DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES						NO. 0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) D	OMPLETED
		095036	B. WING	÷			С
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		09/26/2022
UNIQUE R	REHABILITATION AND HE				901 FIRST STREET NW WASHINGTON, DC 20001		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREI	FIX	CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000	0		12/5/2022
	conducted at this facil 2022. Survey activitie record reviews, and re The facility's census d and survey sample ind The following complain this survey: DC000105 DC00010675, DC0007 The following facility re investigated during this DC00010848, DC0001 DC00010732, DC0001 DC00010302, DC0001 DC00010302, DC0001 DC00010302, DC0001 DC00010135. Federal and Local defid to the investigation of: DC00010577, DC0001 DC00010577, DC0001 DC00010502, DC0001 DC00010523. After analysis of the fin- that the facility was not requirements of 42 CFF Requirements for Long During the survey actual	hts were investigated during 205, DC00010736, 10481, and DC00010174. eported incidents were a survey: DC00010969, 10824, DC00010782, 10730, DC00010702, 0641. DC00010624, 0317, DC00010299, 0242, DC00010241, 0223, DC00010212, and ciencies were cited related DC00010905, 0445, DC00010324, 0898, DC00010463, 0299, DC00010228, and dings, it was determined in compliance with the R Part 483, Subpart B, and Term Care Facilities al harm level deficiencies					
	were identified at: F600 and F689 (Resident #3)	(Resident #204), F686,).					
BORATORY DI		PPLIER REPRESENTATIVE'S SIGNATÚRÉ					
	SUICER/SUI	FUER REPRESEN IATIVE'S SIGNATÚRE	An		TITLE		(X6) DATE
	atement onding with an asta		IN t	X	A mprovision from	12-	01-202-

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 program participation.

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					С
		095036	B. WING		09/26/2022
NAME OF P	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
	REHABILITATION AND HI		90	1 FIRST STREET NW	
			w	ASHINGTON, DC 20001	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE O REFERENCED TO THE APPROPR DEFICIENCY)	CROSS- COMPLETIO
					12/5/202
F 000	Continued from page	1	F 000		
	The following is a dir	ectory of abbreviations			
		t may be utilized in the			
	report:	-			
	AMS - Altered Me				
		nt Reference Date			
	AV- Arteriovenous				
	- Twice- a-da B/P - Blood Pres	-			
		Federal Regulations			
		r Medicare and Medicaid			
	Services				
		Nurse Aide			
	CRF - Community	y Residential Facility			
		egistered Nurse Practitioner			
	D.C District of				
		Columbia Municipal			
	Regulations				
	D/C- Disconti	nue			
	DI- Deciliter DMH - Department	of Montal Haalth			
	DOH- Department	of Mental Health			
		trocardiogram			
		Medical Services (911)			
	F - Fahrenheit				
	FR French				
	G-tube- Gastrostor	ny tube			
	HR- Hour				
		rvice Center			
		tilation/Air conditioning			
	ID - Intellectual	-			
	IDT - Interdiscipli IPCP- Infection P	nary team revention and Control			
		revention and Control			
	Program LPN- Licensed P	ractical Nurse			
	L- Liter				
		nit of mass)			
		Administration Record			

Event ID: 93TP11

Facility ID: JBJ

If continuation sheet Page 2 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/07/20 FORM APPROVE OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		095036	B. WING		09/26/2022
	ROVIDER OR SUPPLIER	ALTH CENTER LLC	I	STREET ADDRESS, CITY, STATE 901 FIRST STREET NW WASHINGTON, DC 20001	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X CORRECTIVE ACTIC REFERENCED TO	OF CORRECTION (EACH (X5) ON SHOULD BE CROSS- COMPLETION D THE APPROPRIATE DATE CIENCY)
F 000	M- minute mL - milliliters (r volume) mg/dl - milligram mm/Hg - millimeters MN midnight N/C- nasal ca Neuro - Neurologica NFPA - National Firn NP - Nurse Prac O2- Oxygen PASRR - Preadmissi Review Peg tube - Percutane Gastrostomy PO- by mouth POA - Power of POS - physician's Prn - As needed Pt - Patient Q- Every RD- Registered N Range o RP R/P - Responsit SBAR - Situation, I Recommendation SCC Special C Sol- Solution TAR - Treatment Ug - Microgram	ata Set metric system unit of mass) netric system measure of s per deciliter s of mercury unula al e Protection Association titioner on screen and Resident ous Endoscopic Attorney s order sheet d d Dietitian urse ROM f Motion ble party Background, Assessment, are Center Administration Record	F	⁰⁰⁰ Unique Rehabilitat Center makes its k operate in substar with both Federal Submission of this Correction (POC) of an admission or ag party, its officers, employees or agen of the facts alleged the conditions set statement of the d	12/5/202 tion and Health best efforts to ntial compliance and State laws. s Plan of does not constitute greement by any directors, nts as to the truth d or the validity of forth on the eficiencies. This (POC) is prepared because it is
SS=D	7(02-99) Previous Versions Obs	-		Facility ID: JBJ	If continuation sheet Page 3 of 151

Facility ID: JBJ

If continuation sheet Page 3 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRU		(X3) DATE	1
		095036	B. WING _					C /26/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREETAD	DRESS, CITY, STATE, ZIP CODE		
				9	01 FIRST S	STREET NW		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC		v	VASHING	TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
								12/5/2022
F 550	Continued from page CFR(s): 483.10(a)(1)(F	550	1.		ΉE	
						AFFECTED RESIDENTS		
	 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the 					Resident #193 was assessed b Licensed nurse on 9/20/22. Res suffered no negative outcomes was in-serviced upon discovery ensure that Resident #193's pri curtain is left closed while recei personal care including bed bar maintain dignity and privacy. Staff #24 was in-serviced by St educator on 9/19/22 to ensure maintain privacy and dignity at Resident #132 and #158 was a by licensed nurse on 9/13/2022 suffered no negative findings. Resident's room was installed of stop sign door banner to discou- residents who wander from ent room. Staff was in-serviced on by staff educator to ensure freq checks are in place during resider wander in other resident rooms	sident Staff to vacy ving ths to aff residents all times. ssessed and vith a urage ering her 11/21/22 uent dent ts to	
	rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The res free of interference, c	right to exercise his or her the facility and as a citizen			2.	IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFI All residents have the potential affected by this practice. Social Director or designee will condu house wide audit to ensure that resident privacy and dignity are maintained during bed baths ar entering resident rooms. Any ne findings will be corrected upon discovery.	to be Work ct a	

Facility ID: JBJ

If continuation sheet Page 4 of 151

	-	D HUMAN SERVICES MEDICAID SERVICES	-			FORM	D: 11/07/2022 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING				PLETED
		095036	B. WING				C /26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREETAD	DRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC			STREET NW STON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued from page		F 55	3.	MEASURE TO PREVENT REOCURRENCE		12/5/2022
	rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:				Staff Educator/designee will pro in-service all Staff on Resident including maintaining privacy an dignity completed by 12/5/2022	rights nd	
	Based on observation and staff interviews, for residents, the facility's	n, record review, resident, or three (3) of 63 sampled s staff failed to ensure that gnity and privacy. Residents' 3.		During grand rounds, staff will on a house wide audit to ensure the resident privacy and dignity are maintained during care and in re room entries. All negative finding be corrected upon discovery.		at esident	
	The findings included	:		4.		ACTION	
	#193 was provided di evidenced by staff exi the privacy curtain op partially naked and re Resident #193 was ad	ting the room and leaving en while resident was ceiving a bed bath. dmitted to the facility on e diagnoses that included egia Affecting Left ost Traumatic Stress		4. MONITORING CORRECTIVE A Social Work Directors or design conduct a house wide audit to e that resident privacy and dignity maintained. This audit will be completed weekly times four (4) monthly times three (3). Negativ findings will be corrected upon discovery. All findings to be report the monthly QAPI for further recommendations.		nee will ensure / are) and ve	
	08/19/22, showed tha following: intact cogni toilet use and persona	Data Set (MDS) dated t the facility's staff coded the tion; totally dependent for al hygiene requiring 1 staff ent on staff and requiring the					
	05/18/22 [Physician C per patient request	order] "Shower twice a week "					
	On 09/19/22 at appro	ximately 10:15 AM,					

Facility ID: JBJ

If continuation sheet Page 5 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095036	B. WING				C /26/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE F	EHABILITATION AND HE	EALTH CENTER LLC			901 FIRST STREET NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 550	bath which was perfo #24 (Certified Nurse A residents bedside and and then exiting the re- privacy curtain while F nude in the bed. During a face-to-face 09/19/22 at approxima #24 (Certified Nurse A findings and stated, "I curtain." Cross Reference DCM 2. Facility staff failed to provided dignity and p and #158. The following was obs 09/12/22: A. During an interview with Resident #132, s keep coming in and o she reported this to a They have not done a During the interview, the male residents that op door, wandered into the around and left out wit the resident.	beserved receiving a bad rmed by two staff. Employee Aide) was observed leaving d opening the privacy curtain born without closing the Resident #193 was partially interview conducted on ately 11:00 AM, Employee Aide) acknowledged the was supposed to close the MR - 3269.1d to ensure that they were privacy to Residents' #132 served on unit 3 north on w on 09/12/22 at 2:30 PM she complained that two men ut of her room. When asked if staff, she stated, "Yes, I did.	F	550			12/5/2022

If continuation sheet Page 6 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		095036	B. WING		_	C 09/26/2022
	ROVIDER OR SUPPLIER	EALTH CENTER LLC		STREET ADDRESS, CITY, STA 901 FIRST STREET NW WASHINGTON, DC 2000		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRECTIVE AC REFERENCED	AN OF CORRECTION (EAC CTION SHOULD BE CROSS D TO THE APPROPRIATE EFICIENCY)	
F 550	02/24/22 with multiple Schizophrenia, Major Generalized Anxiety I A review of the Quart	e diagnoses including: Depressive Disorder, and Disorder. erly Minimum Data set 2, showed that facility staff	F 5	50		12/5/2022
	with Resident #158, s men keep coming in a talk nasty to me, I rep whenever." When as staff, she stated "yes, busy to see or do any During the interview, male residents that op	. During an interview on 09/12/22 at 2:42 PM ith Resident #158, she complained that "two nen keep coming in and out of my room, they alk nasty to me, I report them they come thenever." When asked if she reported this to taff, she stated "yes, but they have been too usy to see or do anything about it". Puring the interview, this surveyor observed two nale residents that opened Resident #158's room				
	around and left out withe resident. Resident #158 was at 06/30/20 with multiple	he door, and then turned ithout communicating with dmitted to the facility on e diagnoses including: Major and Generalized Anxiety				
	dated 07/15/22, show Resident #158 as cog The evidence showed ensure resident dignit maintained because t	d that facility staff failed to				

Facility ID: JBJ

If continuation sheet Page 7 of 151

-					FORM	MAPPROVED 0. 0938-0391		
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ((X3) DATE COMF	SURVEY PLETED		
	095036	B. WING				C 26/2022		
	EALTH CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW WASHINGTON, DC 20001					
(EACH DEFICIENC)	YMUST BE PRECEDED BY FULL					(X5) COMPLETION DATE		
During a face-to-face 09/12/22 at 3:15 PM	interview conducted on with Employee #28, [CNA]					12/5/2022		
nursing station. When monitoring the resider am waiting to be relie employee acknowled and #158 were not being p privacy and made no Medicaid/Medicare Cr CFR(s): 483.10(g) (17 §483.10(g) (17) The f (i) Inform each Medic writing, at the time of facility and when the p Medicaid of- (A) The items and set nursing facility service for which the resident (B) Those other items facility offers and for y charged, and the amo services; and (ii) Inform each Medic changes are made to specified in §483.10(g) section. §483.10(g) (18) The f resident before, or at periodically during the available in the facility services, including an covered under Medica facility's per diem rate	a l asked who was hts for privacy, she stated, "I ved from duty." The ged that Residents' #132 provided with dignity and further comments. overage/Liability Notice 7) (18) (i)-(v) acility must aid-eligible resident, in admission to the nursing resident becomes eligible for rvices that are included in es under the State plan and may not be charged; and services that the which the resident may be bount of charges for those caid-eligible resident when the items and services (a) (17) (i)(A) and (B) of this acility must inform each the time of admission, and e resident's stay, of services y charges for services not are/ Medicaid or by the acility must inform each	F	582	 CORRECTIVE ACTIONS FOR AFFECTED RESIDENTS This deficiency of providing NOM residents affected cannot be retroactively corrected. Resident #202 and resident #253 resident suffered no negative out as a result of this deficiency. IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFECT Medicare services have the pote be affected. Social worker or des will conduct an audit of all comple NOMNC issued weekly for four w and monthly for 3 months beginn 	3 tcomes WITH CTED ed from intial to signee eted veeks, ning			
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER EHABILITATION AND HE SUMMARY STI (EACH DEFICIENCY REGULATORY OR I Continued from page During a face-to-face 09/12/22 at 3:15 PM she was observed sit nursing station. Wher monitoring the reside am waiting to be relie employee acknowled and #158 were not being I privacy and made no Medicaid/Medicare C/ CFR(s): 483.10(g) (17) §483.10(g) (17) The f (i) Inform each Medic writing, at the time of facility and when the I Medicaid of- (A) The items and sen nursing facility service for which the resident (B) Those other items facility offers and for y charged, and the amo services; and (ii) Inform each Medic changes are made to specified in §483.10(g) section. §483.10(g) (18) The f resident before, or at periodically during the available in the facility services, including an covered under Medica facility's per diem rate	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REHABILITATION AND HEALTH CENTER LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 7 During a face-to-face interview conducted on 09/12/22 at 3:15 PM with Employee #28, [CNA] she was observed sitting at the computer at the nursing station. When I asked who was monitoring the residents for privacy, she stated, "I am waiting to be relieved from duty." The employee acknowledged that Residents' #132 and #158 were not being provided with dignity and privacy, she stated, "I am #158 were not being provided with dignity and privacy, she stated, "I AT the ti	S FOR MEDICARE & MEDICAID SERVICES DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILDI 095036 ROVIDER OR SUPPLIER 095036 B. WING. ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EAD DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRE TAG Continued from page 7 During a face-to-face interview conducted on 09/12/22 at 3:15 PM with Employee #28, [CNA] she was observed sitting at the computer at the nursing station. When I asked who was monitoring the residents for privacy, she stated, "I am waiting to be relieved from duty." The employee acknowledged that Residents' #132 and #158 were not being provided with dignity and privacy and made no further comments. Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g) (17) (18) (i)-(v) F \$483.10(g) (17) The facility must (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when charges are made to the items and services specified in \$483.10(g) (17) (i)(A) and (B) of this section. \$483.10(g) (18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for s	S FOR MEDICARE & MEDICAID SERVICES pr DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING 095036 B. WING ROVIDER OR SUPPLIER B. WING EHABILITATION AND HEALTH CENTER LLC B SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued from page 7 During a face-to-face interview conducted on 09/12/22 at 3:15 PM with Employee #28, [CNA] she was observed sitting at the computer at the nursing station. When I asked who was monitoring the residents for privacy, she stated, "I am waiting to be relieved from duty." The employee acknowledged that Residents' #132 and #158 were not being provided with dignity and privacy and made no further comments. Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g) (17) The facility must (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g) (17) (i)(A) and (B) of this section. §483.10(g) (18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those se	MENT OF HEALTH AND HUMAN SERVICES COMMUNITY AND HUMAN SERVICES SFOR MEDICARE & MEDICALS SERVICES COMULTIPLE CONSTRUCTION CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION REVEAL STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, STATE, 2P CODE STREET ADDRESS, CITY, STATE,	MENT OF HEALTH AND HUMAN SERVICES FOR MEDICAL SCORE & MEDICALD SERVICES OMB NC CORRECTION INTERCATION NUMBER: DEVELOPMENT CLAN IDENTIFICATION SUPPLIER IDENTIFICATION OF DESCRIPTION IDENTIFICATION SUPPLIER IDENTIFICATION OF DESCRIPTION IDENTIFICATION SUPPLIER IDENTIFICATION OF DELEMPENT IDENTIFICATION OF DELEMPENT IDENTIFICATION SUPPLIER IDE		

If continuation sheet Page 8 of 151

	MENT OF HEALTH AN				FORM	D: 11/07/2022 A APPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLETED
		095036	B. WING			C 26/2022
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	03/	20/2022
UNIQUE F	REHABILITATION AND HE	EALTH CENTER LLC	-	VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
F 582	and services covered Medicaid State plan, t notice to residents of reasonably possible. (ii) Where changes ar items and services that facility must inform the 60 days prior to imple (iii) If a resident dies of transferred and does facility must refund to representative, or esta deposit or charges all per diem rate, for the resided or reserved of facility, regardless of a discharge notice requi (iv) The facility must r resident representativ the resident within 30 date of discharge from (v) The terms of an a behalf of an individua facility must not conflit these regulations. This REQUIREMENT by: Based on record revi two (2) of 63 sampled failed to ensure that re representatives were Medicare Non-Covera	by Medicare and/or by the the facility must provide the change as soon as is e made to charges for other at the facility offers, the e resident in writing at least mentation of the change. or is hospitalized or is not return to the facility, the the resident, resident ate, as applicable, any ready paid, less the facility's days the resident actually r retained a bed in the any minimum stay or irements. efund to the resident or re any and all refunds due days from the resident's in the facility. dmission contract by or on al seeking admission to the ict with the requirements of r is not met as evidenced ew and staff interview, for residents, facility staff esidents or their provided the Notice of age (NOMNC) form no later before the effective date nee of skilled services. #203.	F 582	3. MEASURE TO PREVENT REOCURRENCE	ACTION gnee will ued the age pon of e listed rvices. 2022. n of d weekly IDT to Non- ovided efore the nuance ACTION gnee will ued nthly for 10, ews and meeting ated to	12/5/2022

Facility ID: JBJ

If continuation sheet Page 9 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		095036	B. WING				C /26/2022	
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			901 FIRST STREET NW WASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE	
F 582	Continued from page	9	F	582	2		12/5/2022	
	stipulates that "The at least two calendar covered services end service if care is not b 1. Resident #202 was 04/08/22 with diagnos Protein-Calorie Malnu Review of Resident #. an effective last day of was on 06/19/22. The facility staff provided F guardian notification of The evidence showed	or the second to last day of being provided daily" a readmitted to the facility on ses that included Severe attrition and Pneumoconiosis. 202's NOMNC form showed of skilled nursing services form also showed that Resident #202's legal on 06/20/22. d that facility staff failed to #202' legal guardian was form prior to the						
	08/22/22 with diagnos Cognitive Communica Hypertension.	admitted to the facility on ses that included: Dementia, ation Deficit and 203's NOMNC form showed						
	an effective last day or 09/01/22. The form al provided Resident #20 notification on 09/01/2 The evidence showed ensure that Resident	of skilled services was on so showed that facility staff 03's representative						

Facility ID: JBJ

If continuation sheet Page 10 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		(X3) DATE	
		095036	B. WING			(09/2	C 26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
				901 FIRST STREET NW			
	EHABILITATION AND HE	EALTH CENTER LLC		WASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR CORRECTIVE ACTION SHO REFERENCED TO THE A DEFICIENCY	OULD BE CROSS		(X5) COMPLETION DATE
F 584 SS=E	During a face-to-face 09/14/22 at 10:41 AM Worker) reviewed Re- NOMNC forms and st give at least two days are ending so that the representative have th doesn't matter if the m staying in the facility.' Safe/Clean/Comfortal CFR(s): 483.10(i)(1) - §483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, the homelike environmen use his or her person possible. (i) This includes ensu receive care and serv physical layout of the independence and do (ii) The facility shall ex the protection of the r or theft. §483.10(i)(2) Housek services necessary to and comfortable inter	inuance of skilled services. interview conducted on , Employee #5 (Social sident #202 and #203's ated, "The protocol is to ' notice that skilled services e resident or their he option to appeal. It esident is going home or Del/Homelike Environment (7) onment. th to a safe, clean, elike environment, including iving treatment and ig safely. ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can ices safely and that the facility maximizes resident tes not pose a safety risk. kercise reasonable care for esident's property from loss eeping and maintenance maintain a sanitary, orderly,	F 584	1. CORRECTIVE ACT AFFECTED RESIDE Facility Maintenance Designee addressed ensure that houseke were provided to ma comfortable envirom the identified six ceil replaced identified fi tiles upon discovery.	ENTS Director or the followin eeping servic intain a safe ment by cleating vent cov ve stained co	ng to ces e, clean, aning: vers and	12/5/2022

If continuation sheet Page 11 of 151

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM	M APPROVED
							1	0. 0938-0391
-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT				(X3) DATE COMP	SURVEY
			A. BUILDI	NG				
		095036	B. WING					C
NAME OF P	ROVIDER OR SUPPLIER	00000		ST	REETAD	DRESS, CITY, STATE, ZIP CODE	09/26/2022	
	NO NDER OR OOT LIER							
UNIQUE F	REHABILITATION AND HE	EALTH CENTER LLC				STREET NW TON, DC 20001		
(X4) ID		ATEMENT OF DEFICIENCIES	ID			PROVIDER'S PLAN OF CORRECTION (EAG		(X5)
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG			CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE	5-	COMPLETION DATE
_				DEFICIENCY)				
								12/5/2022
F 584	Continued from page	11			_			
	in good condition;		F	584	2.	IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFE		
						THE FOTENTIAL TO BE AFFE	CIED	
	§483.10(i)(4) Private	•				No residents were found to have	e been	
	resident room, as spe	cified in §483.90 (e)(2)(iv);				adversely affected. Maintenanc		
	8/83 10(i)(5) Adequa	te and comfortable lighting				director performed a house wide of all ceiling tiles and ceiling ver		
	levels in all areas;					covers on 11/21/22. No other is		
						were identified. Any additional is	ssues if	
	§483.10(i)(6) Comfort	able and safe temperature				found will be corrected upon dis	covery.	
		ly certified after October 1,				•		
		temperature range of 71 to			3.	MEASURE TO PREVENT		
	81°F; and					REOCURRENCE		
	§483.10(i)(7) For the	maintenance of comfortable				The Maintenance Director or De	signee	
	sound levels.					will re-educate the maintenance		
	This REQUIREMENT	is not met as evidenced				associates on conducting round	ls to	
	by:					ensure that the ceiling tiles and		
		ns and interview, facility staff				covers are clean to maintain a s clean, comfortable environment		
	failed to provide hous	a safe, clean, comfortable				residents by 12/5/2022.		
		nced by ceiling vent covers						
		ghout on six (6) of eight (8)				Maintenance Director, will perfo House wide audit, monthly of al		
		nd ceiling tiles that were				tiles and vents covers. All nega		
	stained on five (5) of e	eight resident care units.				findings will be corrected upon		
	The findings included	:				discovery.		
	During an environme	ntal walkthrough of the						
		12, 2022, between 10:00						
		following were observed:						
		-						
		were soiled with dust in						
	common areas includ	ing:						
	Three (3) of five (5)	in the hallway on 4 South						
		B) in the hallway on 4 North						
		n the hallway on 3 South						
		(7) in the dayroom on 3						
	South							

If continuation sheet Page 12 of 151

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 11/07/2022 AAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		095036	B. WING			C 26/2022
	Rovider or Supplier	EALTH CENTER LLC	9	STREET ADDRESS, CITY, STATE, ZIP CODE 001 FIRST STREET NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE CI REFERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
E 504						12/5/2022
F 584 F 600 SS=G	Four (4) of five (5) i 3 North One (1) of two (1) in One (1) of two (2) in One (1) of one (1) in One (1) of one (1) in 2. Ceiling tiles were sincluding: Two (2) in the dinim One (1) in the hally Five (5) in the hally Two (2) in the hally One (1) in the hally These findings were a #15 on September 12 4:00 PM. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's magents.	3) in the hallway on 3 North In the Rehab Department on In the dayroom on 3 North In the hallway on 2 South In the dayroom on 2 South In the dayroom on 2 South In the hallway on 1 South Itained in common areas Ig room on 4 North way on 4 North way on 4 North way on 2 South way on 2 South way on 2 South way on 1 South acknowledged by Employee 2, 2022, at approximately Neglect Im Abuse, Neglect, and right to be free from abuse, ation of resident property, effined in this subpart. This inted to freedom from involuntary seclusion and ical restraint not required to edical symptoms. Ty must- e verbal, mental, sexual, or	F 584	Maintenance Director, will pe house wide audit and then m all ceiling tiles and vents cov months. The results from the observa rounds will be reviewed durin monthly QAPI meeting and t evaluated to determine if fur monitoring is indicated.	erform a full nonthly of rers x 3 ations and ng the hen re-	

Facility ID: JBJ

If continuation sheet Page 13 of 151

	MENT OF HEALTH AN						FORM	M APPROVED
	S FOR MEDICARE & I							0. 0938-0391
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN					PLETED
		095036	B. WING					C /26/2022
NAME OF P	ROVIDER OR SUPPLIER			STR	REETAD	DRESS, CITY, STATE, ZIP CODE		
				901	FIRST S	STREET NW		
UNIQUE F	REHABILITATION AND HE	EALTH CENTER LLC		WA	SHING	TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
TAG F 600	Continued from page involuntary seclusion; This REQUIREMENT by: Based on record revi one (1) of 63 sampled failed to provide Resid necessary care and re resident's needs subs negative physical outd ulcers first observed a These failures resulte #204 when the reside ulcers. The findings included Review of a Complain the State Agency on C allegations that the fa proper to Resident #2 the resident was negli significant physical inj period which resulted Medical record review was admitted to the fa multiple diagnoses that	13 is not met as evidenced ew and staff interview, for d residents, facility staff dent #204 with the equired services to meet the requently, resulting in a come, multiple pressure at advanced stages. d in actual harm to Resident nt obtained facility acquired it, DC00010905, received by 07/29/22 revealed cility failed to provide the 04. The complaint alleged ected and sustained uries over an unknown in hospitalization. v indicated Resident #204 acility on 04/21/16 with at included: Mild ttrition, Dementia, Altered	F 6	500	1.	DEFICIENCY) CORRECTIVE ACTION FOR T AFFECTED RESIDENTS Resident #204 is discharged or 7/23/22. This deficiency cannot retroactively corrected and resi cannot be reassessed.	THE t be dent S WITH ECTED to be ep on ensed es. No	12/5/2022
	Review of physician of -07/14/21, "Monitor sk bleeding (B), Skin Dis every shift and alert M	kin for easy bruising (EB), coloration (SD), None (N)						

