacy. Review of Resident 9's clinical record revealed diagnoses that included dementia (severe memory, thinking, and reasoning decline that interferes with daily life, caused by diseases damaging brain cells) and glaucoma (group of eye diseases damaging the optic nerve). Review of Resident 9's physician orders revealed an order for Dorzolamide HCl - Timolol Mal Ophthalmic Solution 2-0.5%, instill 1 drop in both eyes every 12 hours for glaucoma, with a start date of December 30, 2025. Review of Resident 9's nursing progress notes revealed Resident 9 was admitted to the facility on [DATE], from the hospital, at 9:30 PM. Review of Resident 9's December 2025 MAR, revealed on December 31, 2025, Resident 9's 9:00 PM dose of Dorzolamide HCl - Timolol Mal Ophthalmic Solution was documented 22, which is code for Medication/treatment not administered. Further review of Resident 9's nursing progress notes revealed corresponding documentation with the aforementioned date and time that the medication was unavailable and on order from the pharmacy. Review of Resident 10's clinical record revealed diagnoses that included COPD and hypertension. Review of Resident 10's physician orders revealed an order for Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 MCG/ACT (one millionth of a gram - Aerosol Solution), 2 puff inhales orally every 12 hours for COPD rinse mouth after use, with a start date of January 12, 2026. Review of Resident 10's nursing progress notes revealed Resident 10 was admitted to the facility on [DATE], at 3:14 PM from the hospital. Review of Resident 10's January 2026 MAR revealed on January 12, 2026, Resident 10's 8:00 PM dose of Budesonide-Formoterol Fumarate Inhalation Aerosol was marked 5, which is code for Hold. Further review of Resident 10's nursing progress notes revealed corresponding documentation with the aforementioned date and time that the medication was waiting for pharmacy delivery. Interview conducted with the Nursing Home Administrator (NHA) on January 13, 2026, at approximately 10:30 AM, revealed that the facility had their pixis well stocked and they would not admit a resident without having their medications available. Further interview conducted with the NHA on</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>January 14, 2026, at approximately 2:00 PM, revealed that she would not necessarily expect a resident to have their medications available as ordered by the physician all the time, and will inform their medical provider if a medication is not available.28 Pa. Code 211.9(a)(1) Pharmacy services28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on facility policy review, observations, clinical record review, and staff interview, it was determined that the facility failed to ensure staff implement infection control policies to prevent the spread of infection for three of four residents observed on contact precautions (Residents 1, 2, and 3). Findings include: Review of the facility policy, titled Isolation - Categories of Transmission-Based Precautions with a last revised date of September 2022, revealed 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. A. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. Review of Resident 1's clinical record revealed diagnoses that included diabetes (a chronic condition where the body has trouble regulating blood sugar) and hypertension (high blood pressure). Review of Resident 2's clinical record revealed diagnoses that included hypertension and anxiety (a persistent feeling of worry that interferes with daily life). Review of Resident 3's clinical record revealed diagnoses that included heart failure (a chronic condition where the heart can't pump enough blood and oxygen to the body) and chronic kidney disease (long-term condition where the kidneys are damaged and lose their ability to filter waste and excess fluid from the blood over time). Observation of Resident 1's room on January 13, 2026, at 2:15 PM, revealed Resident 1's call bell was on. On the entrance door to Resident 1's room there was a sign indicating that Resident 1 was on droplet precautions and that it was required to clean your hands before entering and before leaving Resident 1's room. Further observation at that time revealed Employee 3 (Nurse Aid) leave Resident 2 and Resident 3's room, which had a sign on the door indicating both Resident 2 and 3 were on enhanced barrier precautions and that it was required to clean your hands before entering and leaving the room. Employee 3 was then seen entering Resident 1's room to answer the call bell, and did not clean her hands prior to leaving Resident 2 and 3's room and entering Resident 1's room. Employee 3 assisted Resident 1's roommate, who was not on precautions in the bathroom. Observation of Resident 1's room on January 14, 2026, at 12:01 PM, revealed Resident 1's call bell was on. On the entrance door to Resident 1's room there remained a sign indicating that Resident 1 was on droplet precautions. Further observation at that time revealed Employee 3 entered Resident 1's room without cleaning her hands, put gloves on, removed the trash from Resident 1's room, and entered Resident 2 and 3's room without performing hand hygiene in between and wearing the same gloves. Further observation revealed Employee 3 taking the trash bag from Resident 1's room into Resident 2 and 3's room, getting the trash from Resident 2 and 3's room, removing her gloves, and leaving without performing hand hygiene. Review of Resident 1's clinical record revealed a Health Status Progress Note written on January 2, 2026, at 3:06 PM, with text indicating Resident 1 was to be on contact precautions until RVP (Respiratory Syncytial Virus, a very common respiratory virus causing cold-like symptoms but severe illness in infants, older adults, and immunocompromised individuals, leading to bronchiolitis or pneumonia, and spreading via respiratory droplets) results are received. Review of Resident 2's physician orders revealed an order for Resident 2 to be on enhanced barrier precautions starting on August 12, 2025, for dialysis and a peg tube. Review of Resident 2's care plan revealed a focus area that Resident 2 required enhanced barrier precautions related to dialysis and peg tube, with an initiation date of November 6, 2024; and an intervention to change personal protective equipment and perform hand hygiene prior to caring for another resident, initiated on November 6, 2024. Review of Resident 3's physician orders revealed an order for Resident 3 to be on enhanced barrier precautions starting on August 12, 2025, due to having a foley. Review of Resident 3's care plan revealed a</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	focus area that Resident 3 requires enhanced barrier precautions related to foley, with an initiation date of August 13, 2025. During an interview with the Nursing Home Administrator conducted on January 14, 2026, it was revealed that she would have expected Employee 3 to have performed appropriate hand hygiene before entering and leaving the residents' rooms. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services		