Facility ID: JBJ

If continuation sheet Page 14 of 151

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095036	B. WING				C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC			001 FIRST STREET NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
F 600	incontinent episode. W and water, pat dry and shift and as needed." Review of the facility's Management" policy, showed, " Any altera reported to the physic Review of the facility's Program" policy (not of skin checks will be con nurse. This will be do Electronic Medical Re routine care, the Certit observe the resident's are noted this will be do licensed nurse" Review of the facility's Prevent/Heal Pressur showed, " The facility's Prevent/Heal Pressur showed, " The facility resident receives care professional standard pressure ulcers a re receive necessary tre promote healing, prev ulcers from developin physician anytime the signs of non-healing of Per a 03/03/22 physic was to have a "Showe and Wednesday and order was discontinue	continent care with each Vash peri area with soap d apply barrier cream every s "Wound/Pressure Ulcer revised on 10/01/21 ation in skin integrity will be ian immediately" s "Wound Prevention dated) showed, " Weekly nducted by the license cumented in the resident's cord (EMR). Daily, during fied Nursing Assistant will s skin. When abnormalities communicated to the s "Treatment/Services to e" policy (not dated) ty will ensure that a a, consistent with s of practice, to prevent esident with pressure ulcers atment and services to rent infection and prevent e g the nurse will notify the pressure sore is showing or infection" cian's order, Resident #204 er twice a week on Monday per patient request" This ad on 4/20/22.	F	600	 MEASURE TO PREVEN REOCURRENCE: The licensed nurses will skin assessment upon at the wound nurse/designe complete a thorough skir within 24-48 post-admiss validate all impaired area documented and treatme ordered and care plan is Staff Educator/Designee service/education to all li staff and certified nursing following MD orders rega assessment, prevention breakdown and commun issues to the licensed nu the care plans and treatme place. Education will be of 12/5/2022. Staff Educator/Designee service/education to all li on their responsibility reg monitoring the nursing at ensure showers are bein skin assessment comple residents and turning, an properly implemented pe orders. Completed by 12 Staff Educator/Designee in-service/education to a nurse and certified nursii ensure that documentatio shower sheets and skin a accurately reflect the res condition. This will be co 12/5/2022 	complete a dmission and ee will assessment ion and as were initiated. will conduct in- censed nursing gassistants on arding skin of skin icating skin rse to ensure nents are in completed by will conduct in- censed nurses garding ssistants to g given and ted timely for d positioning is r physician /5/22. will conduct an ll licensed ng assistants to on on bath and assessments ident's	
	An Annual Minimum D	Data Set (MDS) dated					

If continuation sheet Page 15 of 151

	RS FOR MEDICARE &					1	0. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			(X3) DATE SURV COMPLETED		
		095036	B. WING			C		
		095036	D. WING		ADDRESS, CITY, STATE, ZIP CODE	09/	26/2022	
NAME OF P	ROVIDER OR SUPPLIER				T STREET NW			
UNIQUE I	REHABILITATION AND HE	EALTH CENTER LLC			IGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETIO DATE	
							12/5/202	
F 600	04/13/22, showed tha Resident #204 as hav impairment; requiring to -two persons' phys and transfers; extensi person physical assist hygiene; frequently in bowel; active diagnos weight loss; at risk for pressure ulcers, wour 1a. Skin area #1- righ 04/18/22 at 4:28 PM ' to touch and no new to require total care v living) cares. Turned a pressure relief" 04/19/22 at 5:14 PM ' (Licensed Nurse) s lubricated. No wound 04/20/22 [Treatment / (TAR)] facility staff do mark (meaning admir indicate that a showe 04/20/22 [physician's weekly on shower day shift every Thu (Thurs 04/20/22 [physician's week and per patient every Thu, Sat (Satur	at facility staff coded ving severe cognitive total dependence with one ical assist for bed mobility ive assistance with one- for toilet use and personal acontinent of urine and ses of Anemia; no significant r pressure ulcers; and no nds or other skin problems. At foot: "Nurses NoteSkin warm skin issues noted. Continued with all ADL (activities of daily and repositioned for "Skin Observation Tool skin is intact, warm and well ;" Administration Record coumented, "yes", a check histered), and initialed to r was completed; order] "Skin Assessment y by license nurse every day sday);" order] "Shower twice a request every day shift rday);"	F 60	90 4	MONITORING CORRECTIV Unit Managers/Designee will weekly skin assessment ong conduct a bath and shower s weekly x 4, then monthly x 3 that these are completed tim accurately. All negative findir addressed upon discovery. F be brought to QAPI monthly recommendations and review	conduct a oing and heet audit to ensure ely and ngs will be indings will for		

Facility ID: JBJ

If continuation sheet Page 16 of 151

	MENT OF HEALTH AN S FOR MEDICARE & I				FOF	ED: 11/07/2022 MAPPROVED O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY IPLETED
		095036	B. WING		0'	C 9/26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	REHABILITATION AND HE	ALTH CENTER LLC		901 FIRST STREET NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHOULD REFERENCED TO THE APPI DEFICIENCY)	D BE CROSS-	(X5) COMPLETION DATE
F 600	04/21/22 treatment ac facility staff initialed to skin assessment was 04/22/22 at 7:34 PM " (interdisciplinary team sig. (significant) chang stable." A care plan with a rev documented the follow -Focus area "[Resider self-care performance impaired balance and "Provide incontinent episode. Wash peri at dry and apply barrier needed. The resident with bathing/showerin necessaryThe resident with bathing/showerin necessaryThe resident with bathing." -Focus area, "[Resider bowel incontinence r/f moisture barrier crear incontinent careRep breakdown." -Focus area, "[Resider impairment to skin int Aspirin use" "Keep lotion on dry skin. Pro routinely and as need -Focus area, "[Resider	Aministration record [TAR] - indicate that the weekly completed; Social Services Note IDT b) meeting was held No ges to report resident is iew date of 4/22/22 ving: ht #204] has an ADL e deficit r/t (related to) other conditions" t care with each incontinent rea with soap and water, pat cream every shift and as requires assistance by staff g routinely and as dent requires assistance by ht #204] has bladder and c deconditioning" "Apply n to skin after each bort any signs of skin ht #204] has potential for egrity r/t fragile skin and skin clean and dry. Use vide incontinent care ed." ht #204] is at risk for pment r/t immobility" ions as ordered	F 600	0		12/5/2022

Facility ID: JBJ

If continuation sheet Page 17 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 A APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			```		CONSTRUCTION		LETED
		095036	B. WING			C 09/26/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	EHABILITATION AND HE			90	01 FIRST STREET NW		
				N	ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued from page	17	F	600			12/5/2022
	assess/record/monito	r wound healing every shift ts and declines to the "D."					
		(TAR) facility staff check mark, and initialed to					
	indicate that a showe The 04/23/22 (Saturd	ay) [Shower/Bath Sheet]					
	documented "comp	lete bed bath," however I nurse signature on the					
		AM Skin Observation Tool" rse documented "No new					
	04/28/22, showed tha "N", meaning no or no directed", "Monitor sk bleeding, skin discolo MD (medical doctor) v documented no refus						
	elongated toenails an Distal aspect of right I sanguineous (sp) sca to distal aspect, noted probing sinus dista noted dry sanguineou aspect recommend vascul healing potential. Ulco	nt is seen bedside for thick, d wound right foot Skin: nallux with noted b and eschar (dead tissue)					

Facility ID: JBJ

If continuation sheet Page 18 of 151

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 A APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) P		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095036	B. WING				C 26/2022	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC			901 FIRST STREET NW WASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 600	during examRecom Please obtain labs: Cl with Diff (differential), panel), ESR (erythroo Please obtain x-rays of osteomyelitis of right H 04/29/22 at 9:23 AM " heelLength: 2.45 cr acquired 4/29/22; [per 100.00; Stat-s - new; 7 Etiology- pressure ulc tissue injury)Dressi dressings- skin prep 04/29/22 at 1:55 PM " toe Length: 1.40 cm Acquired 4/28/22, [pe Stat-s - New; Acquir ArterialDressing ch a day), cleanse wound dressing- Betadine." A 04/29/22 at 10:20 A Assessment Request form documented the areas on right great to problem or symptom s resident had podiatry and then was observe to the right great toe. heel. Skin intact. MD a aware. Treatment ord A 04/29/22 at 11:10 A "Nurses Note Late Em foot care at the bedsid	 probing and purulence mend starting antibiotics. BC (complete blood count) CMP (complete metabolic yte sedimentation rate). of right foot to rule out nallux." Tissue Analytics Right n; width: 2.67 cm; Wound rcent] epithelialization Acquired in house? Yes; er - Suspected DTI (deep ng change frequency - daily, Tissue Analytics Right great n, width: 1.60 cm; Wound rcent] slough/eschar 100.00 red in House? Yes; Etiology ange frequency BID (twice d with- Normal Saline, M Situation Background (SBAR) communication following: Situation: skin be red right heel. Date started: 04/29/2022 foot care at the bed side ed with a right arterial area Reddened area to the right and RP (representative) 	F	600			12/5/2022	

If continuation sheet Page 19 of 151

	-	ID HUMAN SERVICES				FOF	O. 0938-0391	
			(X2) MU	тірі	LE CONSTRUCTION	1	E SURVEY	
	CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:						IPLETED	
			A. DOILDI	ino	,			
		095036	B. WING			0	C 2/26/2022	
NAME OF PI	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE	0.	5/20/2022	
					901 FIRST STREET NW			
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			WASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE CI REFERENCED TO THE APPROPRI/ DEFICIENCY)	OSS-	(X5) COMPLETION DATE	
							12/5/2022	
F 600	Continued from page	19	F	60	00			
		s reddened right heel, skin						
		party was made aware.						
		Right heel elevated on a						
	pillow."							
	The medical record co	ontained wound notes						
	stating:							
	-04/29/22 at 2:18 PM	"Skin/Wound Note						
		and wound evaluation for						
	-	ht great toe Dermatologic						
	- wound(s) presentF	Right heel DTI. Right great						
	toe arterial ulcerPat							
		recommend vascular						
	consultation to evalua							
	recommend x-ray of r osteomyelitis of right l	-						
	-04/29/22 at 2.21 PM	"Skin/Wound Note Late						
		ade aware of resident's right						
	heel wound and right	great toe (podiatry-caused)						
	wound. Nursing staff	aware."						
	The physician gave of on 05/2/22 to request	rders related to these areas the following:						
		at toe surgical site- Paint with						
		and secure with bordered						
	gauze twice daily eve wound healing;" and,	ry day and evening shift for						
	-05/02/22, "Right hee	l D-I - Apply Skin prep and						
	leave open to air dail	y every day shift for wound						
	healing." This order w	as discontinued on 5/9/22.						
	Although the Tissue A	-						
	dressing orders on 4/2							
	days later. Furthermo	umented until '05/02/22, 4 re, there was no						

Facility ID: JBJ

If continuation sheet Page 20 of 151

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 M APPROVED D. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095036	B. WING				C /26/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC			01 FIRST STREET NW		
		TEMENT OF DEFICIENCIES	10	v	VASHINGTON, DC 20001		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
F 600	Continued from page	20	-	200			12/5/2022
1 000		20 that licensed nursing staff	F	600			
		nanges during those 4 days.					
	Resident #204's care to show the following:	plan was updated on 5/4/22					
	[toe] wound related to initiated on 05/04/22 s treatment per physicia	•					
	initiated on 05/04/22 s moisturizers to skin as	nt #204] has right heel [DTI]" showed, "Apply skin s needed. Apply skin prep ght heel with wedge/cushion					
	PM follow-up wound right heel left intact, d Distal aspect of right h distal aspect, noted set improved since last ex 5th toe with noted dry eschar to distal aspect evaluate for healing p Discussed with char deep infection Con- labs. Please obtain la placed. Please obtain	ge nurse as concern for sider antibiotics pending					
	blood count) with Diff	order] "CBC (complete					

Facility ID: JBJ

If continuation sheet Page 21 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
						1		
	"EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDI	ING	B			
			5.14/11/0				С	
		095036	B. WING			09/	/26/2022	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
	EHABILITATION AND HE				901 FIRST STREET NW			
					WASHINGTON, DC 20001			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECTION (E	ACH	(X5)	
PREFIX		MUST BE PRECEDED BY FULL	PREF		CORRECTIVE ACTION SHOULD BE CRC		COMPLETION DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	6	REFERENCED TO THE APPROPRIATI DEFICIENCY)		DATE	
							12/5/2022	
F 600	Continued from page	21	F	60	00			
	protein) next lab day,'	1						
	-05/05/22 [physician's	s order] "X rays 3 views of						
	right foot to r/o (rule o	ut) osteomyelitis- deep						
	wound, pain, physical	l limitation one time only,"						
		s order] "Consult for vascular						
	evaluation for healing	potential"						
		t these treatments were						
	recommended on 04/2							
		not placed until 05/05/22, 8						
	days later.							
	The orders were com	pleted, and the results were:						
	The orders were com	pieteu, anu the results were.						
	-05/07/22 at 10:23 PM	/I "Radiology Results						
	NoteDate of Test: 5/	/6/2022. Type of Test: Right						
	foot, complete, 3+ vie	ws Findings No						
	evidence of osteomye	elitis"						
	-	Consultation Vascular						
		aling potential findings:						
	dry stable gangrene o							
	Diagnosis: toe gangre	ene"						
	00/00/00 at 10:04 DM	A "Laboratory Nata Desulta						
		/ "Laboratory Note Results.						
		2. Type of test CBC W/Diff s: Waiting for doctor's						
	review"	s. Waiting for doctor s						
	Although it was order	ed on 05/05/22, the labs						
	÷	til 06/08/22, 34 days later.						
		$a_1 \cup b_1 \cup b_1 \ge 2$, $b_1 \cup b_2 \cup b_1 \ge 1$						
	The Nurse Practitione	er documented on 06/09/22						
		and medications reviewed."						
	For Resident #204's r	ight foot, the evidence						
		ealed that although facility						

Facility ID: JBJ

If continuation sheet Page 22 of 151

	-	D HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095036	B. WING				C 26/2022
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE F	EHABILITATION AND HE	ALTH CENTER LLC			901 FIRST STREET NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	04/27/22, the resident right great toe wound a right 5th toe wound 04/28/22. Facility staff order for dressing cha days and failed to obt manner. 1b. Skin area #2- sac 06/28/22 at 9:30 AM " (Licensed Nurse) S -pressure, length 3.79 0.0cm, stage -Suspect (right) great toe site - length-1.28cm, width- Stage-N/A. Resident I sites and is followed to 06/29/22 at 12:26 AM stable and verbally re touch, well moisturize bleeding noted. Conti on right foot. Wound c and right great toe. No Betadine prep on righ Provide incontinent ca episode. Wash peri- a pat dry and apply barr shift. Extensive assist 06/30/22 at 3:25 PM " alert and verbally resp touch, well moisturize bleeding noted. Both	nplementing the dent #204 from 04/01/22 to t was first observed with a at 100 percent eschar and at 30 percent eschar on f failed to have a doctor's anges to the right foot for 4 ain ordered labs in a timely rum: Skin Observation Tool tite: Right heel. Type form, width-4.58cm, depth, cted Deep Tissue Injury; R. type - arterial, 0.71cm, depth -0.0cm, has treatment orders for the by the wound team." "Nurses Note Resident is sponseSkin is warm to d. No skin bruising, nue monitoring skin wound dressing intact on right heel to drainage noted. Paint with t great toe in this shift. are with soap and water, rier cream in the evening for ADL care provided" Nurses Note Resident is ponseSkin is warm to d. No skin bruising, heels elevated with pillow to er. Right heel and right great	F	600			12/5/2022

Facility ID: JBJ

If continuation sheet Page 23 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	M APPROVED
			()(0) 1 () ()					0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		COMF	SURVEY PLETED
		095036	B. WING					C /26/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				9	901 FIRST STREET NW			
UNIQUE R	EHABILITATION AND HE	EALIH CENTER LLC		v	WASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULD BE (REFERENCED TO THE APPROPR DEFICIENCY)	CROSS		(X5) COMPLETION DATE
F 600	Continued from page redness noted, ADLS by staff" 06/30/22 (Thursday) [(skin intact/no irritatio section was left blank 07/01/22 at 8:02 AM " unchanged dry and w repositioned every tw right great toe wound 07/02/22 [Shower/Bat section showed facilit and "12", indicating sl "bed bath" 07/02/22 at 11:40 PM warm to touch, well m bleeding noted. Conti on right foot. Wound of and right great toeF each incontinent epists soap and water, pat of in the evening shift. E provided" 07/03/22 at 7:43 AM " repositioned every tw with pillow to prevent and right great toe woo 07/03/22 at 3:35 PM " warm to touchRight	23 and oral hygiene provided Shower/Bath Sheet] "12 n)"; "condition of skin" ; "complete bed bath given". 'Nurses NoteSkin remain rarm to touchTurned and o hours Right heel and dressing intact" th Sheet] "condition of skin" y staff documented a line kin intact/no irritation and "Nurses Note Skin is poisturized. No skin bruising, nue monitoring skin wound dressing intact on right heel Provide incontinent care with ode. Wash peri- area with lay and apply barrier cream extensive assist for ADL care 'Nurses Note Turned and o hours. Both heels elevated pressure ulcer. Right heel pound dressing intact"		600	DEFICIENCY)			12/5/2022
		"Nurses NoteSkin is noisturized. No skin bruising,						

Facility ID: JBJ

If continuation sheet Page 24 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	MAPPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	тірі	LE CONSTRUCTION		(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:						PLETED
			A. BOILDI	ino				с
		095036	B. WING			09/26/20		
NAME OF PF	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		03/	20/2022
					901 FIRST STREET NW			
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			WASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROF DEFICIENCY)	CROSS		(X5) COMPLETION DATE
								12/5/2022
F 600	Continued from page	24	F	60	n			12/ 5/ 2022
		nue monitoring skin wound		00				
		d wound dressing on right						
		beProvide incontinent care						
		episode. Wash peri- area						
	•	pat dry and apply barrier						
	-	shift. The pressure ulcer is						
	a little wider in the res Dressing done"	sident's coccyx area.						
	Dressing done							
	There was no docume actions such as furthe	ented evidence that further er assessment of the						
		physician, or documenting						
	a request for intervent licensed staff on 07/0	tion was taken by the						
	warm to touch, well m	Nurses Note Skin is noisturized. No skin bruising, bleeding noted Right heel						
		bund dressing intact"						
	Care plan focus area,	"[Resident #204] has						
		ent to skin integrity r/t fragile						
	•	showed, "07/04/22 IDT						
	Patient has an actua	an reviewed and updated al wound/sacral DTI."						
		o documented evidence that						
		s further assessment of the						
		physician, or documenting						
	a request for intervention 07/04/22.	tion was taken by the IDT						
		"SBARCommunication						
	Tool Situation Press approx. 10cm*10cm*0							
		2022 Identify whether the						
	problem/symptom has	s gotten worse/better/stayed ted- Worse Pressure ulcer						

Facility ID: JBJ

If continuation sheet Page 25 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					PLETED
	095036 ROVIDER OR SUPPLIER EHABILITATION AND HEALTH CENTER LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 25 of coccyx area got wider and worseAssessment: In my opinion, residents need active pressure ulcer treatment and care" The above SBAR showed that the licensed nurse completing the form listed her own name under the section "person contacted". 07/05/22 at 11:09 PM "Nurses NoteContinue monitoring skin wound on right foot and coccyx area. Wound dressing intact on right heel and right great toeThe pressure ulcer of coccyx area is wider and worse. Approx. 10cm*10cm*0.2, drainage noted. Dressing changed. I notified to Dr. (doctor) about resident's condition via SBAR" Review of the July 2022 TAR from 07/01/22 to 07/05/22, showed that facility staff documented: "N", meaning no or none, in the area that directed, "Monitor skin for easy bruising, bleeding,						С
		095036	B. WING			09/	26/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			901 FIRST STREET NW		
					WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (E/ CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
							12/5/2022
F 600	Continued from page	25	F	600	0		
		-					
	The above SBAR sho	wed that the licensed nurse					
	07/05/22 at 11:09 PM	"Nurses NoteContinue					
	monitoring skin woun	d on right foot and coccyx					
		••					
	condition via SBAR	n					
	-						
		-					
	-						
		•					
		nd repositioned every two					
	hours, every shift.						
	From 07/03/22 to 07/0	05/22 (3 days), there was no					
	PROVIDER OR SUPPLIER REHABILITATION AND HEALTH CENTER LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O Continued from page 25 of coccyx area got wider and worseAssessment: In my opinion, residents need active pressure ulcer treatment and care" The above SBAR showed that the licensed nurse completing the form listed her own name under the section "person contacted". 07/05/22 at 11:09 PM "Nurses NoteContinue monitoring skin wound on right foot and coccyx area. Wound dressing intact on right heel and right great toeThe pressure ulcer of coccyx area is wider and worse. Approx. 10cm*10cm*0.2, drainage noted. Dressing changed. I notified to Dr. (doctor) about resident's condition via SBAR" Review of the July 2022 TAR from 07/01/22 to 07/05/22, showed that facility staff documented: "N", meaning no or none, in the area that						
	Resident #204's sacra	al area.					
	07/06/22 at 3:30 PM "	SBARCommunication					
	Ineuroal doctors han	ie]					

Facility ID: JBJ

If continuation sheet Page 26 of 151

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	
		095036	B. WING			09/	26/2022
	ROVIDER OR SUPPLIER	EALTH CENTER LLC		90	REET ADDRESS, CITY, STATE, ZIP CODE 1 FIRST STREET NW ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (E. CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
F 600	Continued from page	26	F 6	600			12/5/2022
	(Licensed Nurse) S pressure, length- 9.00 depth-0.0cm, stage- Resident has a new a suspected DTI. Thin. mattress. Treatment Repositioning every 2 consult." 07/06/22 [physician's Cleanse with normal apply silver alginate of	cm, width-12.0cm, suspected deep tissue injury. area to the sacrum Frail skin. Pressure relief order in place. 2 hours. Labs and Dietary sorder] "Sacral Wound: saline solution; pat dry, on wound bed and secure ge daily and PRN every day					
	wound site DTI on the initiated on 07/06/22 wound Notify physi Monitor/document/re s/sx (signs and symp 07/07/22 at 11:22 AM Location; sacrum; len cm; depth 0.10 cm 7/6/22; [percent] slou	port PRN (as needed) any toms) of infection" 1 "Tissue Analytics ngth 10.80 cm; width 9.48 Date wound acquired gh/eschar 30.00; Wound					
	evidence revealed th accurately assess, do skin on 07/03/22 and skin breakdown. Add notify the physician fo wound was first docu	sacrum area, the above at facility staff failed to: boument on the resident's report signs of worsening itionally, facility staff failed to or 3 days after the sacrum imented as "wider." seen by the wound Nurse					

Facility ID: JBJ

If continuation sheet Page 27 of 151

CENTER STATEMENT C AND PLAN OF	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095036	· ,	PLE CONSTRUCTION G G STREET ADDRESS, CITY, STATE, ZIP CODE	FOR OMB NO (X3) DATH COM	ED: 11/07/2022 M APPROVED D. 0938-0391 E SURVEY PLETED C //26/2022
	EHABILITATION AND HE	CALTH CENTER LLC		901 FIRST STREET NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROP DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
F 600	with 30% eschar. During a face-to-face 3:25 PM, Employee # reviewed the shower/f #204 and stated, "Wh Aide) is giving the res nurse is to go in to do assessment with the O documents what she s and nurse] sign the ba Skin section should al documents the reside issues and anything n resident refuses the s assessment, it is docu progress note and the During a telephone int PM, Employee #6 (Po [Resident #204] in Ap podiatry services at th Thursday. I noted a du the right 5th toe and a right big toe. I started big toe] and pus just s nurse was in there wit recommendations [lat my note. When I came saw that none of the r followed, so I wrote th finally ordered."	interview on 09/15/22 at 2 (Director of Nursing/DON) bath sheets for Resident en the CNA (Certified Nurse ident a shower or bath, the the head-to-toe skin CNA present. The nurse sees and they both [CNA ath sheet. The Condition of ways be completed. It nt's current wounds or skin ew that is noted. If the hower, bath or skin umented on the form, the e MD and RP are notified." terview on 09/15/22 at 4:34 odiatrist) stated, "I saw ril (2022) as part of regular the facility done every ry, stable, eschar wound on a dry, eschar area near the to debride the area [right started coming out. The th me. I wrote the bas, x-ray, and ultrasound] in e in on May 5th (2022), I ecommendations were em again and they were	F 60			12/5/2022

Facility ID: JBJ

If continuation sheet Page 28 of 151

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
		095036	B. WING		C 09/26/2022
NAME OF PI	ROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIP CC	
UNIQUE R	EHABILITATION AND H	IEALTH CENTER LLC		901 FIRST STREET NW	
				WASHINGTON, DC 20001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR CORRECTIVE ACTION SHO REFERENCED TO THE A DEFICIENCY	ULD BE CROSS- PPROPRIATE DATE
E 000		00			12/5/202
F 600	Continued from page		F 60	00	
		ent's feet is part of the skin ent #204] started getting the			
		foot treated after she was			
		st. The staff [nurses and			
		on to me that they observed			
		Resident #204's] feet." eviewed the July 2022			
		he 07/05/22 SBAR for			
		tated, "The staff documented			
		ments but there's no mention her sacrum area until July			
		first notices the change in			
		ho makes the doctor and			
	-	irses know to notify the			
	•	or any changes and to ogress notes. This SBAR			
		s not done properly. Another			
		e 6th [07/06/22] where the			
	family and doctor we				
F 607		Abuse/Neglect Policies	F 60	07	
SS=D	CFR(s): 483.12(b)(1)) -(3)			
	§483.12(b) The facili	ty must develop and			
	implement written po	plicies and procedures that:			
	§483.12(b)(1) Prohib	bit and prevent abuse,			
	neglect, and exploita				
	misappropriation of r	esident property,			
	§483.12(b)(2) Establ	ish policies and procedures			
	to investigate any su				
	8/183 12(b)(3) Include				
	3400.12(0)(0) 110100	e training as required at	1		
	paragraph §483.95,	c .			
	paragraph §483.95, This REQUIREMEN	e training as required at T is not met as evidenced			
	paragraph §483.95, This REQUIREMEN by:	c .			

Facility ID: JBJ

If continuation sheet Page 29 of 151

		MEDICAID SERVICES			OMB N	M APPROVEI O. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	· · /	E SURVEY PLETED
		095036	B. WING		C 09/26/2022	
	ROVIDER OR SUPPLIER	EALTH CENTER LLC	90	REET ADDRESS, CITY, STATE, ZIP CODE 1 FIRST STREET NW ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPRO DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
F 607	Continued from page		F 607	1. CORRECTIVE ACTION	FOR THE	12/5/20/2
	and procedures. Res #191. The findings included Review of the facility' of Abuse" revised 02/ Sexual abuse is non- of any type with a res limited to sexual hara assault. Procedure case of a resident ab facility will separate th appropriate during the Reporting 1. All allege Administrator, Director shall notify the Depar Agency] via the Even electronicallywithin bodily injury occurred abuse" Review of the facility' with Combative Resid documented, "In ca resident to resident, r resident, supervisor of file a complaint with M Department (MPD) 1. Facility staff failed and Resident #148 di resident-to-resident a	s policy entitled, "Prohibition /2022, read: "Policy: consensual sexual contact sident includes but is not assment coercion or sexual .E. Protection3. In the using another resident, the he resident (s) as e investigationF. ed violations, the or of Nursing, or designee rtment of Health [State at Reporting System in two (2) hours if serious d or there is an allegation of s policy entitled "Dealing dent" revised 07/01/2022, ase of physical altercation, resident to staff and staff to or the designee will call and Metropolitan Police		AFFECTED RESIDENTS Resident #505 was asses toe by licensed nurse on Resident suffered no neg outcomes. Resident #505 on 9/14/22 to ensure resi Resident #148 was move to ensure resident safety. #148 was discharged on resident cannot be asses retroactively. Resident #191 was separ Resident #148 to ensure safety. Resident #191 wa head to toe on 9/20/22 by nurse. Resident suffered outcomes.	ssed head to 9/28/22. ative 5 was moved dent safety. ed on 9/12/22 Resident 9/27/22. The sed rated from resident is assessed / licensed	
	On 09/06/22 at 7:42	PM the facility submitted a				

If continuation sheet Page 30 of 151

OB5036 B: WHG C UNAULE OF PROVIDER OR SUPPLIER STREET ADDRESS, GTY, STATE, ZP CODE STREET ADDRESS, GTY, STATE, ZP CODE STREET ADDRESS, GTY, STATE, ZP CODE SUMMAY STREET IN W UNAULE REHABILITATION AND HEALTH CENTER LLC STREET ADDRESS, GTY, STATE, ZP CODE SUMMAY STREET IN W WASHINGTON, DC 2001 CONCECTIN, ACT OF SUMD BE CARSS. (b) FEACURE DECIDENT MAST DE PRECORD IN FALLY PROVIDERS FLAA OF CORRECTION (EACH CONST.) CONCECTIN, ACT OF SUMD BE CARSS. CONCECTIN, ACT OF SUMD BE CARSS. (c) SUMMAY STREMENT OF DEFICIENCIES provide stress of the PRECORD IN FALLY PROVIDERS FLAA OF CORRECTION (EACH CONST.) Conclusion Conclusion of SUMD BE CARSS. CONCECTIN, ACT OF SUMD BE CARSS. Conclusion of SUMD ADD ADD ADD ADD ADD ADD ADD ADD ADD A		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	PLE CONSTRUCTION		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER UNAVE STREET ADDRESS, CITY, STATE, ZIP CODE OWNER OF PROVIDER OR SUPPLIER OWNER OF PROVIDER OF ALMO CONNECTING (BACH UNQUE REHABILITATION AND HEALTH CENTER LLC STREET ADDRESS, CITY, STATE, ZIP CODE SIP RIST STREET NW WASHINGTON, DC 20001 OWNER OF PROVIDER OF PLANCE OF CONNECTING (BACH OWNER OF PLANCE OF CONNECTING (BACH A IS TREET ADDRESS, CITY, STATE, ZIP CODE OWNER OF PLANCE OF CONNECTING (BACH OWNER OF PLANCE OF CONNECTING (BACH OWNER OF PLANCE OF CONNECTING (BACH DEFICIENCY) DEFICIENCY) DEFICIENCY F 607 Continued from page 30 DEFICIENCY) DEFICIENCY) DEFICIENCY) DEFICIENCY) DEFICIENCY I Resident #46			005026				
UNIQUE REHABILITATION AND HEALTH CENTER LLC 901 FIRST STREET NW WASHINGTON, DC 20001 MID PREEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUSTED PRECEDED BY FULL RESOLUTIONY OR LSC DEMINIPANG NFORMATION) D0 PREEX TAG DEPARTMENT OF DEFICIENCIES (EACH DEFICIENCY WILST BE PRECEDED BY FULL RESOLUTIONY OR LSC DEMINIPANG NFORMATION) D0 PREEX TAG PREEX PRECENCE TO THE APPROPRIATE DEFICIENCY D1 PREEX PREEX TAG PREEX PREEX PRECENCE TO THE APPROPRIATE DEFICIENCY D1 PREEX			095050	D. WING		09/	26/2022
Milling TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL RESULTORY OR LSC IDENTIFYING INFORMATION) PREFX TAG CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPORTATE DEFICIENCY Conditivities F 607 Continued from page 30 Department of Health (DCH) Complaint/ Incident Report Form that documented the following: "Aggressive Behavior (Resident to Resident) [Resident #505]AggressorVictim [Resident #505]AggressorVictim self, otherwise very confused. On 1:1 Nursing supervisionAt About 3 AM today, writer received a call from Nursing Supervisor stating that [Resident #505] ran out of his room to [Resident #144's room]he pushed sitter in the stomach and pushed [Resident #414] down to the floor while she was coming out of hir bathroom" F 607 2. IDENTIFICATION OF OTHERS WITH the POTENTIAL TO BE AFFECTE All residents have the potential to ba supervisionAt About 3 AM today, writer received a call from Nursing Supervisor stating that [Resident #505] ran out of his room to [Resident #144's room]he pushed sitter in the stomach and pushed [Resident #146] down to the floor while she was coming out of hir bathroom" F 607 1A. Resident #505 was admitted to the facility on 09/02/22 with diagnoses that included: Schizzaffective Disorder, Dementia with Behavioral Disturbane, Altered Mental Status, Anxiety Disorder, Other Symptoms and Signs Involving Cognitive Awareness, and Disorientation. F 607 Review of Resident #505 medical record revealed the following; Nroving, Intreatening, screaming, and cursing others, wandering, and intruding on the privacy of others F 607 09/02/22 [Care Plan]: "[Resident #505] has potential to be physically aggressive rh (related to others] F 607			HEALTH CENTER LLC		901 FIRST STREET NW		
 F 607 Continued from page 30 Department of Health (DOH) Complaint/ Incident Report Form that documented the following: "Aggressive Behavior (Resident to Resident) [Resident #505]AggressorVicim [Resident #49][Resident #505] oriented to self, otherwise very confused. On 1:1 Mursing supervisionAt about 3 AM today, writer received a call from Nursing Supervisor stating that [Resident #505] ran out of his room In (Resident #148 sroom)he pushed sitter in the gromach and pushed [Resident #148] down to the floor while she was coming out of her bathroom" 1A. Resident #505 was admitted to the facility on 09/02/22 with diagnoses that included: Schizoaffective Disorder, Dementia with Behavioral Disturbance, Altered Mental Status, Anxiety Disorder, Other Symptoms and Signs Involving Cognitive Awareness, and Disorientation. Review of Resident #505 medical record revealed the following: An Admission Minimum Data Set (MDS) dated 09/02/22 (Zare Plan]: "[Resident #505] has potential to be physically aggressive rif (related to DemontiaGoal: [Resident #505] has potentialGoal: [Resident #505] has potentialGoal: [Resident #505] has potentialGoal: [Resident #505] has potentialGoal: [Resident #505] has potential	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRO	BE CROSS-	COMPLETION
Department of Health (DOH) Complaint/ Incident Report Form that documented the following: "Aggressive Behavior (Resident to Resident) [Resident #14505]AggressorVictim [Resident #148][Resident #505] oriented to self, otherwise very confused. On 1:1 Nursing supervisionAt about 3 AM today, writer received a call from Nursing Supervisor stating that Resident #148] room)At about 3 AM today, writer received a call from Nursing Supervisor stating that Resident #505] ran out of his room to [Resident #148's room)he pushed sitter in the stomach and pushed [Resident #4506] whon to the floor while she was coming out of her bathroom" 1A. Resident #505 was admitted to the facility on 09/02/22 with diagnoses that included: Schizoaffective Disorder, Other Symptoms and Signs Involving Cognitive Awareness, and Disorientation. Review of Resident #505 medical record revealed the following: An Admission Minimum Data Set (MDS) dated 09/02/22 [Care Plan]: "[Resident #505] has potential to be physically aggressive riv (related to others Unterventions: Modify	E 607	Continued from page	a 20	E C	07		12/5/202
09/03/22 [Physician Order]: "Resident on 1:1		Department of Heal Report Form that do "Aggressive Behavia [Resident #505]A [Resident #148] . self, otherwise very supervisionAt abo a call from Nursing 3 [Resident #505] ran #148's room]he p and pushed [Reside while she was comi 1A. Resident #505 w 09/02/22 with diagn Schizoaffective Disc Behavioral Disturba Anxiety Disorder, O Involving Cognitive Disorientation. Review of Resident the following: An Admission Minim 09/02/22 document severely impaired co symptoms of hitting grabbing, threatenir others, wandering, a others. 09/02/22 [Care Plar potential to be phys to) DementiaGoal self or othersInter environment"	th (DOH) Complaint/ Incident boumented the following: or (Resident to Resident) ggressor Victim [Resident #505] oriented to confused. On 1:1 Nursing but 3 AM today, writer received Supervisor stating that out of his room to [Resident bushed sitter in the stomach ent #148] down to the floor ing out of her bathroom" was admitted to the facility on oses that included: order, Dementia with ince, Altered Mental Status, ther Symptoms and Signs Awareness, and #505 medical record revealed hum Data Set (MDS) dated ed that facility staff coded: ognition; displayed behavior , kicking, pushing, scratching, ng, screaming, and cursing and intruding on the privacy of h]: "[Resident #505] has ically aggressive r/t (related : [Resident #505] will not harm ventions: Modify		2. IDENTIFICATION OF O THE POTENTIAL TO B All residents have the por affected. LNHA/ Designed an audit of incident repor past six months (May 20 2022) to ensure the facil implemented it's "Prohib Policy", "Dealing with Co Resident Policy", and re allegation of abuse [sext applicable authorities in manner. Any negative fil corrected upon discover	E AFFECTE been vill conduct rt forms for the 022 to October lity vition of Abuse porting of ual] to the a timely ndings will be y if applicable.	

If continuation sheet Page 31 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRU		(X3) DATE COMP	SURVEY LETED
		095036	B. WING					C 26/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REETAD	DRESS, CITY, STATE, ZIP CODE		
UNIQUE F	REHABILITATION AND HE	EALTH CENTER LLC				STREET NW TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG			PROVIDER'S PLAN OF CORRECTION (E. CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
F 607	Nursing Supervision f every shift" SBAR [Situation, Bac Assessment/Appeara Communication Tool] documented: "Situati resident to the floor [Resident # 148], who bathroom to the floor. redirected and taking (five) nursing staff" 1B. Resident #148 wa 07/28/22 with diagno Obstructive Pulmona Fibrillation, Seizures, Review of Resident # revealed: An Admission Minimu 08/03/22 documented intact cognition; not s stabilize with staff ass off the toilet and from 09/06/22 [Situation, B Assessment/Appeara documented, " [Res another resident to th complained of lowe rating] of 3/10order vertebra X-ray to R/O "	kground, ince, and Request dated 09/06/22 on: Pushing another pushed the resident o was coming from the Resident [#505] was (taken) to his room by 5 as admitted to the facility on ses that included: Chronic ry Disease (COPD), Atrial and History of Falling. 148's medical record Im Data Set (MDS) dated t that facility staff coded: teady; and only able to sistance when moving on or seated to standing. Fackground, ince, and Request (SBAR] sident #148], was pushed by e floor with no injury r back pain, [with a pain given for lumbar and (rule out) fracture due to fall	F	607	3.	MEASURE TO PREVENT REOCURRENCE Education/ Designee will in-se staff and leadership to ensure facility implements it's "Prohibi Abuse Policy", "Dealing with O Resident Policy", and reporting allegation of abuse [sexual] to applicable authorities in a time manner. This will be completed by 12/5 Incidents and accidents are dis during the clinical meetings to that facility implements it's "Pro of Abuse Policy", "Dealing with Combative Resident Policy", a reporting of allegation of abuse to the applicable authorities in manner. Any negative findings corrected upon discovery if ap	rvice all the tion of combative g of the ly /22. scussed ensure ohibition nd e [sexual] a timely will be	12/5/2022

If continuation sheet Page 32 of 151

	MENT OF HEALTH AN S FOR MEDICARE &	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/07/2022 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			COMF	E SURVEY PLETED
		095036	B. WING				C /26/2022
NAME OF PI	ROVIDER OR SUPPLIER		1	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	EHABILITATION AND HE			901	1 FIRST STREET NW		
onigon i				WA	ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE O REFERENCED TO THE APPROPR DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
F 607	Continued from page	32	F	607			12/5/2022
	showed that Resident remained on the same The above evidence as failed to implement it's failure to separate the implement it's "Dealin policy by failing to call Metropolitan Police De incident. During a face-to-face 2:06 PM, Employee # that he received a call Charge Nurse on the #505 had pushed Res separated the two res Resident #505 to his r want to be moved at f pain. The resident sai called 911 for an amb evaluated and transfe employee then stated Director of Nursing (D that I should have also added that Resident # monitoring, but both re same unit until their quover. Cross Reference DCM 2. Facility staff failed t by failure to report Re	Second Floor, that Resident sident # 148 down. Staff idents and redirected room. Resident #148 did not irst and seemed to be in d she called the police, so I ulance to have her rred to the hospital. The , "After speaking with the ON) today, I understand to called the police." He 505 remained on 1:1 esidents remained on the uarantine periods were			4. MONITORING CORRECTI LNHA/ Designee will condu of incident report forms for months (May 2022 to Octol ensure the facility impleme "Prohibition of Abuse Policy with Combative Resident P reporting of allegation of ab to the applicable authorities manner, weekly for four we monthly for three months. F finding will be forward to Q/ review and recommendatio	ct an audit the past six per 2022) to nts it's ", "Dealing olicy", and use [sexual] s in a timely eks and Results of API for	

If continuation sheet Page 33 of 151

		X MEDICAID SERVICES	(Y2) MU	тірі	LE CONSTRUCTION	1	O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
			A. DOILDI				С
		095036	B. WING			09	/26/2022
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					901 FIRST STREET NW		
UNIQUE R	EHABILITATION AND H	HEALIH CENTER LLC			WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE CF REFERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETIOI DATE
							12/5/202
F 607	Continued from page	e 33	F	607	7		
	Resident #191 was a	admitted to the facility on					
		le diagnoses including					
	Depressive Disorder						
		order, Hyperlipidemia, tes Mellitus, Anemia, and					
	Chronic Renal Disea						
	During a face-to-face	e interview conducted with					
)/12/22 at 2:00 PM, when					
		bused she stated, "My					
		my bed at night, take my					
	and call the police of	ve sex with me. I reported her n her."					
		Complaint/Incident Report					
	-	submitted it to the state at 10:23 AM documented,					
		admitted on 06/09/2021 with					
		Mental Status (BIMS)					
		5Resident verbalized that					
		08/09/22 that, "My roommate					
	•	request towards me. She					
		o then called the charge al investigation, roommate					
	•	at the time of report and					
		ided not to continue the					
	•	esident assessments done					
		me Resident were separated					
	and [Resident name	-					
	investigation in prog	ress, final report to follow."					
	Review of the Situat	ion, Background.					
		Form signed and dated on					
	08/09/22 by Employ	ee #2 [Director of Nursing]					
		oximately 3 AM, received call					
	showed, " at appro from police department them that room-mate to her. Writer put pol						

Facility ID: JBJ

If continuation sheet Page 34 of 151

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>·</i>	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		095036	B. WING		09/26/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
UNIQUE R	EHABILITATION AND H	EALTH CENTER LLC		901 FIRST STREET NW WASHINGTON, DC 20001	
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CORRECTIVE ACTION SHO REFERENCED TO THE DEFICIENCE	OULD BE CROSS- COMPLETION APPROPRIATE DATE
					12/5/202
F 607	Continued from page		F 60	17	
	• •	was fast asleep and not t was talking about. Then the anks". Writer upon			
		ent, she denied pain, skin			
		in issues noted, vital signs			
	stable and recorded.	п			
	The evidence showe was reported to the n	d the alleged sexual abuse hight charge nurse on			
		by a phone call from the			
	police who call[ed] th				
		eport form was submitted			
		:23 AM, 28 hours later,			
	abuse [sexual abuse]	ours for an allegation of			
].			
		ew was conducted with			
		on 9/23/22 at 3:00 PM			
		alleged abuse on time to the knowledged the findings.			
	Cross Reference DC	MR 3232.4			
F 608	Reporting of Reason	able Suspicion of a Crime	F 60	8	
SS=D	CFR(s): 483.12(b)(5))(i)-(iii)			
	§483.12(b) The facili	ty must develop and			
		licies and procedures that:			
	§483.12(b)(5) Ensure	e reporting of crimes			
	occurring in federally	-funded long-term care			
		ce with section 1150B of the			
	•	d procedures must include			
		the following elements. covered individuals, as			
		50B(a)(3) of the Act, of that			
		to comply with the following			
	reporting requiremen	its.			
	(A) Each covered ind	Bud alization for all many and the tile of	1		

Facility ID: JBJ

If continuation sheet Page 35 of 151

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		CONSTRUCTION	1	D. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
							С
		095036	B. WING			09/	/26/2022
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JNIQUE F	REHABILITATION AND H	EALTH CENTER LLC			D1 FIRST STREET NW /ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRC REFERENCED TO THE APPROPRIATI DEFICIENCY)	SS-	(X5) COMPLETIO DATE
							12/5/202
F 608	State Agency and one entities for the politica facility is located any crime against any ind or is receiving care fre (B) Each covered ind immediately, but not I forming the suspicion suspicion result in set later than 24 hours if suspicion do not resu (ii) Posting a conspir- rights, as defined at set Act. (iii) Prohibiting and p defined at section 118 This REQUIREMENT by: Based on record revi interviews, for two (2) facility staff failed to re- suspicious crime (phy to another) to the app entity. Residents' #50 The findings included Review of the facility! with Combative Resid documented, "In ca resident -to- resident, to- resident, supervise and file a complaint w Department (MPD) Resident #505	e or more law enforcement al subdivision in which the reasonable suspicion of a lividual who is a resident of, om, the facility. ividual shall report later than 2 hours after a, if the events that cause the rious bodily injury, or not the events that cause the ult in serious bodily injury. cuous notice of employee section 1150B(d)(3) of the reventing retaliation, as 50B(d)(1) and (2) of the Act. T is not met as evidenced iews and resident and staff of 63 sampled residents, eport a reasonable ysical assault of one resident oropriate law enforcement 05 and #148. I: s policy entitled "Dealing dent revised 07/01/2022, ase of physical altercation, , resident- to- staff and staff- or or the designee will call with Metropolitan Police "	F	608	 CORRECTIVE ACTION FOR AFFECTED RESIDENTS Resident #505 was assessed toe by licensed nurse on 9/28/ Resident suffered no negative outcomes. Resident #505 was on 9/14/22 to ensure resident Resident #148 was moved on to ensure resident safety. Res #148 was discharged on 9/27/ resident cannot be assessed retroactively. IDENTIFICATION OF OTHER THE POTENTIAL TO BE AFF All residents have the potentia affected. LNHA/ Designee will an audit of incident report form past six months(May 2022 to 0 2022 to ensure the facility implit's "Prohibition of Abuse Polic "Dealing with Combative Resid Policy", and to report a reason suspicious crime (physical asses one resident to another) to the appropriate law enforcement of Any negative findings will be of upon discovery if applicable. This will be completed by 12/5 	head to 22. moved safety. 9/12/22 ident 22. The S WITH ECTED I to be conduct a for the Dctober olemented y", dent able ault of entity. orrected	

If continuation sheet Page 36 of 151

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	IPLE C	ONSTRI	UCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG			COMP	
		095036	B. WING					C 26/2022
NAME OF P	ROVIDER OR SUPPLIER			STR	EETAD	DDRESS, CITY, STATE, ZIP CODE	03/	
				901	FIRST	STREET NW		
UNIQUE F	REHABILITATION AND H	EALIH CENTER LLC		WA	SHING	STON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×		PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETIO DATE
F 608	Continued from page	36	F 6	208				
1 000	Schizoaffective Disor Behavioral Disturban	der, Dementia with ce, Altered Mental Status,	FU	000	3.	MEASURE TO PREVENT REOCURRENCE		
	Anxiety Disorder, Other Symptoms and Signs Involving Cognitive Awareness, and Disorientation. On 09/06/22 at 7:42 PM the facility submitted a					Education/ Designee will in-see staff and leadership to ensure facility implements it's "Prohib Abuse Policy", "Dealing with (Resident Policy", and report a	the ition of Combative	
	Department of Health Report Form that doc "Aggressive Behavior [Resident #505]Ag	n (DOH) Complaint/ Incident cumented the following: r (Resident to Resident)	reasonable suspicio assault of one reside the appropriate law in a timely manner.		reasonable suspicious crime (assault of one resident to ano the appropriate law enforcement	physical ther) to ent entity		
	self, otherwise very c supervisionAt abou a call from Nursing S [Resident #505] ran c #148's room]he pu and pushed [Residen	onfused. On 1:1 Nursing t 3 AM today, writer received				Incidents and accidents are di during the clinical meetings ar management meeting to ensu facility implements it's "Prohib Abuse Policy", "Dealing with 0 Resident Policy", report a reas suspicious crime (physical ass one resident to another) to the	nts are discussed etings and risk g to ensure that s "Prohibition of ng with Combative ort a reasonable vsical assault of	
	Review of Resident # the following:	505 medical record revealed				appropriate law enforcement e timely manner. Any negative findings will be o	entity in a	
	09/02/22 documented severely impaired cos symptoms of hitting, I grabbing, threatening	um Data Set (MDS) dated d that facility staff coded: gnition; displayed behavior kicking, pushing, scratching, g, screaming, and cursing and intruding on the privacy of	ior ning, g		upon discovery if applicable.			
	potential to be physic	: "[Resident #505] has cally aggressive r/t (related [Resident #505] will not harm entions: Modify						
	to) DementiaGoal: self or othersInterve environment" 09/03/22 [Physician 0	[Resident #505] will not harm						

Facility ID: JBJ

If continuation sheet Page 37 of 151

CENTER STATEMENT C	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DNSTRUCTION		PRINTED: 11/07/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		095036	B. WING			_		C 26/2022	
	ROVIDER OR SUPPLIER	ALTH CENTER LLC		901 F	EET ADDRESS, CITY, ST. FIRST STREET NW SHINGTON, DC 2000		00,1	20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	CORRECTIVE AC REFERENCE	AN OF CORRECTION (EAC CTION SHOULD BE CROS D TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 608	(five) nursing staff" Resident #148 Resident #148 Resident #148 was ac 07/28/22 with diagnos Obstructive Pulmonan Fibrillation, Seizures, Review of Resident # revealed: An Admission Minimu 08/03/22 documented intact cognition; not st stabilize with staff ass off the toilet and from 09/06/22 [Situation, B Assessment/Appeara documented, " [Res another resident to the complained of lower rating] of 3/10order vertebra X-ray to R/O "	Aground, nce, and Request dated 09/06/22 on: Pushing another pushed the resident was coming from the Resident [#505] was (taken) to his room by 5 dmitted to the facility on ses that included: Chronic ty Disease (COPD), Atrial and History of Falling. 148's medical record m Data Set (MDS) dated that facility staff coded: eady; and only able to istance when moving on or seated to standing. ackground, nce, and Request (SBAR] ident #148], was pushed by e floor with no injury back pain, [with a pain	F	508	LNHA/ Desi of incident r months(May ensure the f "Prohibition with Comba report a rea- (physical as another) to t enforcemen weekly for fo for three (3)	NG CORRECTIVE A ignee will conduct ar report forms for the p y 2022 to October 20 facility implements i of Abuse Policy", "E tive Resident Policy sonable suspicious a sault of one residen the appropriate law it entity in a timely m our (4) weeks and m months. Results of ard to QAPI for revie lations.	n audit bast six 022) to t's Dealing ", and crime t to nanner. nonthly finding		

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/07/2022 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		095036	B. WING			(09/2	C 26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC		901 FIRST STREET NW WASHINGTON, DC 2000 [.]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRECTIVE AC REFERENCED	N OF CORRECTION (EAC TION SHOULD BE CROSS TO THE APPROPRIATE EFICIENCY)		(X5) COMPLETION DATE
F 608	Continued from page		F 60	3			
F 609 SS=D	failed to call and file a Police Department (M During a face-to-face 2:06 PM, Employee # that he received a cal Charge Nurse on the #505 had pushed Res separated the two res Resident #505 to his n want to be moved at f pain. The resident sai called 911 for an amb evaluated and transfe employee then stated Director of Nursing (D that I should have als Reporting of Alleged V CFR(s): 483.12(c)(1)(§483.12(c) In respons neglect, exploitation, o must: §483.12(c)(1) Ensure involving abuse, negle mistreatment, includin source and misapprop are reported immedia hours after the allegat that cause the allegat serious bodily injury, o	showed that facility staff complaint with Metropolitan IPD) after the incident. interview on 09/20/22 at 30, Night Supervisor, stated I from Employee #31, Second Floor, that Resident sident # 148 down. Staff idents and redirected room. Resident #148 did not irst and seemed to be in d she called the police, so I ulance to have her rred to the hospital. The , "After speaking with the ON) today, I understand to called the police." <i>Violations</i> 4) se to allegations of abuse, or mistreatment, the facility that all alleged violations ect, exploitation or reg injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to	F 60				

Facility ID: JBJ

If continuation sheet Page 39 of 151

		MEDICAID SERVICES				1	. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTR		(X3) DATE COMP	SURVEY LETED
			A. BUILDIN	G			
		005030	B. WING				C
		095036	D. WING			09/:	26/2022
NAME OF PI	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HI	EALTH CENTER LLC			STREET NW		
				WASHING	GTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETIO DATE
				1.	CORRECTIVE ACTION FOR	THE	
F 609	Continued from page	39	F 6	09	AFFECTED RESIDENTS		
	officials (including to	the State Survey Agency and			Resident #53 was assessed h	head to	
	adult protective service	ces where state law provides			toe on 9/20/22 by the licensed		
		-term care facilities) in			Resident suffered no negative		
		e law through established			outcomes.		
	procedures.				Resident #193 was assessed	haad ta	
	§483.12(c)(4) Report the results of all investigations to the administrator or his or her				toe on 9/13/22 by the licensed		
					with no negative outcomes. T		
c a	•	ative and to other officials in			incident of alleged abuse was	reported	
	•	e law, including to the State			on 9/13/22 to the proper authors	orities.	
		n 5 working days of the			Upon discovery, alleged staff	member	
		leged violation is verified			was separated from Resident		
		e action must be taken. Γ is not met as evidenced			ensure resident safety.		
	by:				Resident #403 was discharge		
		on, record review, resident			11/26/21. The resident cannot	ot be	
		for three (3) of 63 sampled staff failed to: report an			assessed retroactively.		
	incident of alleged sta			2.	IDENTIFICATION OF OTHER		
		he State Agency; report an			THE POTENTIAL TO BE AF	FECTED	
	unusual incident in w	hich a resident was found			All residents have the potentia	al to be	
	unresponsive after go	ping into the facility's			affected. LNHA/ Designee wil		
	courtyard; and report				an audit of incident report forr		
	•	esident's allegation of staff			past six months(May 2022 to		
		lation of dignity. Residents'			2022) to ensure the facility im its policy on reporting incider		
	#193, #53, and #403.				alleged abuse and reporting of		
	The findings included	l:			incidents to the appropriate la enforcement entity in a timely	w	
	Review of the facility	s policy titled "Prohibition of					
	Abuse" revised on 02	2/22, stated "Anyone who					
	• •	y kind of abuse should report					
		mmediate Supervisor.					
	-	Administrator or Manager on					
	Duty or in his/her a	-					
	Supervisor or his/her	accident form for any					
		and submit it to the Director					
		eAll alleged violations,					

Facility ID: JBJ

If continuation sheet Page 40 of 151

		D HUMAN SERVICES MEDICAID SERVICES			FORM	0: 11/07/2022 1 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		LETED
		095036	B. WING			C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			9	01 FIRST STREET NW		
UNIQUE R	EHABILITATION AND HE		v	VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EAU CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued from page	40	F 609	3. MEASURE TO PREVENT REOCURRENCE		12/5/2022
	the administrator, Dire shall notify the Depart Event Reporting Syste phone in the event the unavailable within twe knowledge of the alleg (2) hours if serious bo there is an allegation of 1. The facility's staff fa alleged abuse that Re the State Agency. Resident #193 was ac 05/18/22, with multiple the following: Diabete Complications Type 2 Nondominant Side, Pe Disorder and Major De An observation and re conducted on 09/13/2 #193, he stated "An a the morning because she is not going to cha While in the room she and curses and uses of #193 went on to expla room with another sta "speech" (Speech lan- other staff observed w	ector of Nursing or designee ment of Health, via the em electronically or by a electronic system being inty-four (24) hours of ged incident and within two dily injury has occurred or of abuse" alled to report an incident of asident #193 made to staff to dmitted to the facility on e diagnoses that included s Mellitus Without , Hemiplegia Affecting Left ost Traumatic Stress epressive Disorder. esident interview were 2 at 3:00 PM, with Resident ide gets angry with me in I have diarrhea, she told me ange me in the morning. talks loud on her phone explicit language." Resident in that the aide was in the ff who he said was from guage pathologist) and the <i>y</i> hat occurred.		Education/ Designee will in-serve staff and leadership to ensure the facility implements its policy on reporting of unusual incidents to appropriate law enforcement en- timely manner. This will be completed by 12/5/2 Incidents and accidents are disc during the clinical meetings to e- the facility implements its policy reporting incident of alleged abu- reporting of unusual incidents to appropriate law enforcement en- timely manner. Any negative fin- will be corrected upon discovery applicable.	use and the tity in a 22. cussed nsure of on use and the tity in a dings	
	08/19/22, showed that following: intact cogn	Data Set (MDS) dated t the facility's staff coded the ition; totally dependent for al hygiene requiring one (1)				

If continuation sheet Page 41 of 151

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTI	RUCTION	1	D. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	IG		Сом	PLETED
							С
		095036	B. WING			09	/26/2022
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
UNIQUE F	REHABILITATION AND H	EALTH CENTER LLC			T STREET NW GTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	SS-	(X5) COMPLETION DATE
				4.	MONITORING CORRECTIVE ACT	ON	12/5/2022
F 609	Continued from page	41	F 6	609		المربح مربح	
	staff assist; bathing re				LNHA/ Designee will conduct of incident report forms for the		
		nd requiring the support of			months(May 2022 to October		
two (2) staff; impairment on both sides for both the upper and lower extremities.					ensure the facility implements	its policy	,
				on reporting incident of allege			
	Review of the facility's grievance folder showed				and reporting of unusual incid the appropriate law enforcement		
no documented evidence of the allegation of					in a timely manner, weekly for		
	abuse/neglect that Re				weeks and monthly for three (
	-	ent with the aide and there			months. Results of finding will	be	
		ne medical record of a report			forward to QAPI for review an	d	
	made to the State Ag	•			recommendations.		
	09/13/22 at 4:07 PM, Nursing) was question asked if the facility control and reported Resider to the State Agency. never reported any of	interview conducted on Employee #2 (Director of ned by the Surveyor and onducted an investigation nt #193's allegation of abuse Employee #2 stated, "He f this to me." Employee #2 had not reported this to the					
	09/15/22 at 3:14 PM, language pathologist #193) communicated	interview conducted on Employee #25 (Speech) stated "He (Resident many things about his care					
	CNA (Certified Nurse deal with other reside	en he was refused care by a Aide) due to her needing to ents. It was very ssive, inconsiderate tone,					
	harsh, critical and not respectful. I spoke to my supervisor and reported this"						
	happened on Monda	on to explain that the incident y 09/12/22, and she said that er supervisor that day.					
	09/15/22 at approxim	interview conducted on ately 3:30 PM, Employee ab) stated "(Employee #25)					

Facility ID: JBJ

If continuation sheet Page 42 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
		095036	B. WING				/26/2022
	ROVIDER OR SUPPLIER	EALTH CENTER LLC		901	REET ADDRESS, CITY, STATE, ZIP CODE FIRST STREET NW SHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRC REFERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
F 609	change his diaper. E explain that Employe behavior as rude and about it. 2. Facility staff failed where Resident #53 vas after going into the co Resident #53 was ad 12/10/19, with multipl Tobacco Use, Hemipl Following Cerebral In Cataract, Other Psyc and Cognitive Comm Review of the medica following: 03/22/22 [Quarterly M showed that the facili cognition. Resident h upper or lower extrem and walker for mobilit Review of the physici following: 05/31/22 [Physician C the nearest ER (emer in mental status one f 05/31/22 at 5:04 PM] Resident returned f suspected ingestion c	f a conversation that ff, and he asked staff to mployee #48 went on to e #25 described the CNA's that he did not tell anyone to report an unusual incident was found unresponsive burtyard to smoke. mitted to the facility on le diagnoses that included: legia and Hemiparesis farction, History of Falling, hoactive Substance Abuse unication Deficit. al record revealed the Minimum Data Set (MDS)] ty staff coded: intact as no impairment in the nity, and uses a wheelchair ty. ans' orders revealed the Drder] "Send the resident to rgency room) due to change time only" [Nursing Progress] " rom courtyard with of opioids around 2:40 PM ristics of unresponsiveness,	F	509			12/5/2022

Facility ID: JBJ

If continuation sheet Page 43 of 151

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M				FOR	D: 11/07/2022 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION IG		E SURVEY PLETED
	095036	B. WING		09	C / 26/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I	
UNIQUE REHABILITATION AND HE	ALTH CENTER LLC		901 FIRST STREET NW WASHINGTON, DC 20001		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
substance abuseno naloxone (opiate anta 0.4mg/ml is administe intramuscular to rever- the injection the reside breathing is low and si resident to (hospital) for the facility at 3:58 pm 05/31/22 at 5:50 PM [I Resident is a smoke 2.45pm when he retur court yard to have a cl physical status, sweat assisted to his bed an assessment done, pup sweating profusely an questions, skin was w shallow-respiratory. O minute via nasal cann signs but still not respo " The medical record lar evidence that the facil Agency, the unusual of Resident #53 became given Naloxone and so During a face-to-face i 09/21/22 at approxima (Director of Nursing) s	history of psychoactive tified DR (Doctor)and gonists) 2 doses of red at 2:50 pm and 3:00 pm se Opioid overdose. After ent is still unresponsive and hallow911 took the or further treatment and left " Nursing Progress] " er and was observed around ned from smoking in the hange in his mental and ing profusely. Resident was d a complete head to toe bils were fixed and dilated, d could not answer arm to touch, breathing was xygen started at 2 liters a ulaResident had vital onding to touch and voice cked any documented ity reported to the State boccurrence in which unresponsive and was ent to the hospital.	F 6			12/5/2022

Facility ID: JBJ

If continuation sheet Page 44 of 151

		D HUMAN SERVICES MEDICAID SERVICES				FORI	D: 11/07/2022 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		095036	B. WING				C /26/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC					
	011111100/07			V	WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIAT DEFICIENCY)	SS-	(X5) COMPLETION DATE
F 609	Continued from page	44	E	609			12/5/2022
1 000	3. Facility staff failed t investigation of Resid verbal abuse and viola State Agency.	o report the results of it's ent #403's allegation of staff ation of dignity rights to the		009			
	08/02/21 with multiple	dmitted to the facility on diagnoses that included: tus, Visual Disturbances n.					
	(FRI), DC00010223 a by the State Agency of The resident stated by the staff and his dig employee was very up and my wife tried to fin	nprofessional When me nd out about the medication, e so defensive, rude and					
	Review of Resident #4 revealed the following						
	08/08/21 showed facil	one-person physical assist					
	Entry No mood indi behaviors observed very aggressive and a Resident pushed site was shouting and curs	Resident and wife were abusive toward writer. (side) (sp) table at writer sing writer, just because the resident was not enough. sors informed					

Facility ID: JBJ

If continuation sheet Page 45 of 151

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		PLETED
		095036	B. WING				C 26/2022
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE F	EHABILITATION AND HE	ALTH CENTER LLC			01 FIRST STREET NW /ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 609	Documentation Late E Pushed site (side) (sp Screaming. Cursing a screaming at writer with 08/24/21 at 6:17 PM " Patient seen on tele nurse manager and were listened to and h 08/25/21 at 9:37 PM " The resident was see [08/24/21]at 5.55 pt telemedicine visit, the compliant about the n previous day evening specific, the resident st abused by the staff ar violatedAn investig employee was identifi suspended pending o Employee was intervi asked the employee t resident but employee statement was receive notified she will be on outcome of investigat Review of the facility's documented evidence the results of the inve Agency. During a face-to-face 09/20/22 at 11:13 AM Nursing/DON) stated	Entry Hitting others. b) table on writer. t others. Cursing and ith his wife on the phone." Physicians Progress Note emedicine rounds with the d staff. Patient complaints have been addressed" Progress Note Late Entry n on telemedicine rounds m in his roomDuring the resident stated he had a urse that worked the shift [08/23/21] to be stated he was verbally hd his rights and dignity ation was initiated, the ed and immediately utcome of investigation ewed The Unit manager o go and apologized to e refused employee ed via email. Employee was suspension pending ion."	F	609			12/5/2022

Facility ID: JBJ

If continuation sheet Page 46 of 151

		MEDICAID SERVICES					0. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			(X3) DATE COMP	SURVEY LETED	
		095036	B. WING				C 26/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREETAD	DRESS, CITY, STATE, ZIP CODE			
UNIQUE F	EHABILITATION AND HE	EALTH CENTER LLC			STREET NW TON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE	
F 610	Continued from page	46	F 04	0			12/5/202	
	1.0	40 orrect Alleged Violation	F 61 F 61					
F 610 SS=D	CFR(s): 483.12(c)(2)	FOI	0					
	neglect, exploitation, must: §483.12(c)(2) Have e violations are thoroug §483.12(c)(3) Preven neglect, exploitation, investigation is in pro- §483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on record revi interview for three (3) facility staff failed to: incident in which a re- unresponsive; and to	t further potential abuse, or mistreatment while the gress. the results of all administrator or his or her ative and to other officials in e law, including to the State n 5 working days of the eged violation is verified e action must be taken. is not met as evidenced ew, resident, and staff of 63 sampled residents, nvestigate an unusual sident was found take necessary corrective nt-to-resident incident.		1.	CORRECTIVE ACTION FOR AFFECTED RESIDENTS Resident #53 was admitted to hospital on 5/31/22 and return 6/2/22 in stable condition. He assessment completed on 6/3 licensed nurse and suffered r negative outcomes. Resident #148 was discharge This deficiency cannot be corr retroactively. Resident #505 was assessed toe by licensed nurse on 9/28 Resident suffered no negative outcomes. Resident #505 was on 9/14/22 to ensure resident	o the ned on ad to toe 3/2022, by no ed 9/27/22. rected head to 5/22. es s moved		
	of Abuse" revised 02/ Sexual abuse is non- of any type with a res limited to sexual hara	s policy entitled, "Prohibition						

Facility ID: JBJ

If continuation sheet Page 47 of 151

		D HUMAN SERVICES MEDICAID SERVICES			FORM	0: 11/07/2022 1 APPROVED . 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION		LETED
		095036	B. WING			C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	001	-0/2022
			9	01 FIRST STREET NW		
UNIQUE R	EHABILITATION AND HE	ALIH CENTER LLC	v	VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
						12/5/2022
F 610	Continued from page	47	F 610			
		using another resident, the		2. IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFE		
	facility will separate the			THE POPENTIAL TO BE AT L		
	appropriate during the Reporting 1. All allege			All residents have the potential		
		r of Nursing, or designee		affected. LNHA/ Designee will c an audit of incident report forms		
	shall notify the Depart	=		past six months(May 2022 to Oc		
	Agency] via the Event			2022) to ensure the facility imple	ements	
	-	two (2) hours if serious or there is an allegation of		its policy on properly investigat unusual incident; and to take ne		
	abuse"	or there is an allegation of		corrective actions after a resider		
				resident incident in a timely man	ner.	
	1.The facility staff faile	ed to investigate an unusual		Any negative findings will be ad	dressed	
		Resident #53 was found		upon discovery.		
		ing to the courtyard to				
	•	ntly required Naloxone and transport to the hospital.				
	(Opiale anayonisis) a	and transport to the hospital.				
	Resident #53 was adr	nitted to the facility on				
	•	e diagnoses that included:				
	Tobacco Use, Hemiple					
		farction, History of Falling,				
	and Cognitive Commu	noactive Substance Abuse				
	Review of the medica following:	I record revealed the				
	showed that the facilit cognition. Resident ha	as no impairment in the				
	upper or lower extrem and walker for mobility	ity, and uses a wheelchair y.				
	Review of the physicia following:	ans' orders revealed the				
		Order] "Send the resident to gency room) due to change ime only"				

Facility ID: JBJ

If continuation sheet Page 48 of 151

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/07/202 M APPROVE D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		STRUCTION		E SURVEY PLETED
		095036	B. WING			09	C /26/2022
	ROVIDER OR SUPPLIER	EALTH CENTER LLC		901 FI	T ADDRESS, CITY, STATE, ZIP CODE RST STREET NW IINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
F 610	05/31/22 at 5:04 PM Resident returned f suspected ingestion of with clinical character slow breathing, sleep Resident (has a) is a substance abusem naloxone (opiate anta 0.4mg/ml is administer intramuscular to reve the injection the resid breathing is low and s resident to (hospital) the facility at 3:58 pm 05/31/22 at 5:50 PM Resident is a smok 2.45pm when he retur court yard to have a of physical status, sweat assisted to his bed an assessment done, pu sweating profusely an questions, skin was v shallow-respiratory. Of minute via nasal can signs but still not resp " The medical record la evidence that the fact episode of becoming During a face-to-face 09/21/22 at approxim (Director of Nursing) investigated the resid	[Nursing Progress] " rom courtyard with of opioids around 2:40 PM ristics of unresponsiveness, iness and sweating. history of psychoactive otified DR (Doctor)and agonists) 2 doses of ered at 2:50 pm and 3:00 pm rse Opioid overdose. After lent is still unresponsive and shallow911 took the for further treatment and left " [Nursing Progress] " er and was observed around irned from smoking in the change in his mental and ting profusely. Resident was nd a complete head to toe upils were fixed and dilated, nd could not answer varm to touch, breathing was Dxygen started at 2 liters a hulaResident had vital bonding to touch and voice acked any documented ility investigated resident's unresponsive on 05/31/22.	F6	510	3. MEASURE TO PREVEN REOCURRENCE Education/ Designee will staff and leadership on th Policy and procedures to facility implements its po properly investigating any incident; and to take need corrective actions after a resident incident in a time. This will be completed 12 Incidents and accidents a during the clinical meetin the facility implements its investigating incident of a and reporting of unusual the appropriate law enfor in a timely manner. Any n findings will be corrected discovery if applicable.	in-service all ne Abuse ensure the licy on y unusual essary resident-to- ely manner. 2/5/2022. are discussed to ensure s policy on alleged abuse incidents to recement entity negative	12/5/202

Facility ID: JBJ

If continuation sheet Page 49 of 151

	-	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		INSTRUCTION		PLETED
		095036	B. WING				C 26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
	EHABILITATION AND HE			901 F	FIRST STREET NW		
		EALTH CENTER LLC		WAS	HINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
							12/5/2022
F 610	Continued from page	49	F 61	10			
	Employee #2 stated,	"We do not have it."					
	Cross Reference DCI	MR 3232.2			4. MONITORING CORRECT	IVE	
		teles the measurement			ACTION		
	2. Facility staff failed t	eparating Residents' #505			LNHA/ Designee will conduct ar		
		dent-to-resident incident.			of incident report forms for the p months(May 2022 to October 20		
					ensure the facility implements its		
	On 09/06/22 at 7:42 F	PM the facility submitted a			on investigating incident of alleg		
	Department of Health	(DOH) Complaint/ Incident			abuse, take necessary correctiv		
	Report Form that doc	umented the following:			actions after a resident-to-reside		
		(Resident to Resident)			incident and reporting of unusua incidents to the appropriate law	11	
	[Resident #505]Ag				enforcement entity in a timely m	anner.	
		[Resident #505] oriented to			weekly for four (4) weeks and m	nonthly	
		onfused. On 1:1 Nursing t 3 AM today, writer received			for three (3) months. Results of		
	a call from Nursing Su				will be forward to QAPI for revie recommendations.	w and	
	-	but of his room to [Resident			recommendations.		
		shed sitter in the stomach					
	and pushed [Residen	t #148] down to the floor					
	while she was coming	g out of her bathroom"					
		as admitted to the facility on					
	09/02/22 with diagnos						
	Schizoaffective Disor	ce, Altered Mental Status,					
		er Symptoms and Signs					
	Involving Cognitive Av	• • •					
	Disorientation.						
	Review of Resident # the following:	505 medical record revealed					
		m Data Set (MDS) dated that facility staff coded:					
		nition; displayed behavior					
		kicking, pushing, scratching,					
		, screaming, and cursing Id intruding on the privacy of					

If continuation sheet Page 50 of 151

		ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES				OMB NC	0. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ECONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDI	NG _			
		095036	B. WING				C /26/2022
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				9	001 FIRST STREET NW		
	EHABILITATION AND HE	EALIH CENTER LLC		V	NASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (E. CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
	Continued from page others. 09/02/22 [Care Plan]: potential to be physic to) DementiaGoal: self or othersInterve environment" 09/03/22 [Physician C Nursing Supervision f every shift" SBAR [Situation, Bac Assessment/Appeara Communication Tool] documented: " Situati resident to the floor [Resident # 148], who bathroom to the floor redirected and taking (five) nursing staff" 1B. Resident #148 wa 07/28/22 with diagnon Obstructive Pulmona Fibrillation, Seizures, Review of Resident # revealed: An Admission Minimu 08/03/22 documented	50 "[Resident #505] has ally aggressive r/t (related [Resident #505] will not harm entions: Modify Drder]: "Resident on 1:1 for Elopement and Fall Risk kground, ance, and Request dated 09/06/22 fon: Pushing another .pushed the resident to was coming from the Resident [#505] was (taken) to his room by 5 as admitted to the facility on ses that included: Chronic ry Disease (COPD), Atrial and History of Falling.	TAG		REFERENCED TO THE APPROPRIATE DEFICIENCY)	•	
	off the toilet and from 09/06/22 [Situation, B Assessment/Appeara	-					

Facility ID: JBJ

If continuation sheet Page 51 of 151

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					С
		095036	B. WING		09/26/2022
IAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
JNIQUE R	EHABILITATION AND H	EALTH CENTER LLC		FIRST STREET NW SHINGTON, DC 20001	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (E	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	
					12/5/202
F 610	Continued from page		F 610		
		he floor with no injury			
		er back pain, [with a pain r given for lumbar and			
		D (rule out) fracture due to fall			
	"				
	00/00/22 [Dhusisian	Orderik "Trenefer resident to			
		Order]: "Transfer resident to ergency Room) for further			
	evaluation of rib pain				
		's alpha census on 09/20/22			
		nt #505 and Resident #148 ne unit after the incident.			
	2:06 PM, Employee that he received a ca	e interview on 09/20/22 at #30, Night Supervisor, stated all from Employee #31, e Second Floor, that Resident			
	#505 had pushed Re	sident # 148 down. Staff sidents and redirected			
		room. Resident #148 did not			
		first and seemed to be in aid she called the police, so I			
	called 911 for an aml	-			
		erred to the hospital. The			
		d, "After speaking with the			
		DON) today, I understand so called the police." He			
		#505 remained on 1:1			
	_	residents remained on the			
	same unit until their o	quarantine periods were			
F 000	Cross Reference DC		F 000		
F 622 SS=D	Transfer and Dischar CFR(s): 483.15(c)(1)	•	F 622		
	§483.15(c) Transfer				

Facility ID: JBJ

If continuation sheet Page 52 of 151

	S FOR MEDICARE &			LE CONSTRUCTION		0.0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE COMP	PLETED	
			A. BUILDING	·		С	
		095036	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	CITY, STATE, ZIP CODE		
				901 FIRST STREET NW			
UNIQUE F	EHABILITATION AND HE	ALIH CENTER LLC		WASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRECTIVE ACTION REFERENCED TO	F CORRECTION (EACH N SHOULD BE CROSS- THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
E 000						12/5/202	
F 622	Continued from page		F 62	2			
	§483.15(c)(1) Facility (i) The facility must peremain in the facility, discharge the resident (A) The transfer or discressident's welfare and cannot be met in the facility of the transfer or discressident's welfare and cannot be met in the facility of the transfer or discressident's welfare and cannot be met in the facility of the transfer or discression of the transfer or the the the transfer or the transfer or the transfer or the transfer or discression of a facility payment or a facility of the transfer or transfer or transfer or transfer or the transfer or tra	requirements- emit each resident to and not transfer or t from the facility unless- scharge is necessary for the t the resident's needs facility; scharge is appropriate s health has improved dent no longer needs the the facility; viduals in the facility is ne clinical or behavioral viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. if the resident does not paperwork for third party hird party, including l, denies the claim and the by for his or her stay. For a s eligible for Medicaid after , the facility may charge a le charges under Medicaid;		facility. This can corrected. 2. IDENTIFICATIO THE POTENTIA All residents hav affected. Social designee will co audit of all disch three months (A 2022) to ensure required for resi is included. This	SIDENTS was discharged b longer resides at the anot be retroactively ON OF OTHERS WITH AL TO BE AFFECTED we the potential to be work director or onduct a house wide harges home for the last august 2022 to October that the information dent-initiated discharge s will be completed by gative findings will be		
	(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger						

If continuation sheet Page 53 of 151

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 11/07/2022 A APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		LETED
		095036	B. WING			C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	EHABILITATION AND HE	ALTH CENTER LLC	90	01 FIRST STREET NW		
			v	VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000						12/5/2022
F 622	Continued from page		F 622	3. MEASURE TO PREVENT		
	that failure to transfer	or discharge would pose.		3. MEASURE TO PREVENT REOCURRENCE		
	in paragraphs (c)(1)(i) section, the facility mu or discharge is docum medical record and ap communicated to the institution or provider. (i) Documentation in t must include: (A) The basis for the t (i) of this section. (B) In the case of para section, the specific re be met, facility attemp needs, and the servic facility to meet the nee (ii) The documentation (2)(i) of this section m (A) The resident's phy discharge is necessar (A) or (B) of this section (B) A physician when necessary under para this section. (iii) Information provid must include a minime (A) Contact informatio responsible for the ca (B) Resident represen contact information (C) Advance Directive	sfers or discharges a the circumstances specified (A) through (F) of this ust ensure that the transfer nented in the resident's opropriate information is receiving health care he resident's medical record ransfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this esident need(s) that cannot ots to meet the resident e available at the receiving ed(s). In required by paragraph (c) ust be made by- visician when transfer or ry under paragraph (c) (1) on; and transfer or discharge is graph (c)(1)(i)(C) or (D) of ed to the receiving provider um of the following: on of the practitioner re of the resident. Intative information including e information tions or precautions for ropriate.		The Director of Social Work or designee will re-educate the So workers on ensuring that all res discharges to home include all necessary information, including of the resident's discharge sumi consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to a safe and effective transition of are in place. This will be complet 12/5/2022.	ident g a copy mary, s o ensure f care	

Facility ID: JBJ

If continuation sheet Page 54 of 151

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING 095036 09/26/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW UNIQUE REHABILITATION AND HEALTH CENTER LLC WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL CORRECTIVE ACTION SHOULD BE CROSS-PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) MONITORING CORRECTIVE ACTION 12/5/2022 4. Social worker will conduct an audit on F 622 Continued from page 54 F 622 all discharges weekly for four (4) (F) All other necessary information, including a weeks, and monthly for three (3) copy of the resident's discharge summary, months to ensure that the information consistent with §483.21(c)(2) as applicable, and required for resident-initiated discharge any other documentation, as applicable, to ensure is complete. a safe and effective transition of care. The results from the audits will be reviewed during the monthly QAPI This REQUIREMENT is not met as evidenced meeting for 3 months and then reby: evaluated to determine if further Based on record review and staff interview.for monitoring is indicated. All negative one (1) of 63 sampled residents, the facility's staff findings will be corrected upon failed to ensure the information required for discovery. resident-initiated discharge to occur was a part of the medical record. Resident #254. The findings included: Resident #254 was admitted to the facility on 08/20/21 with diagnoses of unspecified fracture of right Calcaneus, Fracture of Right Femur, Fracture of Facial Bone, Laceration of Other Parts of the Head, Blindness of Left Eye and Gastrostomy Status. A review of the resident's medical record showed the following: Physician's order dated 08/20/21 directed, "Admit to skilled level of care. The resident requires SNF [skilled nursing facility] covered care on a daily basis." Care plan initiated 08/25/21 with revision date 11/04/21 Focus: "[resident name] shows potential for discharge and his family member expresses wishes for discharge to home". Goal: "[resident name] will be discharged to home when rehabilitation/self-care goals are met, and he is medically cleared." Target date 11/29/21. Discharge Summary dated 10/26/2021 at 2:15

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 55 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II T	- וחו	CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:				· · /	LETED
			A. BUILDII	NG _			~
		095036	B. WING _				C 26/2022
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				9	01 FIRST STREET NW		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC		v	ASHINGTON, DC 20001		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EA		(X5)
PREFIX	(/ MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG	Х	CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE	iS-	COMPLETION DATE
TAG	REGULATORTOR		IAG		DEFICIENCY)		
-	.						12/5/2022
F 622	Continued from page		F	622			
		harged home to [home					
		ility today 10/26/2021 at					
	12:30 PM. At the req						
		ling planned discharge with					
		ttendant) services. Resident					
		ne facility by his mother with					
		portationresident has					
	feeding tube in place						
		(17/21. 11:00 am at [hospital					
	-	regular diet, mechanical soft					
	texture water flush	-					
	Fracture of right cal						
	-	cast removed has an					
		weight bearing status					
	Medication reconciliat						
	-	to resident and mother.					
	was given to reside						
	medication"	I 6 days' supply of home					
	There was no evidence	ce that facility staff					
	documented arranger	ments or instructions for					
	care specific to Resid	ent #254's gastrostomy					
	feeding tube post disc	charge.					
		interview on 09/20/22 at					
	1:32 PM, Employee #						
	-	dings and stated that she					
		rker that carried out the					
		rangements at that time for					
_	Resident #254.		_				
F 625		olicy Before/Upon Trnsfr	F	625			
SS=D	CFR(s): 483.15(d)(1)	(2)					
	§483.15(d) Notice of I	bed-hold policy and return-					
		before transfer. Before a					
	nursing facility transfe	ers a resident to a hospital or					

Facility ID: JBJ

If continuation sheet Page 56 of 151

<u>JENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRI	JCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				
							С
		095036	B. WING			09/	26/2022
NAME OF PF	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE		
JNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			STREET NW TON, DC 20001		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		CORRECTIVE ACTION SHOULD BE CF REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
E 005	a		_				12/5/202
F 625	Continued from page		F 62	5 1	CORRECTIVE ACTION FOR		
	the resident goes on t nursing facility must p the resident or reside	provide written information to			AFFECTED RESIDENTS	(III L	
	specifies-	ni representative triat			Desident #252 did not suffer		
	•	e state bed-hold policy, if			Resident #253, did not suffer negative outcomes as a resu	any It of failure	
		resident is permitted to			to provide a bed hold policy t		
		sidence in the nursing			resident or resident represen		
	facility;	-			Resident was discharged on		
	(ii) The reserve bed p	ayment policy in the state			This cannot be corrected ret	oactively.	
	plan, under § 447.40	of this chapter, if any;					
	(iii) The nursing facilit			2.	IDENTIFICATION OF OTHE	RS WITH	
	paragraph (e)(1) of th	ch must be consistent with is section, permitting a		2.	THE POTENTIAL TO BE AF	-	
	resident to return; and				All residents discharged have		
		pecified in paragraph (e)(1)			to be affected by this practice		
	of this section.				worker /Designee will conduc		
	\$192 15(d)(2) Pod bo	Id notice upon transfer. At			wide audit for the past 3 mor October) of residents who ar		
	the time of transfer of	old notice upon transfer. At			discharged or transferred to		
		apeutic leave, a nursing			to ensure that resident and re		
		o the resident and the			parties are notified and provi		
		e written notice which			copy of the bed hold policy.		
		of the bed-hold policy			negative findings will be corr	ected upon	
	•	oh (d)(1) of this section.			discovery.		
		is not met as evidenced		3.	MEASURE TO PREVENT		
	by:				REOCURRENCE		
		ew and staff interview, for					
		d residents, facility staff			Staff Educator/designee will		
	•	dent #253's responsible			in-service to the Social Servi licensed nurses on providing		
		ice of the bed-hold policy			and/or resident representativ		
	when he was transfer	red to the hospital.			written Bed Hold Policy upon		
	The findings included:				from the facility. Medical records clerk, will at	tach the	
	Resident #253 was a	dmitted to the facility on			bedhold policy to all hospital packages. Education will be		
		e diagnoses that included:			by 12/5/2022.	completed	
		al Dialysis, Chronic Atrial					
	Fibrillation and Hyper						

Facility ID: JBJ

If continuation sheet Page 57 of 151

The RESULTATORY OR LSC IDENTIFYING INFORMATION) The Date The REPERENCED TO THE APPROPRIATE Date Definition Definition Definition Definition F 625 Continued from page 57 F F F 625 Review of a Facility Reported Incident (FRI), DC00010324, received by the State Agency on 10/19/21 documented, "Resident was scheduled to dialysis today 92/821 by 10 am atDialysis Center At 9:10am, Resident was transported out of the facility via a wheelchair At 3:40pm, Dialysis Center MD (medical doctor) to be evaluated per stroke protocols" F 625 Conduct a house wide audit for the beginning August 2022 of residents who are transferred or discharged to the hospital and monitored ongoing to ensure that resident and responsible parties are notified and provided with a copy of the bed hold policy that was attached to the transfer package when a resident was transfer out of the facility and to ensure they were updated in writing of the number of bed hold days remaining. This audit will be completed monthly for the past three (3) months, weekly times four and opoke to RN (registered nurse)she said resident will be admitted to further evaluate for a stroke. MD (medical doctor) was notified of resident stamission" There is no documented twian tacility staff provided Resident #253's RP with the bed			ID HUMAN SERVICES				FORM	M APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED OB3036 B. WINC STREET ADDRESS, CITY. STATE, 2IP CODE 09/26/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE, 2IP CODE 09/26/2022 UNIQUE REHABILITATION AND HEALTH CENTER LLC STREET ADDRESS, CITY. STATE, 2IP CODE 09/26/2022 (AND OF CORRECTION (EACH PREETK) SUMMARY STATEMENT OF DEFICIENCIES IP STREET ADDRESS, CITY. STATE, 2IP CODE 000000000000000000000000000000000000							1	
OP3602 E. VINC OP367022 NAME OF PROVIDER OR SUPPLICE STREET ADDRESS, CITY, STATE, 20° CODE bit FIRST STREET NW WASHINGTON, DC 20001 STREET ADDRESS, CITY, STATE, 20° CODE bit FIRST STREET NW WASHINGTON, DC 20001 OP1000000000000000000000000000000000000				()			COMP	PLETED
UNQUE REHABILITATION AND HEALTH CENTER LLC Def FIRST STREET NW WASHINGTON, DC 2001 PMD IP PRETX TVG SUMMARY STATEMENT OF OFFICIENCES (RECOVERY FLANCE OCONCECTION EACH (RECOVERT FLANCE) Def PRETX TAG PROVERY FLANCE OCONCECTION EACH (RECOVERT FLANCE PROVERY FLANCE OCONCECTION EACH (RECOVERT FLANCE) Def PRETX TAG PROVERY FLANCE OCONCECTION EACH (RECOVERT FLANCE) Def PRETX TAG PROVERY FLANCE OCONCECTION EACH (RECOVERT FLANCE) Def PRETX TAG PROVERY FLANCE OCONCECTION EACH (RECOVERY FLANCE) Def PRETX TAG PROVERY FLANCE OCONCECTION EACH (RECOVERY FLANCE) Def PRETX TAG PROVERY FLANCE (PROVERY FLANCE) Def PROVERY FLANCE (PROVERY FLANCE (PROVERY FLANCE) Def PRETX TAG PROVERY FLANCE (PROVERY FLANCE) Def PRETX TAG PROVERY FLANCE (PROVERY FLANCE) Def PROVERY FLANCE (PR			095036	B. WING				-
UNIQUE REHABILITATION AND HEALTH CENTER LLC WASHINGTON, DC 2001 (PA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MOST BERECORD BY FULL RECULATORY OR LSC IDENTFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS) CMST. DOM: DURING CORRECTIVE ACTION SHOULD BE CROSS) CMST. DURING CORRECTIVE ACTION SHOULD BE CROSS. CMST. DURING CORRECTIVE ACTION REFERENCED TO THE APPROPRIATE DEFICIENCY CMST. DURING CORRECTIVE ACTION CMST. DURING CORRECTIVE ACTIO	NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>I</u>	
We ID Metry SUMMARY STREMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETRY TAG PROVIDER'S PLANOF CORRECTION(EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETING INFORMATION DECIDING PRETRY ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETING INFORMATION DECIDING PRETRY ACTION DECIDING INFORMATION DECIDING PRETRY ACTION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDING INFORMATION DECIDINAL DECIDING INFORMATION </td <td></td> <td></td> <td></td> <td></td> <td>90</td> <td>01 FIRST STREET NW</td> <td></td> <td></td>					90	01 FIRST STREET NW		
PREFIX TAG CONNECTION PREFIX TAG CONNECTION SHOULD BE CROSS- REFERENCED TO TAME APPROPRIATE CONNECTION DEFICENCY F 625 Continued from page 57 Review of a Facility Reported Incident (FRI), DC00010324, received by the State Agency on 10/19/21 documented,**Resident was scheduled to dialysis today 9/28/21 by 10am atDialysis Center At 9:10am, Resident was transported out of the facility via a wheelchair At 3:40pm, Dialysis Center MD (medical doctor) to be evaluated per stroke protocols* F 625 Collinement of the facility via a wheelchair At 3:40pm, Dialysis Center MD (medical doctor) to be evaluated per stroke protocols* Social worker /Designee will conduct a house wide audit for the beginning August 2022 of residents who are transferred or discharged to the hospital and monitored ongoing to ensure that resident #253's responsible party was his sister. An Admission Minimum Data Set (MDS) dated 07/31/21 showed facility staff coded: severely impaired cognition and received dialysis while a resident. The face sheet that documented that Resident #253's responsible party was his sister. Social worker /Designee will completed monthly for the past three (3) months, weekly times four and spoke to RN (registered nurse) she said resident will be admitted to further evaluate for a stroke. MD (medical doctor) was notified of resident admission at 8:15pm. RP (representative) was also called and notified of resident admission at 8:15pm. RP (representative)	UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC		w	ASHINGTON, DC 20001		
F 625 Continued from page 57 F 625 Review of a Facility Reported Incident (FRI), DC00010324, received by the State Agency on 10/19/21 documented, "Resident was schedule to dialysis today 9/28/21 by 10am atDialysis Center At 9:10am, Resident was transported out of the facility via a wheelchair At 3:40pm, Dialysis Nursecalled the unit that resident has been sent to [Hospital Name] ER (emergency room) by Dialysis Center MD (medical doctor) to be evaluated per stroke protocols* Social worker /Designee will conduct a house wide audit for the beginning Adgust 2022 of residents who are transferred or discharged to the hospital and monitored ongoing to ensure that resident and responsible parties are notified and provided with a copy of the bed hold policy that was attached to the transfer package when a resident was transfer out of the facility and to ensure they were updated in writing of the number of bed hold days remaining. This audit will be completed monthly for the past three (3) months, weekly times four and spoke to RN (registered nurse) she said resident will be admitted to further evaluate for a stroke. MD (medical doctor) was notified of resident admission at 8:15pm. RP (representative) was also called and notified of resident admission* F 625 Op/282/21 at 8:30 PM "Nurses NoteWriter called [Hospital Name] ER (emergency room) at 8:10pm and spoke to RN (registered nurse) she said resident will be admitted to further evaluate for a stroke. MD (medical doctor) was notified of resident admission* F 625 There is no documented evidence that facility staff provided Resident #253's RP with the bed A montistic Admission*	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	K	CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE		COMPLETION
 Review of a Facility Reported Incident (FRI), DC00010324, received by the State Agency on 10/19/21 documented, " Resident was scheduled to dialysis today 9/28/21 by 10am atDialysis Center At 9:10am, Resident was transported out of the facility via a wheelchair At 3:40pm, Dialysis Center MD (medical doctor) to be evaluated per stroke protocols* Review of Resident #253's medical record revealed the following: The face sheet that documented that Resident #253's responsible party was his sister. An Admission Minimum Data Set (MDS) dated 07/31/21 showed facility staff coded: severely impaired cognition and received dialysis while a resident. 09/28/21 at 8:30 PM "Nurses Note Writer called [Hospital Name] ER (emergency room) at 8:10pm and spoke to RN (registered nurse) she said resident admission at 8:15pm. RP (representative) was also called and notified of resident admission at 8:15pm. RP There is no documented evidence that facility staff provided Resident at 253's RP with the bed 								12/5/2022
 DC00010324, received by the State Agency on 10/19/21 documented, "Resident was scheduled to dialysis today 9/28/21 by 10am atDialysis Center At 9:10am, Resident was transported out of the facility via a wheelchair At 9:40pm, Dialysis NurseCalled the unit that resident has been sent to [Hospital Name] ER (emergency room) by Dialysis Center MD (medical doctor) to be evaluated per stroke protocols* Review of Resident #253's medical record revealed the following: The face sheet that documented that Resident #253's responsible party was his sister. An Admission Minimum Data Set (MDS) dated 07/31/21 showed facility staff coded: severely impaired cognition and received dialysis while a resident. 09/28/21 at 8:30 PM "Nurses NoteWriter called [Hospital Name] ER (emergency room) at 8:10pm and spoke to RN (registered nurse) she said resident admission* Oprecentative) was also called and notified of resident admission* There is no documented evidence that facility staff provided Resident #253's RP with the bed 	F 625	Continued from page	57	F 62	625			
 10/19/21 documented, "Resident was scheduled to dialysis today 9/28/21 by 10am astDialysis Codar 9/28/21 b		Review of a Facility R	Reported Incident (FRI),					
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There is no documented evidence that facility staff provided Resident #253's RP with the bed		resident admission at	8:15pm. RP					
There is no documented evidence that facility staff provided Resident #253's RP with the bed								
staff provided Resident #253's RP with the bed		resident's admission .	" 					
			-					
		hold policy.	TH #203 S KP WITH THE DEC					
During a face-to-face interview conducted on		During a face-to-face	interview conducted on					
09/22/22 at 2:36 PM, Employee #5 (Social Worker) acknowledged the finding and made no		09/22/22 at 2:36 PM,	Employee #5 (Social					

If continuation sheet Page 58 of 151

			()(0)		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		с
		095036	B. WING		09/26/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	09/20/2022
				01 FIRST STREET NW	
UNIQUE F	REHABILITATION AND H	EALTH CENTER LLC	v	VASHINGTON, DC 20001	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIA DEFICIENCY)	- 1
					12/5/202
F 625	Continued from page	58	F 625		<i>, -, -</i>
	further comments.				
	Cross Reference DC	MR 3270.1			
F 636		0	F 636		
SS=D	CFR(s): 483.20(b)(1))(2)(i)(iii)			
	§483.20 Resident As	sessment			
	-	duct initially and periodically			
	a comprehensive, ac				
		nent of each resident's			
	functional capacity.				
	§483.20(b) Compreh	ensive Assessments			
		nt Assessment Instrument.			
	A facility must make	a comprehensive			
		dent's needs, strengths,			
		preferences, using the			
		instrument (RAI) specified sment must include at least			
	the following:	sment must menude at least			
		demographic information			
	(ii) Customary routir	ne.			
	(iii) Cognitive pattern	1S.			
	(iv) Communication.				
	(v) Vision. (vi) Mood and behav	ior patterns			
	(vii) Psychological we	-			
		ning and structural problems.			
	(ix) Continence.				
		s and health conditions.			
	(xi) Dental and nutriti				
	(xii) Skin Conditions (xiii) Activity pursuit				
	(xiv) Medications.				
	(xv) Special treatmer	nts and procedures.			
	(xvi) Discharge plann				
	(xvii) Documentation	of summary information			
	regarding the additio	nal assessment performed			

Event ID: 93TP11

Facility ID: JBJ

If continuation sheet Page 59 of 151

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 APPROVED 0. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		JCTION		LETED
		095036	B. WING				C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	TREETAD	DRESS, CITY, STATE, ZIP CODE	00/1	20/2022
			9	01 FIRST	STREET NW		
UNIQUE R	EHABILITATION AND HE	ALIH CENTER LLC	v	ASHING	TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 626	Continued from no no	50	E 000				12/5/2022
F 636	Continued from page		F 636				
	the Minimum Data Se	gered by the completion of the completion of the completion of the completion of the complete th					
	(xviii) Documentation			1.	CORRECTIVE ACTION FOR T	ΉE	
		essment process must			AFFECTED RESIDENTS		
		tion and communication			Resident # 1 was discharged fr	om the	
	licensed and nonlicen				facility on 4/22/22. This cannot		
	members on all shifts.				corrected retroactively.		
		equired. Subject to the I in §413.343(b) of this		2.	IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFE		
	assessment of a resid timeframes specified i through (iii) of this sec prescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmission significant change in t mental condition. (For "readmission" means following a temporary or therapeutic leave.) (iii)Not less than once This REQUIREMENT by: Based on record revis one (1) of 63 sampled failed to complete Res	ttion. The timeframes 3(b) of this chapter do not days after admission, is in which there is no he resident's physical or purposes of this section, a return to the facility absence for hospitalization every 12 months. is not met as evidenced ew and staff interview, for residents, facility staff sident #1's Minimum Data ht within 14 days of the			All residents have the potential affected. MDS Nurse/Designee conduct a house wide audit to e that all current residents, new admissions and readmissions h complete Minimum Data Set (M assessment completed within 1 of the assessment reference da (ARD). Any negative findings w corrected upon discovery as appropriate.	will ensure ave a IDS) 4 days ate	
	The findings included:						
	-	itted to the facility on diagnoses that included: and Malignant Neoplasm of					

Facility ID: JBJ

If continuation sheet Page 60 of 151

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN			ICTION	(X3) DATE COMP	
		095036	B. WING					26/2022
	ROVIDER OR SUPPLIER	EALTH CENTER LLC		901	FIRSTS	DRESS, CITY, STATE, ZIP CODE STREET NW FON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 636	Continued From page	nued From page 60 F 636			12/5/2022			
	 Review of Resident #1's medical record revealed the following: A Quarterly MDS dated 03/16/22 showed facility staff coded: intact cognition; required supervision and set-up only for activities of daily living; and no functional limitation in range of motion. 03/31/22 at 5:24 PM "Social Service Note/Overnight stay spoke with resident and his nephew Resident is going to his nephew college graduation and will be celebrating with his family. Resident will be using 7 of his 18 days of calendar year overnight stay. Resident will be picked up by his family on Saturday, April 2nd and will be returning back to the nursing center on Saturday, April 9th accompanied by his nephew. Residents medications for the week has been ordered, and the nephew has received medication education. Social worker informed the resident and nephew that resident will have 11 days left of the 18 overnight stay. Social worker will continue to provide support and assistance as needed to resident and family during resident nursing home stay." 				3.	MEASURE TO PREVENT REOCURRENCE		
						Staff Educator/Designee will pro- education/in-service to the interdisciplinary team on the ac and timely development of MDS assessments to ensure that the comprehensive Minimum Data Set (MDS) assessment were co- within 14 days of the assessme reference date (ARD). Education completed by 12/5/2022. During clinical meeting, the MD will notify the IDT of scheduled assessments to ensure that assessments are completed with days of the assessment referent (ARD).	curate ompleted nt n will be S nurse MDS hin 14	
	LOA (leave of absence returner [return] 4/9/2 04/02/22 at 6:02 PM " alert and oriented whe at 6:00 pm with his net that 'He received more resident medication is pharmacy to be picke	Nurses NoteResident was en he left the facility for LOA ephewnephew told me edication education, s ordered to the nearest d up'. Resident will be back nedication given before he						

If continuation sheet Page 61 of 151

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
							. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		STRUCTION	(X3) DATE SURVEY COMPLETED	
		095036	B. WING _			C 09/26/2022	
NAME OF PR	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		
				901 FIF	RST STREET NW		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC		WASH	INGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 636	Continued from page	61	Fé	636			12/5/2022
	04/09/22 at 11:13 PM who had been on LO/ expected back today. made to the familyw [Medical Doctor] had workeris made awar 04/10/22 at 8:09 AM " had been on LOA was Several calls were ma any response. The do made aware of this [RP] and he stated that [Resident #1] to [Hosp profuse rectal bleedin hospital and on speak nurse confirmed that [admitted for low Hem and [Medical Doctor]] Review of the "Dischat MDS with an assess of 04/02/22 showed th (Assessment Adminis documented, " Sect H, I, J, K, M, N, O, P, The form was noted to signed on 09/11/2022 The evidence showed documented an ARD #1's "Discharge - Retu however, it was not co 09/11/22, five months During a face-to-face 09/22/22 at 12:20 PM	"Nurses NoteResident A with the family was Several calls had been <i>i</i> thout any response. been notified. The social re." Nurses NoteResident who s expected back yesterday. Ade to his relative without octor and social worker were another call was made to at they had to transfer bital Name] in Virginia for g. Call was made the king to his nurse there, the Resident #1] was being boglobin. The social worker had been notified" arge - Return Anticipated" hent reference date (ARD) hat in Section Z tration) facility staff ions A, B, C, D, E, G, GG, Qcompleted 9/11/2022". b have been electronically c. that facility staff of 04/02/22 on Resident um Anticipated" MDS ompleted and signed until later.			4. MONITORING CORRECTIVE A MDS Nurse/Designee will condu- audit to ensure that all new adm and readmissions have a compl Minimum Data Set (MDS) asses completed within 14 days of the assessment reference date (AR audit will be done for the past 3 months(August 2022 – October weekly times four (4), then mon times three (3). This will be repor- monthly to the Quality Assurance Performance Improvement team further recommendation. All neg- findings will be corrected upon discovery.	uct an hissions ete ssment D). This 2022), thly orted ce and n, for	

Facility ID: JBJ

If continuation sheet Page 62 of 151

TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
					С		
		095036	B. WING		09/26/2022		
NAME OF PI	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE			
UNIQUE R	REHABILITATION AND HI	EALTH CENTER LLC		FIRST STREET NW SHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS- COMPLETION		
E 020					12/5/202		
F 636			F 636				
		help us sometimes on the 've seen that an MDS was ed one on the 11th					
F 641 SS=E	,	ients	F 641				
	resident's status. This REQUIREMENT by: Based on record revi four (4) of 63 sampled failed to accurately co (MDS) for one reside one resident's bowel and one resident's fal Residents' #20, #102	at accurately reflect the is not met as evidenced iew and staff interview, for d residents, facility staff ode the Minimum Data Set nt's functional impairment, status, one resident's fall II and oxygen use. , #133, and #158.					
	The findings included 1. Facility staff failed #20's functional impa	to accurately code Resident					
	04/02/18 with multiple Muscle Weakness, H	mitted to the facility on e diagnoses that included: emiplegia and Hemiparesis, pe 2 Diabetes Mellitus.					
	Review of the resider the following:	nt's medical record revealed					
		ed 05/25/22 showed facility al impairment on one side for emities.					

Facility ID: JBJ

If continuation sheet Page 63 of 151

CENTER STATEMENT C	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	FORI OMB NC (X3) DATE COMF	D: 11/07/2022 M APPROVED D. 0938-0391 : SURVEY PLETED C
		095036	B. WING				/26/2022
	ROVIDER OR SUPPLIER	ALTH CENTER LLC		90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 FIRST STREET NW /ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE CF REFERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
F 641	optimal status and qui imposed by Hemipleg on 06/02/22. 07/15/22 at 3:15 PM [" Rt (right) sided we contracture" A Quarterly MDS date staff coded: no function for lower extremities. The evidence showed inaccurately coded Re any impairment to her During a face-to-face 09/20/22 at 1:23 PM, Coordinator) reviewed "OK." 2. Facility staff failed to #102's bowel status. Resident #102 was act 11/19/20 with diagnos Constipation and End (ESRD). Review of Resident # revealed: A Quarterly MDS date	elated to) right sided on 06/02/22. "[Resident #20] will maintain ality of life within limitations ia/Hemiparesis" reviewed [Physicians Progress Note] eakness. Right hand flexion ed 08/25/22 showed facility onal impairment in upper onal impairment on one side I that facility staff esident #20 as not having oupper extremities. interview conducted on Employee #9 (MDS d both MDS' and stated, o accurately code Resident dmitted to the facility on tes that included: Stage Renal Disease	F	641	 CORRECTIVE ACTION FOR AFFECTED RESIDENTS Resident #20 MDS assessm corrected for accuracy on 11 based on the documentation medical records. Resident so negative outcomes. Resident #102 MDS assessor corrected for accuracy on 11 based on the documentation medical records. Resident so negative outcomes. Resident #133 MDS assessor corrected for accuracy 11/17 based on the documentation medical records. Resident so negative outcomes. Resident #158 MDS was cor accuracy on 11/17/2022 bas documentation in the medica Resident suffered no negative outcomes. IDENTIFICATION OF OTHER THE POTENTIAL TO BE AN All resident MDS Assessment the potential to be affected. I Director/Designee will compl house wide audit on the mos quarterly and annual MDS assessments for the month of September 2022 to ensure a functional impairments, bowo bladder status, history of falls status on the use of oxygen. findings will be corrected upo discovery. 	ent was /17/2022 in the uffered no ment was /17/2022 in the uffered no ment was 7/2022. in the uffered no rrected for ed on the al records /e ERS WITH FFECTED nts have MDS lete a st recent of accuracy of el and s, and Any	12/5/2022

Facility ID: JBJ

If continuation sheet Page 64 of 151

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTR	(X3) DATE SURVEY COMPLETED		
		095036 B. WING					C / 26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREETAD	DDRESS, CITY, STATE, ZIP CODE		
	EHABILITATION AND HE	ALTH CENTER LLC		901 FIRST	STREET NW		
				WASHING	STON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRC REFERENCED TO THE APPROPRIATI DEFICIENCY)	SS-	(X5) COMPLETION DATE
E 0.14			_				12/5/2022
F 641	Continued from page		F	641			
	frequently incontinent Review of the Certifie	d Nurse Aide (CNA)		3.	MEASURE TO PREVENT REOCURRENCE		
	days) for the aforement facility staff document "continent" at all times that facility staff docur "continent" at all times The evidence showed	-			MDS Director/Designee will pr education/in-service to the interdisciplinary team on prope completion of the MDS assess ensure accuracy of functional impairments, bowel and bladd history of falls, and status on t oxygen. This will be completed 12/5/22.	er sment to er status, he use of	
	09/21/22 at 3:49 PM, Coordinator) reviewed not sure why it [MDS] incontinent" for bowel shows [Resident #102	the MDS and stated, "I am		4.	MONITORING CORRECTIVE MDS Director/Designee will con house wide audit on the most quarterly and annual MDS assessments for the month of September, and two comprehe assessments monthly for three months to ensure accuracy of impairments, bowel and bladd history of falls, and status on t	emplete a recent ensive e (3) functional er status,	
	MDS was accurately or resident's falls. Resident #133 was ac 10/01/21 with diagnos Hypertension, Muscle Status, Other Abnorm and Bradycardia.	dmitted to the facility on ses that included anemia, weakness, Altered Mental alities of Gait and Mobility, rly MDS) dated 03/02/22, id in section J (Health			oxygen. Findings will be repor monthly to the Quality Assurar Performance Improvement tea further recommendation. All no findings will be corrected upor discovery.	ted nce and nm for egative	

Facility ID: JBJ

If continuation sheet Page 65 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING .		COMF	PLETED	
		095036	B. WING			C 09/26/2022		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		_0,_0	
				2	901 FIRST STREET NW			
		CALIFI CENTER LLC		,	WASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued from page	65	F	641	1		12/5/2022	
	J1700 - Did the reside last month prior to adu facility staff coded "0" resident have a fall ar months prior to admiss staff coded "0", indica J1800- Has the reside admission/entry or rea assessmentwhiche staff coded "0", indica Review of a Facility R form to Department of 08/20/22, showed, " himself to the floor ea while transferring from Review of the care pla with a focus area of, " moderate risk for falls problems showed, 12 with no injury, and 08, unwitnessed fall with Review of the Annual revealed in section J of staff coded the followi J1800 - "Any Falls si Assessmentwherev coded as "1"	ent have a fall anytime in the mission/entry or reentry, , indicating no; Did the hy time in the last 2-6 asion/entry or reentry? facility ting no ent had any falls since entry or the prior wer is most recent? facility ting no. reported complaint/Incident f Health submitted on . Resident stated he lowered rly morning around 6 am h bed to chair" an revised on 08/22/2022 [Resident #133] is at r/t [related/to] Gait/Balance /21/21, alleged he had a fall /20/22, stated he had no injury." MDS dated 09/02/22, (Health Conditions) facility						

Facility ID: JBJ

If continuation sheet Page 66 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095036	B. WING		-		C /26/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
			9	001 FIRST STREET NW			
	EHABILITATION AND HE	EALTH CENTER LLC	· · ·	WASHINGTON, DC 2000	01		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRECTIVE AC REFERENCE	AN OF CORRECTION (EAC CTION SHOULD BE CROS D TO THE APPROPRIATE EFICIENCY)		(X5) COMPLETION DATE
F 641	Continued from page	66	F 641				12/5/2022
1 0 1 1		interview conducted on	F 041				
	09/21/22 at 12:35 PM						
		edged the finding and made					
	no further comments.						
	4. Facility staff failed t	to accurately code the MDS					
	-	58's fall and oxygen use.					
	-						
	Resident #158 was ac						
	on,06/30/20, with mul	ilepsy, Diabetes Mellitus,					
		lure, Chronic Obstructive					
	Pulmonary Disease a						
	Failure.						
	Review of Resident #	158's modical record					
	revealed the following						
		j.					
		cility Complaint/Incident					
		d to Department of Health					
		At around 1:30 PM during					
		8], was observed on the ckAccording to staff that					
	found her"	ckAccording to stall that					
		Complaint/Incident Report					
	form submitted to Dep						
		At 9:30 PM, [Resident #158] floor laying on her left side					
		Resident stated, I can't					
	remember how I got o						
	D · · · · · · · · · · · · · · · · · · ·	0					
		S dated 07/15/22 revealed					
	coded:	onditions) facility staff					
	J1700 - Did the reside	ent have a fall anytime in the					

If continuation sheet Page 67 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		095036	B. WING			C 09/26/2022		
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			01 FIRST STREET NW VASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 641 F 642 SS=D	facility staff coded "0" resident have a fall ar months prior to admiss staff left "blank", indic J1800- Has the reside admission/entry or ree assessmentwhiche staff did code "0", indi 4B. Physician's order "Oxygen at 2LPM [lite cannula every shift Review of Annual MD in Section O0100 (Sp Procedures, and Prog section was left blank The evidence showed accurately code Resid 06/02/22 and on 09/00 During a face-to-face 09/21/22 at 12:35 PM Coordinator) acknowl Resident #158's MDS comments. Coordination/Certifica CFR(s): 483.20(h)-(j)	mission/entry or reentry, , indicating no; Did the ny time in the last 2-6 ision/entry or reentry? facility ating no ent had any falls since entry or the prior over is most recent? facility icating no. dated 07/13/22 directed ers per minute] via Nasal S dated 07/15/22 revealed ecial treatments, grams), the oxygen therapy indicating "not on oxygen" d that facility staff failed to dent #158's MDS on 2/22 oxygen use. interview conducted on , Employee #8 (MDS edged both of the findings in i' and made no further ation of Assessment		641			12/5/2022	
	§483.20(h) Coordinat A registered nurse mu each assessment with participation of health	ust conduct or coordinate n the appropriate						
	§483.20(i) Certificatio	n.						

Facility ID: JBJ

If continuation sheet Page 68 of 151

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 11/07/2022 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED			
		095036	B. WING				C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREETAD	DRESS, CITY, STATE, ZIP CODE		-0/-0
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC			STREET NW TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 642	certify that the assess §483.20(i)(2) Each inc portion of the assess the accuracy of that p §483.20(j) Penalty for §483.20(j) 1 Under M individual who willfully (i) Certifies a material resident assessment in penalty of not more th assessment; or (ii) Causes another inc and false statement in subject to a civil mone \$5,000 for each asses §483.20(j)(2) Clinical of constitute a material a This REQUIREMENT by: Based on record revisione (1) of 63 sampled knowingly falsified Re	ered nurse must sign and ment is completed. dividual who completes a nent must sign and certify ortion of the assessment. Falsification. ledicare and Medicaid, an and knowingly- and false statement in a s subject to a civil money an \$1,000 for each dividual to certify a material a resident assessment is ey penalty or not more than assment. disagreement does not	F 64	2 1. 2.	`	THE om the be SWITH ECTED to be conduct arge gust-	12/5/2022
	Liver Cell Carcinoma Prostate.						

Facility ID: JBJ

If continuation sheet Page 69 of 151

	S FOR MEDICARE &						D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRU		COMI	E SURVEY PLETED
		095036	B. WING	C 09/26/2022			
NAME OF P	ROVIDER OR SUPPLIER	•		STREETAD	DRESS, CITY, STATE, ZIP CODE		
UNIQUE F	REHABILITATION AND HE	EALTH CENTER LLC			STREET NW TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE OF REFERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
F 642	staff coded: intact cog and set-up only for ac functional limitation in 03/31/22 at 5:24 PM ¹ Note/Overnight stay nephew Resident is college graduation an family. Resident will b calendar year overnig picked up by his famil and will be returning b Saturday, April 9th ac Residents medication ordered, and the nepl education. Social wor and nephew that resid the 18 overnight stay. to provide support an resident and family du stay." 04/02/22 [physician's LOA (leave of absence [return] 4/9/2022" 04/02/22 at 6:02 PM ¹ alert and oriented who at 6:00 pm with his ne that 'He received m resident medication is pharmacy to be picke by 4/9/2022. All due r left the facility well tol	ed 03/16/22 showed facility gnition; required supervision ctivities of daily living; and no a range of motion. 'Social Service . spoke with resident and his going to his nephew do will be celebrating with his be using 7 of his 18 days of ght stay. Resident will be ly on Saturday, April 2nd back to the nursing center on companied by his nephew. Is for the week has been hew has received medication ker informed the resident dent will have 11 days left of . Social worker will continue d assistance as needed to uring resident nursing home order] "Resident is out for by 4/2/2022 and will 'Nurses NoteResident was en he left the facility for LOA ephewnephew told me edication education, s ordered to the nearest of up'. Resident will be back nedication given before he erated"	F 64	3. 12 4.	MEASURE TO PREVENT REOCURRENCE MDS Director/Designee will education/in-service to the interdisciplinary team on pro completion of the MDS asse ensure accuracy of resident' status. This will be complete 12/5/22. MONITORING CORRECTIV MDS or Designee will condu wide audit on all discharge assessments for 3 months (/ October), 2 Comprehensive assessment weekly x 4 and Comprehensive Assessmen 3 Months. This will be reported monthly Quality Assurance and Perfor Improvement team for furthe recommendation. All negativ will be corrected upon discor	per ssment to s discharge d by E ACTION ct a House August- MDS 2 t Monthly X v to the ormance r e findings	

Facility ID: JBJ

If continuation sheet Page 70 of 151

	-	D HUMAN SERVICES					FORM	M APPROVED	
		MEDICAID SERVICES						D. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED C 09/26/2022		
		095036	B. WING						
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP	CODE			
					901 FIRST STREET NW				
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			WASHINGTON, DC 20001				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO CORRECTIVE ACTION SH REFERENCED TO THE DEFICIEN	OULD BE CROS		(X5) COMPLETION DATE	
								12/5/2022	
F 642	Continued from page		F	64	2				
	made to the family w								
	[Medical Doctor] had workeris made awa	been notified. The social re."							
	04/10/22 at 8:09 AM "	Nurses NoteResident who							
		s expected back yesterday.							
	Several calls were ma	ade to his relative without							
		octor and social worker were							
		another call was made to							
		at they had to transfer pital Name] in Virginia for							
	profuse rectal bleedin								
		king to his nurse there, the							
		[Resident #1] was being							
		oglobin. The social worker							
	and [Medical Doctor]	had been notified"							
		arge - Return Anticipated"							
		nent reference date (ARD)							
	of 04/02/22 showed th								
	(Assessment Adminis	ions A, B, C, D, E, G, GG,							
		Qcompleted 9/11/2022".							
		o have been electronically							
	signed on 09/11/2022	-							
		that Resident #1 left the							
		LOA and did not return.							
	However, review of th	-							
	Anticipated" MDS sho	/22 that they assessed							
		pleted Sections A through Z							
		MDS dated 04/02/22.							
	•	interview conducted on							
	09/22/22 at 12:20 PM								
		The MDS person who did s in to help us sometimes on							
		ust've seen that an MDS							

Facility ID: JBJ

If continuation sheet Page 71 of 151

	S FOR MEDICARE &				OMB NO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		095036	B. WING		С
	ROVIDER OR SUPPLIER	033030		STREET ADDRESS, CITY, STATE, ZIP CODI	09/26/2022
	NO NDER OR OOT LIER			901 FIRST STREET NW	-
UNIQUE R	REHABILITATION AND HE	EALTH CENTER LLC		WASHINGTON, DC 20001	
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION (EACH (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)	D BE CROSS- COMPLETION
					12/5/202
F 642	Continued from page	71	F 642	2	
	was missing and com [09/11/22]."	pleted one on the 11th			
F 656		Comprehensive Care Plan	F 656	6	
SS=D	CFR(s): 483.21(b)(1)	-			
	§483.21(b) Comprehe	ensive Care Plans			
		cility must develop and			
		nensive person-centered			
	care plan for each res	sident, consistent with the			
	-	th at §483.10(c)(2) and			
	§483.10(c)(3), that in				
	-	ames to meet a resident's I mental and psychosocial			
		ied in the comprehensive			
		nprehensive care plan must			
	describe the following				
	(i) The services that a	are to be furnished to attain			
		ent's highest practicable			
		psychosocial well-being as			
		24, §483.25 or §483.40; and			
		would otherwise be required			
		.25 or §483.40 but are not esident's exercise of rights			
	-	ding the right to refuse			
	treatment under §483				
	-	ervices or specialized			
		s the nursing facility will			
	provide as a result of				
		a facility disagrees with the			
	rationale in the reside	RR, it must indicate its			
		h the resident and the			
	resident's representa				
	(A) The resident's goa				
	desired outcomes.				
		eference and potential for			
	future discharge. Fac	ilities must document			
		s desire to return to the			

Facility ID: JBJ

If continuation sheet Page 72 of 151

	S FOR MEDICARE &					1	D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ISTRUCTION	(X3) DATE COME	SURVEY
			A. BUILDING	3			
		005026	B. WING				С
		095036	B. WING			09/	/26/2022
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HI	EALTH CENTER LLC					
				WASI	HINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
							12/5/202
F 656	Continued from page	72	F 65	56			
		ssed and any referrals to s and/or other appropriate			1. CORRECTIVE ACTION FOR AFFECTED RESIDENTS	THE	
	entities, for this purpo				Resident #64 was educated o	n the on	
		n the comprehensive care			the risk and benefits related to		
		in accordance with the			proper use of oxygen supplen		
	-	h in paragraph (c) of this			following the doctor's order. R oxygen tubing and nasal canr		
	section.	is not met as evidenced			marked with a date and time		
	by:	is not met as evidenced			discovery. Staff was educated		
		n, record review, resident			on the resident's oxygen supp	olement	
		or two (2) of 63 sampled			use during resident rounds to		
	residents, facility staf				that it is set-up properly accor		
		mprehensive person-centered care plan to	the resident's MD orders and care pla				
		's use of supplemental					
	oxygen; and impleme	nt one resident's care plan			Resident #64 comprehensive	care plan	
	intervention of having	a one to one (1:1)			was reviewed to ensure oxyge		
		he courtyard. Residents'			supplement us in accordance		
	#64, and #176.				orders and interventions are p		
	The findings included	:			implemented on 9/20/2022. R suffered no negative outcome		
	1 Eacility staff failed	to develop a comprohensive			Resident #176 is supervised a		3
	-	to develop a comprehensive plan to address Resident			while in the courtyard by the c		
	#64's use of supplem	-			monitor staff upon discovery.		
					#176 signed a social contract 10/27/22 to abide by the facili		
	Resident #64 was ad	mitted to the facility on			and conduct including alcohol		
		e diagnoses that included:			consumption. Resident #176		
		Second Degree, Anxiety			comprehensive care plan was		
	Disorder Unspecified	Fall, and Anemia.			and updated to reflect the app		
					care based on the resident's r These interventions are prope		
	•	n and interview conducted			implemented. Resident suffer		
		ximately 9:40 AM, Resident			negative outcomes		
		th his oxygen tubing and			-		
		on the bed, the tubing was					
		te and time and the oxygen					
		sident #64 stated, "I turn my d take off the nasal cannula					
	when I don't need it."	a take on the hasal callinula					

If continuation sheet Page 73 of 151

CENTER	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRU		FORM	D: 11/07/2022 M APPROVED D. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _			COMF	C
		095036	B. WING				/26/2022
NAME OF P	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE	<u>.</u>	
UNIQUE F	REHABILITATION AND HE	EALTH CENTER LLC	-		STREET NW TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	Review of the medica following: A Quarterly Minimum 06/24/22, showed tha following: intact cogni therapy was performe assessment. 03/18/22 [Physician's Medications" 05/18/22 [Physician's (Liters Per Minute) via needed for sob (Short The medical record la of a care plan that act of oxygen as needed During a face-to-face 09/22/22 at 1:00 PM, Nurse 2 south) ackno plan that addressed ru treatment and stated, shortness of breath." Cross Reference DCM 2. Facility staff failed t #176's care plan inter supervision while in th During an observatior approximately 4:30 PI #176 was observed y staff as he wheeled h station with two secur	I record revealed the Data Set (MDS) dated the facility staff coded the tion; and that oxygen ed during the last 14 days of Order] "Staff to Administer Order] "Oxygen at 2 LPM a NC (Nasal Cannula) as thess of Breath)" acked documented evidence ddressed Resident #64's use for shortness of breath. interview conducted on Employee #32 (Charge wledged there was no care esidents prescribed oxygen "He (Resident #64) has MR 3210.4 to implement Resident vention of having 1:1 he courtyard.	F 656	2.	IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFI All residents who require 1:1 supervision and residents who oxygen supplementation have potential to be affected by this of practice. House wide audit will completed by the Unit managers/Designee on resider 1:1 supervision and residents of oxygen supplements to ensure comprehensive care plans are and properly implemented. Any negative findings will be correct discovery. MEASURE TO PREVENT REOCURRENCE Staff Educator/Designee will ex- the Interdisciplinary team regar accurate completion of a comprehensive person-centered plan and proper implementation care plans on all residents with supervision and residents on of supplements. Education will be completed by 12/5/2022.	ECTED use the deficient be its with in that accurate ded upon	

If continuation sheet Page 74 of 151

CENTER	MENT OF HEALTH AN S FOR MEDICARE & I		(X2) MULTIP	PLE CONSTRUCTION	FORM	D: 11/07/2022 MAPPROVED D: 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		3	COMF	C
		095036	B. WING			26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC		901 FIRST STREET NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (E, CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
						12/5/2022
F 656	coming in from the co a bottle of alcohol in h drunken. I said to him that and he started ye got in the elevator. I c #1/Administrator]. The with me and we follow Resident #176 was ac 08/25/15 with diagnos Abuse with Intoxication Fibrillation. Review of Resident #' revealed the following 10/18/21 [physician's (supplement) HCI (Hy (milligrams) Give 1 tal day for Alcohol abuse Care plan focus area, behavior problem of d r/t (related to) life style showed, "can go to staff or family membe courtyard (initiated 06 A Quarterly Minimum 08/23/22 showed facill Interview for Mental S score of 15, meaning or verbal behavioral s others; independent w (ADLs); required supe the unit; and used a w	ed, "I saw [Resident #176] urtyard (smoking area) with is lap that was 75% already he's not allowed to have lling and cussing at me and alled [Employee e other security officer came red him up here." dmitted to the facility on ses that included: Alcohol n, Anemia and Atrial 176's medical record : order] "Thiamine drochloride) Tablet 100 MG olet by mouth one time a " "[Resident #176] has a rinking liquor in the facility e" revised on 08/19/22 [Local Store] with facility r1:1 supervision while in /08/22)" Data Set (MDS) dated ity staff coded: a Brief tatus (BIMS) summary intact cognition; no physical ymptoms directed towards <i>i</i> th activities of daily living ervision for locomotion off	F 65	4. MONITORING CORRECT ACTION House wide audit will be comp the Unit managers/Designee or residents with 1:1 supervision residents on oxygen suppleme ensure that comprehensive ca are accurate and properly impl Any negative findings will be co upon discovery. This will be co during the three (3) month per (August 2022- October 2022), times four (4), then monthly fo months. Results to be reviewe at QAPI meetings for further recommendations. All negative will be corrected upon discove	TIVE leted by n and nts to re plans emented. orrected mpleted od weekly three (3) d during e findings	

Facility ID: JBJ

If continuation sheet Page 75 of 151

					OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		с
		095036	B. WING		09/26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
				901 FIRST STREET NW	
UNIQUE R	EHABILITATION AND H	EALTH CENTER LLC		WASHINGTON, DC 20001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO CORRECTIVE ACTION SH REFERENCED TO THE DEFICIENC	OULD BE CROSS- APPROPRIATE DATE
					12/5/202
F 656	Continued from page	75	F 65	6	12/ 5/ 202
	evening shift 3:00 PM	1 - 11:00 PM showed that			
		scheduled for the courtyard,			
	Employee #16 and #	17, both Smoke Aides.			
	During a face-to-face	interview conducted on			
		l, when asked if she was			
	aware that Resident a				
	•	es when in the courtyard,			
	Employee #16 stated	, "No."			
	During a telephone in	terview conducted on			
		I, Employee #17 stated that			
	he also was not awar	e that Resident #176			
	required 1:1 supervis	ion while in the courtyard.			
	The evidence showe	d that facility staff failed to			
		lan intervention of providing			
		:1 supervision while in the			
	courtyard.				
	Cross Reference DC	MR 3210.4			
F 657			F 65	7	
SS=D	CFR(s): 483.21(b)(2)				
	§483.21(b) Compreh	ensive Care Plans			
	•	prehensive care plan must			
	be-	·			
		7 days after completion of			
	the comprehensive a				
	(II) Prepared by an In includes but is not lim	terdisciplinary team, that			
	(A) The attending phy				
		e with responsibility for the			
	resident.				
	(C) A nurse aide with	responsibility for the			
	resident.	1 1 1 1 1 1 1 1 1 1 1 1			
	(D) A member of food (E) To the extent prac	and nutrition services staff.			

Facility ID: JBJ

If continuation sheet Page 76 of 151

						1	0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTR G		(X3) DATE COMF	PLETED
			A. BUILDIN				с
		095036	B. WING				26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREETAI	DDRESS, CITY, STATE, ZIP CODE		
	EHABILITATION AND HI			901 FIRST	STREET NW		
				WASHING	GTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
							12/5/202
F 657	Continued from page		F 6	-		тис	
	An explanation must	resident's representative(s). be included in a resident's		1.	CORRECTIVE ACTION FOR AFFECTED RESIDENTS	INC	
		participation of the resident			Resident #20 comprehensive	care plan	
	not practicable for the	presentative is determined e development of the			on fall and skin care was revie		
	resident's care plan.				modified to ensure that it is an and interventions are properly		
		staff or professionals in			implemented on 9/20/2022. R	esident	
	disciplines as determ or as requested by th	ined by the resident's needs			head to toe assessment was		
		ised by the interdisciplinary			by the licensed nurse on 9/20 Resident suffered no negative		
	team after each asse	ssment, including both the			outcomes.		
	comprehensive and c assessments.	quarterly review					
		Γ is not met as evidenced		2.	IDENTIFICATION OF OTHER THE POTENTIAL TO BE AF	-	
		iew, resident and staff			All residents have the potentia	al to bo	
		of 63 sampled residents,			affected by this deficient prac		
		update Resident #20's fall			ADON/Designee will conduct	an audit	
		cus areas with new goals er he sustained a fall and			of five comprehensive care pl ensure that the fall history and		
		ed with a bruise on his right			reviewed and modified accura	ately and	
	cheek.	C C			timely. Any negative findings corrected upon discovery.	will be	
	The findings included	l:					
	Resident #20 was ad	mitted to the facility on					
	04/02/18 with multiple	e diagnoses that included:					
		lemiplegia and Hemiparesis, pe 2 Diabetes Mellitus.					
	Review of Resident # revealed the following						
	staff coded: unable to	•					
		Status (BIMS); required with one person physical					
		idependent with locomotion					
		onal impairment in upper					

If continuation sheet Page 77 of 151

					STRUCTION	1	0. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		STRUCTION	(X3) DATE COMF	PLETED
		095036	B. WING				C /26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE	03/	20/2022
					RST STREET NW		
UNIQUE I	EHABILITATION AND HE	EALTH CENTER LLC		WASH	IINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
F 657	Continued from page	77	F	657	3. MEASURE TO PREVENT REOCURRENCE		12/5/202
	extremities; functional lower extremities; who since admission/entry assessment. 09/12/22 at 9:20 PM " location of fall: Hallwa added to residents ca 09/12/22 at 9:50 PM " 9pm during the staff r Resident sitting on the chair" 09/13/22 at 4:54 PM " Assessment Request Tool situation- purp right chick bone of res face was observed wit the right chick (sp) bo painMD (medical d ray of facial bones an Care plan focus area that he fell 2 days ag injury noted" revised o observed sitting on There was no docume staff updated this care interventions after the Care plan focus area, alteration in skin integ	I impairment on one side for eelchair for mobility; no falls or reentry or the prior 'Post Fall HuddleSpecific ay Was a new intervention ire plan Yes" 'Nurses NoteResident at egular round saw the e floor beside his wheel 'Situation Background ' (SBAR) Communication ble discoloration noted at the sident's faceResident's ith a purple discoloration at one. Resident complained of octor) made aware and X d skull ordered" , "[Resident #20] reported to from the wheelchair, no on 09/12/22 showed, " the floor in the hallway." ented evidence that facility e plan with new goals and e fall on 09/12/22. , "[Resident #20] is at risk for grity" reviewed on . Observe skin condition			 Staff Educator/Designee will the Interdisciplinary team reg accurate completion of a comprehensive person center plan to ensure that the fall an areas are reviewed and modi accurately and timely. Educa completed by 12/5/2022. During the weekly risk manage meeting, the IDT will review a incidents and accidents and accidents and accidents and accidents. All find be corrected upon discovery. During the clinical meeting, a and accidents are reviewed a team and residents comprehensive care plan are updated accuratimely including fall and skin All findings will be corrected to discovery. MONITORING CORRECTIVE ADON/Designee will conduct of five comprehensive care pensure that the fall and skin a reviewed and modified accur timely. Any negative findings corrected upon discovery. The will be conducted weekly time then monthly times three to b reviewed during at Quality as and Assurance meetings for 	arding the red care d skin ified tion will be gement all ensure that e plan are y including dings will Il incidents by the IDT ensive ately and incidents. upon E ACTION can audit lans to areas are ately and will be is audit es four, resessment	

If continuation sheet Page 78 of 151

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _				LETED
		095036	B. WING				C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADI	DRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC			STREET NW TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued from page	78	F 657				12/5/2022
F 658 SS=D	09/19/22 at 3:43 PM, Unit Manager) review areas and made no fu Cross Reference DCM Services Provided Me CFR(s): 483.21(b)(3)(§483.21(b)(3) Compre The services provided as outlined by the com must- (i) Meet professional s This REQUIREMENT by: Based on observation interview, in one (1) o administration observation interview, in one (1) o administration observation standards of practice. The findings included: According to the "Lon Medication Pass", " unacceptable because accurately be compar Administration Record least two of the seven	MR 3210.4 eet Professional Standards i) ehensive Care Plans d or arranged by the facility, nprehensive care plan, standards of quality. is not met as evidenced n, record review and staff f four (4) medication vations, facility staff failed to us within the professional g-Term Care Nursing: pre-pouring medications is e the medications: cannot ed to the Medications d (MAR) and violates at rights of medication),	F 658		CORRECTIVE ACTION FOR T AFFECTED RESIDENTS Employee #11 was given a med pass training and competency to Employee #11 passed the comp test conducted by the staff educ 10/22/22. IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFE All resident in the facility have to potential to be affected. MEASURE TO PREVENT REOCURRENCE The Staff Educator/Designee w provide education /in-service to licensed nurses on medication administration. Education will be completed by 12/5/2022.	dication est. petency cator on S WITH ECTED he	
	https://ceufast.com/co	ourse/long-term-care-nursin					

If continuation sheet Page 79 of 151

		MEDICAID SERVICES	-		1	. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY LETED
ND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING		COMP	LETED
					С	
		095036	B. WING		09/2	26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				901 FIRST STREET NW		
	EHABILITATION AND HE	EALTH CENTER LLC		WASHINGTON, DC 20001		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(EACH	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CORRECTIVE ACTION SHOULD BE C REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
E 050			_			12/5/202
F 658	Continued from page	79	F 65	-		
	g-medication-pass			4. MONITORING CORRE ACTION	CTIVE	
		administration conducted on				
		on unit 4 South, the following		The Staff development/Desi		
		yee #11 (Licensed Practical		observe med pass on one n		
	<i>,</i>	resident's medications (6 in		per week for four weeks, on per month for 3 months to e		
	total) into a medicine			pass is done accurately per		
	pressure and was abo	ked the resident's blood		of practice. Results of the au		
	•	employee was stopped by		given to Quality Assurance		
	the State Surveyor.	e employee was slopped by		Performance Improvement (Committee	
	the State Surveyor.			for review and recommenda		
	At the time of the obs	ervation, Employee #11 was		negative findings will be con		
	asked if that's the star			discovery and additional on training if indicated.	the spot	
		ation. Employee #11 stated,		training ir indicated.		
		t's how it is done. I know the				
		ng to give. It seems a lot to				
		ges to the bedside. If the				
	resident refused a me	edication, I can just take it				
	out because I know w	hat the pills looks like."				
F 660	Discharge Planning P	Process	F 66	0		
SS=D						
	§483.21(c)(1) Discha	rge Planning Process The				
		and implement an effective				
		ocess that focuses on the				
		poals, the preparation of				
		partners and effectively				
		t-discharge care, and the				
	reduction of factors le	U				
	readmissions. The fac	cility's discharge planning				
	process must be cons	sistent with the discharge				
		.15(b) as applicable and-				
		charge needs of each				
	resident are identified					
	development of a disc	charge plan for each				
	resident.					
	(ii) Include regular re-	evaluation of residents to				

If continuation sheet Page 80 of 151

		MEDICAID SERVICES				1	. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRU		(X3) DATE COMP	SURVEY LETED
			A. BUILDING	G			~
		095036	B WING				C 26/2022
	ROVIDER OR SUPPLIER	033030			DRESS, CITY, STATE, ZIP CODE		
NAME OF FI	CONDER OR SOFFLIER				STREET NW		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			TON, DC 20001		
				WASHING	•	(5.4.0)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE CF REFERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
F 660	Continued from page	90	F.0/	~~			12/5/202
F 000	Continued from page		F 66	50			
		require modification of the lischarge plan must be					
		to reflect these changes.		1.	CORRECTIVE ACTION FO	RTHE	
		sciplinary team, as defined			AFFECTED RESIDENTS		
	by §483.21(b)(2)(ii), ii	n the ongoing process of					
	developing the discha	•			Resident #402 was discharg		
		er/support person availability			facility on 8/11/22. This cann retroactively be corrected.	101	
	and the resident's or						
		nd capability to perform t of the identification of					
	discharge needs.			2.	IDENTIFICATION OF OTHE THE POTENTIAL TO BE A	-	
	(v) Involve the resider	nt and resident			All residents who discharge	-	
	representative in the				the potential to be affected b		
	discharge plan and in				deficient practice. SW or des		
	resident representativ			will conduct a house wide au			
	(vi) Address the resid			discharges for the past three (August 2022 – October 202			
	•	treatment preferences. (vii) Document that a resident has been asked			current residents to ensure of		
	about their interest in				planning care plan and meet		
	regarding returning to				completed and the needs of		
	0	cates an interest in returning			residents are met for a succe discharge back to the comm		
		facility must document any			negative findings will the cor		
	referrals to local conta				upon discovery.		
	appropriate entities m						
	(B) Facilities must up						
		olan and discharge plan, as nse to information received					
		contact agencies or other					
	appropriate entities.						
		e community is determined					
		facility must document who					
	made the determinati						
		o are transferred to another					
	LTCH, assist resident	narged to a HHA, IRF, or					
		ecting a post-acute care					
		a that includes, but is not					
	limited to SNF, HHA,						

If continuation sheet Page 81 of 151

CENTER	MENT OF HEALTH AN S FOR MEDICARE & I DF DEFICIENCIES		(X2) MULTIPLE		FORM	0: 11/07/2022 1 APPROVED 0: 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMP	leted C
		095036	B. WING			26/2022
	ROVIDER OR SUPPLIER	ALTH CENTER LLC	9	TREET ADDRESS, CITY, STATE, ZIP CODE 01 FIRST STREET NW VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 660	the data is available. The post-acute care st assessment data, data data on resource use the resident's goals of preferences. (ix) Document, completed on the resident's need record, the evaluation needs and discharge evaluation must be dis resident's representat information must be in discharge plan to facil to avoid unnecessary discharge or transfer. This REQUIREMENT by: Based on record revision one (1) of 63 sampled failed to develop a dis Resident #402 that act discharge back to the The findings included: Resident #402 was act 10/14/21 with multiple Multiple Sclerosis, Dif Failure and Hypertens Review of a Complain the State Agency on 1	ata, data on quality n resource use to the extent The facility must ensure that a on quality measures, and is relevant and applicable to care and treatment ete on a timely basis based Is, and include in the clinical of the resident's discharge plan. The results of the scussed with the resident or ive. All relevant resident corporated into the itate its implementation and delays in the resident's is not met as evidenced ew and staff interview, for residents, facility staff charge care plan for Idressed her needs for community. dmitted to the facility on diagnoses that included: ficulty in Walking, Heart sion. t, DC00010481, received by 2/30/21 documented, " een trying to get discharged e since 09/24/21"	F 660		lucate ding the arge esses ack to the ll be o ensure urate dent. ted and to	

Facility ID: JBJ

If continuation sheet Page 82 of 151

		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/07/2022 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRU	JCTION	(X3) DATE COMF	SURVEY PLETED
		095036	B. WING					C 26/2022
	ROVIDER OR SUPPLIER	ALTH CENTER LLC	_	90 [.]	1 FIRST S	DRESS, CITY, STATE, ZIP CODE STREET NW TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 660	Section F (Care Plann An Admission Minimu 10/20/21 showed facil impaired cognition; re to total dependence wi for bed mobility, trans use and personal hyg discharged to the corr already occurring; refe not needed. 11/18/21 at 3:46 PM " Discharge meetingv (interdisciplinary team [Representatives] [F part of the meeting [Resident #402] has b Agency]social work them for exactly what given resident has a cardiovascular appoin neurology appointmer [2022], and the cardio discharge date was no social worker made th has to stay for 90 day aging and another gro building in the residen going out and coming	social Services on" showed, Section E ent/Planning) was left blank; ning) was left blank. m Data Set (MDS) dated lity staff coded: moderately quired extensive assistance th one-person physical assist fer, dressing, eating toilet iene; expected to be munity; discharge plan erral to the contact agency Care Plan Meeting Note vas done today The IDT b) present Resident #402] refused to be The family friend said that een given 20hrs by [Home cer said she will callto ask benefit resident has been	F	660	4.	MONITORING CORRECTIVE A SW or designee team will cond house wide audit of all discharg the past three months (August 2 October 2022) and ongoing to e discharge planning care plan ar meeting were completed and th of the residents are met for a successful discharge back to th community. Any negative findin the corrected upon discovery. T audit will be conducted weekly four (4), then monthly times the be reviewed during at QAPI me for further recommendations. A negative findings will be correct discovery.	ACTION uct a jes for 2022 – ensure nd ne needs gs will This times ee (3) to eetings II	
	Late Entry [Repres	sentative] wants the resident they were informed that it						

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 MAPPROVED D. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION		PLETED
		095036	B. WING				C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC			001 FIRST STREET NW		
				v	VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (E/ CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 660	Continued from page	83	E	660			12/5/2022
1 000		arged. They have to have a	F	000			
		e must have services in the					
	home [Representati						
		placed on her home so that					
	0	t the house Social Worker					
	to find out about the ra	f Columbia) Office of Aging amp"					
	01/14/22 at 10:17 AM	"Social Services					
		Review" showed, Section					
		nent/Planning) was left					
	blank; Section F (Care	e Planning) was left blank.					
		Social Work Progress Note					
	-	orker was called to the floor					
		anager for the resident in					
		tated that the Home Health de care for the resident is					
	• •	vill notify nursing when the					
		ide) services will be placed					
		lischarge planning meeting					
	will be scheduled."						
	06/07/22 at 12:56 PM	"Social Work Progress					
	Note IDT Meeting w	-					
		s status and discharge. IDT					
		nt and attorney. Her son					
		Resident is alert and					
		nce. She expressed a desire in the community. Resident					
		o the safe at home program					
		er home. Resident needs					
		at she can return home					
		ansition Specialist] DC					
		community Serviceshas					
	-	services. There is no date					
	been completed. The						
	•	June 13, 2022 at 1PM via					

Facility ID: JBJ

If continuation sheet Page 84 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION		ESURVEY PLETED C
		095036	B. WING				C /26/2022
NAME OF PI	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			901 FIRST STREET NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
F 660	conference call" 06/13/22 at 7:47 AM " Late EntryDischarge held on behalf of resid IDT Team met with re Community Transition phone. The discharge postponed to 6/27/20 repairs to the resident done by the Safe at H 15 hours of PCA Serv she needs 24 hours' of the Attending Physicia agency who has verb hours states they do r provide her services. another agency." 07/14/22 at 4:35 PM " Note [Home Care A resident's PCA hours Today, resident comp 07/15/22 at 7:30 AM " Late Entry Discharge conference call on be the services in place a Safe At Home has a necessary modification bed and wheelchair h Resident is suppose 7/21/2022" 08/11/22 at 11:33 AM Note Discharge Sumr discharged to home. S	Social Work Progress Note e Planning Meeting was dent to plan her discharge. sident and her brother. Specialistparticipated by e planning meeting was 22 at 1:30PM because t's home have not been lome program. Resident has rices; however, nursing feels care. Nursing will meet with an for her opinion. The ally accepted resident's PCA not have the nursing staff to RP may need to select 'Social Work Progress gency Name] has accepted (15) per 7 days a week. leted assessment" 'Social Work Progress Note ge IDT meeting was held via half of resident to discuss and to set a discharge date already completed the ons in the home. Hospital as already been delivered ed to be discharged on "Social Work Progress mary: Resident was She was escorted by her sident will received 15	F	660			12/5/2022

Facility ID: JBJ

If continuation sheet Page 85 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		· · ·	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED	
		095036	B. WING _				C 26/2022
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY			
UNIQUE F	REHABILITATION AND HE	EALTH CENTER LLC		901 FIRST STREET NW WASHINGTON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	CORRECTIV	S PLAN OF CORRECTION (EA /E ACTION SHOULD BE CROS NCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 660 F 684 SS=D	Nursing Services will (physical therapy) and services also medicativity will be monitored in the Transition Specialist, Community Services. follow resident in the Review of the compre- documented evidence a discharge care plan interventions to addred discharge needs. During a face-to-face 09/16/22 at 3:02 PM, Worker) stated, "For the Social Services A out, it would have aut plan in PCC (Point Cl social services are re discharge care plan." Cross Reference DCl Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Bas assessment of a reside that residents received accordance with profe- practice, the compre- care plan, and the residents received	be providedfor PT d OT (occupational therapy) tion management. Resident he community by Community DC Office on Aging and Case Worker will also community" whensive care plan lacked to that facility staff developed to with goals and tess Resident #402's interview conducted on Employee #5 (Social the area "Care Planning" of ssessment, if it was filled omatically generated a care ick Care). Regardless, sponsible to initiating the WR - 3270.2b Are indamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure to treatment and care in essional standards of inensive person-centered	F				12/5/2022

Facility ID: JBJ

If continuation sheet Page 86 of 151

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 A APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING				PLETED
		095036	B. WING				C 26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREETAD	DRESS, CITY, STATE, ZIP CODE		
	EHABILITATION AND HE	ALTH CENTER LLC		901 FIRST S	STREET NW		
				WASHING	TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	two (2) of 63 sampled failed to ensure: Resid psychiatric evaluation that Resident #253 wa pressure medications physician. Residents' The findings included Review of the "Medica Administration Record February 2022 showe of medication and treat assigned to the reside right medicationd evaluation. Licensed to medication and treat the physician orders . 1. Facility staff failed to #194 was provided a timely manner. Resident #194 was act 12/02/19 with diagnos of Cerebral Infarction, Depressive Disorder. Review of a Facility R DC00010299, received 10/02/21 documented the dining room area of jumped the linesh	ew and staff interview, for residents, facility staff dent #194 was provided a in a timely manner; and as administered his blood as ordered by the #194 and #253. ation/Treatment d and Initials" policy dated d, "Prior to administration atment, the licensed nurse ent must check am validate dosage assessment, nurses will administer nent to residents following " o ensure that Resident psychiatric evaluation in a dmitted to the facility on ses that included: Sequelae Aphasia and Major eported Incident (FRI), d by the State Agency on I, " [Resident #36] was in while waiting for banking ne (Resident #194) reacted	F 684	1. 1. 2.	CORRECTIVE ACTION FOR T AFFECTED RESIDENTS Resident #194 received her psychological evaluation. Psycl evaluation and medications rev completed on 9/29/22 and 10/2 Resident was determined to be appropriate with the current medications. Psychiatrist stated resident does not require any immediate changes in her psycl care. Resident #253 is discharged 10/14/2021. This cannot be retroactively be corrected. IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFI All residents who require a psychological evaluation and re on Midodrin Medication have th to be affected. Unit Managers/I will conduct a house wide audit the residents who require psycl evaluation and all residents on medication to ensure that resid provided psychiatric evaluation provided Midrodin as prescribe physician by 12/5/22. Any issue will be corrected upon discover	THE h riew was 25/22. d that the chiatric striction S WITH ECTED esidents ne ability Designee of all hological Midodrin ents are , and d by the es found	
	the dining room areajumped the linesh	while waiting for banking					

If continuation sheet Page 87 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRU		(X3) DATE COMP	SURVEY PLETED
		095036	B. WING					C 26/2022
NAME OF P	ROVIDER OR SUPPLIER					DRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC				STREET NW TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Review of Resident # revealed the following A Quarterly Minimum 08/17/21 where facilit cognitive impairment; behaviors directed tow walking in the corridoo locomotion off the uni motion; and used a w 10/01/21 at 3:45 PM " Assessment Request Tool Situation: Resid altercationAt around #194]while she was dining room for bankin male resident known 408B (Resident #36), she asked him to mov her Resident stated were present and imm Social services directed director asked resider time, and she stated y Resident spoke with t report." Care plan focus area involved in physical a resident on 10-01- 21 documented, " Psyc 10/04/21 at 4:37 PM " EntryPost incident I meetingmeeting foll main dining room area today 10-04-21 with th	194's medical record g: Data Set (MDS) dated y staff coded: severe no physical or verbal wards others; supervision for r; independent with t; no impairment in range of alker for mobility. Situation Background (SBAR)Communication dent to resident d 10:45 AM per [Resident is in the area of the main ng resident stated that a to be the resident in room came in front of her and ve he became aggressive to d that security and staffs nediately separated them. or called the policeservice nt does she feel safe at this ves, she feels safe he police and filed her , "[Resident #194] was litercation with another " initiated on 10/01/21 ch consult."	F	684	3.	MEASURE TO PREVENT REOCURRENCE Staff Educator/Designee will co service/education to all licensed staff and on following ensuring orders on Psych evaluations ar implemented in a timely manne service on the importance of a medication administration as or by the physician. Education will be completed by 12/5/2022. MONITORING CORRECTIVE Unit Managers/Designee will co house wide audit of all the resid who require psychological eval and residents on Midodrin med weekly times four then three tim monthly for three months. Resu be given to QAPI monthly for recommendations to ensure se and medications are provided t and accurately according to the physician's orders. All negative will be corrected upon discover	ACTION AC	12/5/2022

If continuation sheet Page 88 of 151

	-	ID HUMAN SERVICES				FOR	M APPROVED
		MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			COMF	SURVEY
		095036	B. WING				C /26/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				90 ⁻	1 FIRST STREET NW		
	EHABILITATION AND HE	EALIH CENTER LLC		W	ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
	Continued from page be followed up for me psychiatrist consult 10/04/21 [physician's 02/18/22 at 12:45 AM Note Psychiatric Net to evaluate mental sta for behavioral disturbation The evidence showed for Resident #194 to nevaluation on 10/04/2 02/18/22, four (4) more During a face-to-face 12:50 PM, Employee stated, "When there's evaluation order, the we let them know the ordered for a residen see what caused the getting seen." Cross Reference DCI	88 edication review and " order] "Psych consult" I "Physicians Progress ew EvaluationPatient seen atus and adjust medications ance" d that the physician's order receive a psychiatric 1 was not completed until nths later. interview on 09/15/22 at #10 (4th floor Unit Manager) a psych (psychiatric) psych doctors are called and re's a new evaluation t. I will have to check and delay in [Resident #194] MR - 3271.1d			REFERENCED TO THE APPROPRIATE		DATE
	06/07/21 with multiple	dmitted to the facility on e diagnoses that included: al Dialysis, Chronic Atrial tension.					
	-	teported Incident (FRI), ad by the State Agency on					

Facility ID: JBJ

If continuation sheet Page 89 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVI 0MB NO. 0938-03
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		X3) DATE SURVEY COMPLETED
		095036	B. WING			C 09/26/2022
	ROVIDER OR SUPPLIER	EALTH CENTER LLC		STREET ADDRESS, CITY, STAT 901 FIRST STREET NW		
				WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRECTIVE ACT REFERENCED	N OF CORRECTION (EAC FION SHOULD BE CROSS TO THE APPROPRIATE FICIENCY)	
F 684	atDialysis Center transported out of the At 3:40pm, Dialysis N resident has been ser (emergency room) by (medical doctor) to be protocols resident during dialysisright responds to command Review of Resident # revealed the following 07/25/21 [physician's Thursday and Saturds Disease" An Admission Minimu 07/31/21 showed faci impaired cognition an resident. Care plan focus area, medical diagnosis of 08/03/21 showed "v pressure) within acce by MD (medical docto ordered" 08/10/21 [physician's blood pressure) HCI ((milligrams), give 1 ta day every Mon (Mono (Friday), Sun (Sunday pressure), please hol	d, "Resident was today 9/28/21 by 10am . At 9:10am, Resident was efacility via a wheelchair lursecalled the unit that in to [Hospital Name] ER o Dialysis Center MD e evaluated per stroke had elevated HR (heart rate) t-sided mouth drop, and slow d outside of baseline" 253's medical record g: order] "Dialysis on Tuesday, ayfor End Stage Renal im Data Set (MDS) dated dility staff coded: severely id received dialysis while a , "[Resident #253] has Hypotension" reviewed on will maintain BP (blood ptable range as determined or) Give medications as	F 6	84		12/5/202

Facility ID: JBJ

If continuation sheet Page 90 of 151

		ID HUMAN SERVICES				FORM	M APPROVED
						1	0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COMF	PLETED
			A. BUILDI	ING _			<u> </u>
		095036	B. WING				C /26/2022
	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	09/	20/2022
NAME OF Pr	CONDER OR SUPPLIER				, , ,		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			901 FIRST STREET NW WASHINGTON, DC 20001		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EA	CH	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREF		CORRECTIVE ACTION SHOULD BE CROS	SS-	COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	i	REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
							/- /
F 004							12/5/2022
F 684	Continued from page	90	F	684	ł		
		ation Record (MAR) for					
	September 2021 show	-					
		ne 5 MG on the following					
	dates:						
	09/03/21 at 1:00 PM -						
	09/05/21 at 9:00 AM -						
	09/05/21 at 1:00 PM -						
	09/05/21 at 5:00 PM -						
	09/10/21 at 9:00 AM -						
	09/10/21 at 1:00 PM -						
	09/10/21 at 5:00 PM -						
	09/12/21 at 5:00 PM -						
	09/13/21 at 9:00 AM -	SBP 130/76 HR 80					
	09/13/21 at 1:00 PM -	SBP 127/68 HR 80					
	09/17/21 at 9:00 AM -	SBP 118/60 HR 76					
	09/17/21 at 1:00 PM -	SBP 126/70 HR 74					
	09/17/21 at 5:00 PM -	· SBP 119/79 HR 79					
	09/19/21 at 1:00 PM -						
	09/19/21 at 5:00 PM -						
	09/20/21 at 9:00 AM -						
	09/20/21 at 1:00 PM -						
	09/22/21 at 9:00 AM -						
	09/22/21 at 1:00 PM -						
	09/24/21 at 9:00 AM - 09/24/21 at 1:00 PM -						
	09/27/21 at 9:00 AM -						
	09/27/21 at 1:00 PM -						
	55/21/21 at 1.00 1 M -						
	The evidence showed	that facility staff					
		ne 5 MG to Resident #253					
		order directed to not do so					
	· ·	od pressure was over 110					
	and the heart rate was	-					
	-	interview conducted on					
		, Employee #19 (2nd Floor					
	Unit Manager) stated	that education is provided					

Facility ID: JBJ

If continuation sheet Page 91 of 151

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 095036 09/26/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW UNIQUE REHABILITATION AND HEALTH CENTER LLC WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CORRECTIVE ACTION SHOULD BE CROSS-PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 12/5/2022 F 684 Continued from page 91 F 684 to nurses about medications and following the parameters for administration. 1. CORRECTIVE ACTION FOR THE Cross Reference DCMR - 3211.1 AFFECTED RESIDENTS F 685 F 685 Treatment/Devices to Maintain Hearing/Vision Resident #53 was assessed head to SS=D CFR(s): 483.25(a)(1)(2) toe by licensed nurse on 9/27/22. Resident suffered no negative §483.25(a) Vision and hearing outcomes. Resident #53 saw an To ensure that residents receive proper treatment ophthalmologist on 10/13/2022. and assistive devices to maintain vision and Resident was prescribed with new hearing abilities, the facility must, if necessary, glasses and is ordered. assist the resident-**IDENTIFICATION OF OTHERS WITH** 2. §483.25(a)(1) In making appointments, and THE POTENTIAL TO BE AFFECTED §483.25(a)(2) By arranging for transportation to All residents who require glasses could and from the office of a practitioner specializing in be affected. Unit managers will conduct the treatment of vision or hearing impairment or a house wide audit for all residents to the office of a professional specializing in the ensure that residents receive proper provision of vision or hearing assistive devices. assistive device to maintain vision by This REQUIREMENT is not met as evidenced 12/5/2022. Any negative findings will be bv: corrected upon discovery. Based on observation, record review, resident and staff interview, for one (1) of 63 sampled residents, facility staff failed to ensure that one resident received the proper assistive device to maintain vision. Resident #53. The findings included: Resident #53 was admitted to the facility on 12/10/19 with multiple diagnoses that included: Unspecified Cataract, Hemiplegia and Hemiparesis Following Cerebral Infarction and History of Falling. During an observation and face-to-face interview conducted on 09/21/22 at approximately 11:30

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 92 of 151

	-	ND HUMAN SERVICES MEDICAID SERVICES					FORI	D: 11/07/202 M APPROVEI). 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN				(X3) DATE COMF	SURVEY PLETED
		095036	B. WING				C 09/26/2022	
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET	DRESS, CITY, STATE, ZIP CODE			
UNIQUE R	EHABILITATION AND HI	EALTH CENTER LLC	901 FIRST STREET NW WASHINGTON, DC 20001					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG			PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
F 685	Continued from page	92	F 6		3.	MEASURE TO PREVENT REOCURRENCE		12/5/202
r F f C C C C C C C C C C C C C C C C C C	AM, Resident #53 sta months ago and he n Review of the medica following:				Staff Educator/designee will pr service or education to ensure residents that residents receive assistive device to maintain the This will be completed by 12/5	that e proper eir vision.		
	 06/02/22 [Physician's Order] "Ophthalmology Consult Treat as needed" 06/16/22 [Ophthalmology Assessment] Documented that Resident #53 required glasses and instructs "Encourage full-time use for distance and reading" A Quarterly Minimum Data Set (MDS) dated 06/22/22, showed that the facility staff coded the following: In section B (Hearing, Speech, and Vision) "Adequate" was coded for ability to see in adequate light (with glasses or other visual appliances) and facility staff coded resident as not needed corrective lenses. In section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) summary score "15" indicating intact cognition. Review of the facility's grievance binder revealed 2 handwritten grievances dated 07/18/22 and 07/19/22, concerning Resident #53 not having eyeglasses to aid in his vision. A grievance dated 07/18/22, documented "Resident stated that he reported his eyeglasses were broken months ago to nursing staff. He has waited 3 months for a new pair" 				4.	MONITORING CORRECTIVE Unit Managers/Designee will of an audit of Unit managers will a house wide audit for all resid ensure that residents receive p assistive device to maintain vis the past 3 months, then four (4 weekly for one month then three monthly for three months. Reside the given to QAPI monthly for recommendations. All negatives with residents missing devices maintain their vision will be ref an ophthalmologist upon disco	onduct conduct ents to oroper sion for times et times ults will e findings to erred to	
	has impaired visual fu unspecified Cataracts	unction r/t (related to)						

If continuation sheet Page 93 of 151

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONS A. BUILDING	ISTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
		(AS) DATE SURVET
		COMPLETED
		С
095036 B. WING		-
	TADDRESS, CITY, STATE, ZIP CODE	09/26/2022
	RST STREET NW	
UNIQUE REHABILITATION AND HEALTH CENTER LLC	HINGTON, DC 20001	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAG	PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	. ,
F 685 Continued from page 93 F 685 07/21/22 had the following interventions "Arrange consultation with eye care practitioner as requiredMonitor /document /report PRN (as needed) any s/sx (signs and symptoms) of acute eye problemsSudden visual lossTell the resident where you are placing their items" During a face-to-face interview conducted on 09/21/22 at approximately 1:00 PM, Employee #42 (Charge Nurse) stated "He [Resident #53] lost his glasses, we will ask the social worker to help him get them replaced." F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer F 686 SS=G CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident and staff interviews, for one (1) of 63 sampled residents, facility staff failed to ensure residents received care consistent with the professional standards of practice, to prevent new ulcers. Residents "#204		12/5/2022

Facility ID: JBJ

If continuation sheet Page 94 of 151

	-	ID HUMAN SERVICES						MAPPROVED
		MEDICAID SERVICES						0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRU		(X3) DATE COMF	SURVEY
-			A. BUILDI	NG _				с
		095036	B. WING					26/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	STREETAD	DRESS, CITY, STATE, ZIP CODE	03/	
				9	01 FIRST	STREET NW		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC		v	NASHING	TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
								12/5/2022
F 686	Continued from page	94	F	686	5			
		ed in actual harm to Resident ant obtained facility acquired			1.	CORRECTIVE ACTION FOR T AFFECTED RESIDENTS	HE	
	The findings included	:				Resident #204 is discharged on This deficiency cannot be retroa corrected and resident cannot b reassessed.	actively	
	skin checks will be con nurse. This will be do Electronic Medical Re- routine care, the Cert observe the resident's are noted this will be licensed nurse" Review of the facility's Prevent/Heal Pressur showed, " The facili resident receives care professional standard pressure ulcers a re receive necessary tre promote healing, prevulcers from developin physician anytime the signs of non-healing of Review of the facility's Management" policy,	dated) showed, "Weekly inducted by the license cumented in the resident's ecord (EMR). Daily, during ified Nursing Assistant will a skin. When abnormalities communicated to the s "Treatment/Services to re" policy (not dated) ty will ensure that a e, consistent with ls of practice, to prevent esident with pressure ulcers atment and services to vent infection and prevent e g the nurse will notify the e pressure sore is showing or infection" s "Wound/Pressure Ulcer revised on 10/01/21 ation in skin integrity will be			2.	IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFE All resident has the potential to affected. House wide skin swee assessments were completed of 11/16/22 on all residents by lice nurses to identify any skin issue new findings from the skin swee	be p n nsed es. No	
	received care, consis	ensure Resident #204 tent with professional to prevent pressure ulcer						

If continuation sheet Page 95 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	APPROVED
					ONOTO		1	0. 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF				(X3) DATE COMP	
_			A. BUILDING	G				
		005000						С
		095036	B. WING				09/	26/2022
NAME OF PR	ROVIDER OR SUPPLIER			STR	REETAD	DRESS, CITY, STATE, ZIP CODE		
	EHABILITATION AND HE			901	FIRST	STREET NW		
				WA	SHING	TON, DC 20001		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID			PROVIDER'S PLAN OF CORRECTION (EA	СН	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX			CORRECTIVE ACTION SHOULD BE CROS	S-	COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG			REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
						,		
F 000	.				•			12/5/2022
F 686	Continued from page	95	F 68	86	3.	MEASURE TO PREVENT REOCURRENCE:		
	development found at	t advanced stages.				REOCORRENCE.		
						House wide skin sweep assess	ments	
		dmitted to the facility on				were completed on 11/16/22, for		
		e diagnoses that included:				residents by licensed nurses to		
		Alnutrition, Dementia,				any skin issues. No new finding	s from	
		, Muscle Weakness and				the skin sweep.		
	Osteoporosis.							
	Deview of a Complete							
		nt, DC00010905, received by				The licensed nurses will comple	ete a	
	the State Agency on (skin assessment upon admissio		
	and appropriate care	to provide the proper care				the wound nurse/designee will		
		#204] was neglected and				complete a thorough skin asses		
	-	bhysical injuries over an				within 24-48 post-admission an		
		h resulted in her current				validate all impaired areas were		
	hospitalization"	The sulled in her current				documented and treatments are		
						ordered and care plan is initiate	u.	
	Review of Resident #	204's medical record				Staff Educator/Designee will co	nduct in-	
	revealed the following					service/education to all licensed		
						staff and certified nursing assist		
	07/14/21 [physician's	order] "Monitor skin for easy				following MD orders regarding s	skin	
		g (B), Skin Discoloration				assessment, prevention of skin		
		shift and Alert MD with any				breakdown and communicating		
		Aspirin EC (enteric coated)				issues to the licensed nurse to the care plans and treatments a		
	daily"					place. Education will be comple		
	-					12/5/2022.	~,	
	08/26/21 [physician's	order] "Provide incontinent						
		inent episode. Wash peri						
	area with soap and w	ater, pat dry and apply						
	barrier cream every s	hift and as needed"						
		order] "Shower twice a						
	-	Wednesday and per patient						
	request" (Discontinu	ued on 04/20/22)						
	An Annual Minimum							
		t facility staff coded: A Brief						
		status (BIMS) summary						
	score of 7, indicating	severe cognitive						

If continuation sheet Page 96 of 151

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONS	TRUCTION	(X3) DATE	
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG		COMF	PLETED
							С
		095036	B. WING			09/	26/2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
JNIQUE F	REHABILITATION AND H	EALTH CENTER LLC			ST STREET NW NGTON, DC 20001		
				WAGHIN			0.(7)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIOI DATE
F 686	to -two people's physical assist for toi hygiene; frequently ir bowel; active diagnos weight loss; at risk fo pressure ulcers, wou Skin area #1- right fo 04/18/22 at 4:28 PM to touch and no new to require total care of living) cares. Turned pressure relief" 04/19/22 at 5:14 PM (Licensed Nurse) s lubricated. No wound 04/20/22 [Treatment (TAR)] facility staff do mark (meaning admini indicate that a showed 04/20/22 [physician's weekly on shower da shift every Thu (Thur 04/20/22 [physician's	total dependence with one sical assist for bed mobility, assistance with one-person let use and personal noontinent of urine and ses of Anemia; no significant or pressure ulcers; and no nds or other skin problems. not: "Nurses NoteSkin warm skin issues noted. Continued with all ADL (activities of daily and repositioned for "Skin Observation Tool skin is intact, warm and well " Administration Record boumented "yes", a check nistered), and initialed to er was completed. s order] "Skin Assessment by by license nurse every day sday)" s order] "Shower twice a	F	586	Staff Educator/Designee w service/education to all lice on their responsibility rega monitoring the nursing ass ensure showers are being skin assessment complete residents and turning, and properly implemented per orders. Completed by 12/5 Staff Educator/Designee w in-service/education to all nurse and certified nursing ensure that documentation shower sheets and skin as accurately reflect the resid condition. This will be com 12/5/2022 4. MONITORING CORRECT Unit Managers/Designee w weekly skin assessment o conduct a bath and showe weekly x 4, then monthly x that these are completed t accurately. All negative fin addressed upon discovery be brought to QAPI month recommendations and rev	ensed nurses arding sistants to given and ed timely for positioning is physician 5/22. vill conduct an licensed g assistants to n on bath and sessments lent's upleted by TIVE ACTION will conduct a ngoing and er sheet audit (3 to ensure imely and udings will be y. Findings will	
	 04/21/22 (Thursday) [Shower/Bath Sheet] "12 (skin intact/no irritation); complete bed bath" 						

If continuation sheet Page 97 of 151

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 M APPROVED D. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095036	B. WING				C /26/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC			01 FIRST STREET NW VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRC REFERENCED TO THE APPROPRIATI DEFICIENCY)	SS-	(X5) COMPLETION DATE
							12/5/2022
F 686	Continued from page	97	F	686			12, 3, 2022
	(interdisciplinary team	Social Services Note IDT) meeting was held No ges to report resident is					
	ADL self-care perform impaired balance and on 04/22/22 showed, with each incontinent with soap and water, cream every shift and requires assistance by bathing/showering rou	"[Resident #204] has an nance deficit r/t (related to) other conditions", reviewed "Provide incontinent care episode. Wash peri area pat dry and apply barrier as needed. The resident y staff with utinely and as necessary as assistance by staff for					
	"Apply moisture barrie incontinent care. Cala cream to buttocks and incontinent changes e every two hours and o PRN (as needed). Re breakdown."	continence r/t ved on 04/22/22 showed, er cream to skin after each zime (skin protectant paste) d perineal area with every shift. Incontinent check change when soiled and port any signs of skin					
	skin and Aspirin use" showed, "Keep skin c	nt to skin integrity r/t fragile					
	for pressure ulcer dev	"[Resident #204] is at risk elopment r/t immobility" showed, "administer					

Facility ID: JBJ

If continuation sheet Page 98 of 151

	-	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		E SURVEY PLETED
		095036	B. WING				C /26/2022
NAME OF PR	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
				ę	901 FIRST STREET NW		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC		١	WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
F 686	as ordered assess/ healing every shift declines to the MD." 04/23/22 [TAR] facility check mark, and initia shower was complete 04/23/22 (Saturday) ["complete bed bath nurse signature on the 04/26/22 at 11:29 AM (Licensed Nurse)N Review of the April 20 04/28/22, showed tha "N", meaning no or no directed, "Monitor skin skin discolorationev (medical doctor) with care behaviors; and the and repositioned ever 04/28/22 at 4:56 PM " seen bedside for thick wound right foot Sk hallux with noted same eschar (dead tissue) for purulence and deep po of right 5th toe with no and eschar to distal a vascular consult to ever Ulcer right 5th toe. Dr Ulcer right Hallux. Paid debridement of ulcer for	ed administer treatments /record/monitor wound report improvements and / staff documented "yes", a aled to indicate that a ed Shower/Bath Sheet] ". There was no licensed e form. "Skin Observation Tool o new skin issues noted" 222 TAR from 04/01/22 to at facility staff documented: one, in the area that n for easy bruising, bleeding, very shift and alert MD any changes; no refusal of hat the resident was turned ry two hours. "Podiatry Note Patient is k, elongated toenails and kin: Distal aspect of right guineous (sp) scab and to distal aspect, noted orobing sinus distal aspect oted dry sanguineous scab spect recommend valuate for healing potential. y eschar right 5th toe in right Hallux. Partial to patient tolerance. Noted	F	686			12/5/2022
	Ulcer right 5th toe. Dr Ulcer right Hallux. Pai debridement of ulcer to deep probing and pur	y eschar right 5th toe in right Hallux. Partial to patient tolerance. Noted					

Facility ID: JBJ

If continuation sheet Page 99 of 151

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 A APPROVED D. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		PLETED
		095036	B. WING				C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			01 FIRST STREET NW VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	obtain x-rays of right f of right hallux" 04/29/22 at 9:23 AM " heelLength: 2.45 cr acquired 4/29/22; [per 100.00; Status - new; Etiology- pressure ulc tissue injury)Dressi dressings- skin prep 04/29/22 at 1:55 PM " toe Length: 1.40 cm Acquired 4/28/22, [per Status - New; Acqui ArterialDressing ch a day), cleanse wound dressing- Betadine" 04/29/22 at 10:20 AM Assessment Request ToolSituation: skin a right heel. Date proble 04/29/2022 residen the bed side and then arterial area to the right to the right heel. Skin (representative) award 04/29/22 at 11:10 AM Resident had Podiatry 4/28/22 and a right gr	MP, ESR, CMP. Please foot to rule out osteomyelitis Tissue Analytics Right m; width: 2.67 cm; Wound rcent] epithelialization Acquired in house? Yes; eer - Suspected DTI (deep ng change frequency - daily, ." Tissue Analytics Right great n, width: 1.60 cm; Wound rcent] slough/eschar 100.00 red in House? Yes; Etiology ange frequency BID (twice d with- Normal Saline, "Situation Background (SBAR)Communication areas on right great toe red em or symptom started: th had podiatry foot care at was observed with a right ht great toe. Reddened area intact. MD and RP e. Treatment order in place." "Nurses Note Late Entry y foot care at the bedside on eat toe ulcer was observed e and Resident has skin is intact. Responsible are. No indication of pain. n a pillow."	F	686			12/5/2022
	04/29/22 at 2:18 PM "	Skin/Wound Note					

If continuation sheet Page 100 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SUR COMPLET	
		095036	B. WING				C /26/2022
NAME OF P	ROVIDER OR SUPPLIER	l			REET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE F	REHABILITATION AND HE	EALTH CENTER LLC			FIRST STREET NW SHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
F 686	Comprehensive skin a consult: right heel, rig - wound(s) presentF toe arterial ulcerPat 4/28/22. Per podiatry, consultation to evalua recommend x-ray of r osteomyelitis of right 04/29/22 at 2:21 PM ' Entry MD, R/P ma heel wound and right wound. Nursing staff 05/02/22 [physician's surgical site- Paint wi secure with bordered and evening shift for 05/02/22 [physician's Apply Skin prep and I day shift for wound he 05/09/22) The evidence showed documented dressing no physician's orders Furthermore, there wa that licensed staff per during those 4 days. 05/05/22 at 6:02 PM ' wound right foot Ba intact, deferred to wor right hallux with noted noted scant purulence last examdistal asp noted dry sanguineou	and wound evaluation for th great toe Dermatologic Right heel DTI. Right great tient seen by podiatry , recommend vascular ate healing potential, right foot to rule out hallux" "Skin/Wound Note Late ade aware of resident's right great toe (podiatry-caused) aware." order] "Right great toe th Betadine (antiseptic) and gauze twice daily every day wound healing" order] "Right heel DTI - eave open to air daily every ealing" (discontinued on d that the Tissue Analytics orders however, there was until 05/02/22, 4 days later. as no documented evidence formed dressing changes "Podiatry Notefollow-up andage to right heel left und care. Distal aspect, e however improved since bect of right 5th toe with	F 6	686			12/5/2022

Facility ID: JBJ

If continuation sheet Page 101 of 151

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 A APPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		LETED
		095036	B. WING				C 26/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				90	1 FIRST STREET NW		
				w	ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued from page	101	F	686			12/5/2022
		ered)Discussed with ern for deep infection"					
	05/05/22 [physician's evaluation for healing	order] "Consult for vascular potential"					
	05/07/22 at 10:23 PM NoteDate of Test: 5, foot, complete, 3+ vie evidence of osteomye	/6/2022. Type of Test: Right ws Findings No					
	mentioned above reverses staff documented to in interventions for Resident of the resident right great toe wound a right 5th toe wound 04/28/22. Facility staff	ight foot, the evidence ealed that although facility nplementing the dent #204 from 04/01/22 to t was first observed with a at 100 percent eschar and at 30 percent eschar on f failed to have a doctor's anges to the right foot for 4					
	Skin area #2- sacrum	:					
	(Licensed Nurse) S -pressure, length 3.79 0.0cm, stage -Suspec (right) great toe site - length-1.28cm, width- Stage-N/A. Resident sites and is followed b	ocm, width-4.58cm, depth, oted Deep Tissue Injury; R. type - arterial, 0.71cm, depth -0.0cm, has treatment orders for the					

Facility ID: JBJ

If continuation sheet Page 102 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI	LE CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
							с
		095036	B. WING			09/	26/2022
NAME OF PI	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIQUE R	EHABILITATION AND HE				901 FIRST STREET NW		
					WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
							12/5/2022
F 686	Continued from page	102	F	686	36		
		sponseSkin is warm to					
	touch, well moisturize						
		nue monitoring skin wound dressing intact on right heel					
		o drainage noted. Paint with					
		at great toe in this shift.					
		are with each incontinent					
		area with soap and water,					
		rier cream in the evening t for ADL care provided"					
	alert and verbally resp touch, well moisturize bleeding noted. Both prevent pressure ulce toe wound dressing in	'Nurses Note Resident is ponseSkin is warm to ed. No skin bruising, heels elevated with pillow to er. Right heel and right great htact, no drainage and and oral hygiene provided					
	06/30/22 [Shower/Bat intact/no irritation)"; "c was left blank; "comp	condition of skin" section					
	unchanged dry and w	'Nurses Noteskin remain varm to touchTurned and o hours Right heel and dressing intact"					
	section showed facilit	th Sheet] "condition of skin" y staff documented a line kin intact/no irritation and					
	warm to touch, well m bleeding noted. Conti on right foot. Wound o	"Nurses Note Skin is noisturized. No skin bruising, nue monitoring skin wound dressing intact on right heel Provide incontinent care with					

If continuation sheet Page 103 of 151

CENTER	S FOR MEDICARE &	D HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC	D: 11/07/2022 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		095036	B. WING				C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC			01 FIRST STREET NW /ASHINGTON, DC 20001		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EA	~н	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
E 696		400	_				12/5/2055
F 686	Continued from page		F	686			
		ode. Wash peri- area with ry and apply barrier cream					
		xtensive assist for ADL care					
	provided"						
	07/03/22 at 7:43 AM "	Nurses Note Turned and					
	repositioned every two	o hours. Both heels elevated					
		pressure ulcer. Right heel					
	and right great toe wo	und dressing intact"					
	07/03/22 at 3:35 PM "	Nurses Noteskin dry and					
	warm to touch Right						
	wound dressing is cha staff."	angedADL provided by					
	07/03/22 at 11:35 PM	"Nurses NoteSkin is warm					
	to touch, well moisturi						
		nue monitoring skin wound					
	0 0	d wound dressing on right eProvide incontinent care					
		episode. Wash peri- area					
		pat dry and apply barrier					
	÷	shift. The pressure ulcer is					
	a little wider in the res Dressing done"	ident's coccyx area.					
	Dressing done						
		ented evidence that further					
	actions such as furthe						
	a request for intervent	physician, or documenting tion was taken by the					
	licensed staff on 07/03	3					
	07/04/22 at 1.57 PM "	Nurses Note Skin is					
		noisturized. No skin bruising,					
	No skin bruising and	bleeding noted Right heel					
	and right great toe wo	und dressing intact"					
	Care plan focus area, potential for impairme	"[Resident #204] has nt to skin integrity r/t fragile					

Facility ID: JBJ

If continuation sheet Page 104 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		095036	B. WING				C 26/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00,	
				90	01 FIRST STREET NW		
UNIQUE F	EHABILITATION AND HE	EALTH CENTER LLC		W	VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	skin and Aspirin use" meeting held. Care pl Patient has an actual Although it was discus meeting, there was not further actions such a resident, notifying the a request for interven on 07/05/22 at 10:44 PM Tool Situation Press approx. 10cm*10cm*(symptom started 7/3/2 problem/symptom ha the same since it star of coccyx area got wid worseAssessment: need active pressure The above SBAR sho completing the form li the section "person co 07/05/22 at 11:09 PM monitoring skin wound area. Wound dressing right great toeThe p area is more wider an 10cm*10cm*0.2, drain changed. I notified to condition via SBAR Review of the July 20 07/05/22, showed tha "N", meaning no or no directed, "Monitor skin	showed, "07/04/22 IDT an reviewed and updated al wound/sacral DTI." ssed at the care plan o documented evidence that s further assessment of the physician, or documenting tion was taken by the IDT "SBARCommunication sure ulcer on coccyx, 0.2Date problem or 2022 Identify whether the s gotten worse/better/stayed ted- Worse Pressure ulcer der and In my opinion, residents ulcer treatment and care" wwed that the licensed nurse sted her own name under ontacted". "Nurses NoteContinue d on right foot and coccyx g intact on right heel and pressure ulcer of coccyx d worse. Approx. hage noted. Dressing Dr. (doctor) about resident's "	F 6	\$86			12/5/2022

Facility ID: JBJ

If continuation sheet Page 105 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) D.	ATE SURVEY DMPLETED
		095036	B. WING			09/26/2022
	ROVIDER OR SUPPLIER	EALTH CENTER LLC		STREET ADDRESS, CITY, STATE, Z 901 FIRST STREET NW WASHINGTON, DC 20001	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		THE APPROPRIATE	(X5) COMPLETION DATE
F 686	any changes"; no refucheck mark, and initia incontinent care was applied to peri area e resident was turned a hours, every shift. From 07/03/22 to 07// documented evidence physician or requeste Resident #204's sacra 07/06/22 at 3:30 PM ¹⁷ Tool Situation suspe Date problem/sympto Person contacted [medical doctor's nam 07/06/22 at 5:04 PM ¹⁷ (Licensed Nurse) S pressure, length- 9.00 depth-0.0cm, stage-s Resident has a new a suspected DTI. Thin. mattress. Treatment of Repositioning every 2 consult." 07/06/22 [physician's Cleanse with normal apply silver alginate of with borded (sp) gaug shift for skin care" (dia Care plan focus area, wound site DTI on the initiated on 07/06/22 s	usal of care behaviors; a als to indicate that provided with barrier cream very shift; and that the and repositioned every two 05/22 (3 days), there was no e facility staff notified the ed any intervention for al area. "SBARCommunication ected DTI on the sacral om started 07/06/2022 . son [RP] Provider visit ne]" "Skin Observation Tool Site: sacrum. Type- cm, width-12.0cm, suspected deep tissue injury. area to the sacrum Frail skin. Pressure relief order in place. 2 hours. Labs and Dietary order] "Sacral Wound: saline solution; pat dry, on wound bed and secure ge daily and PRN every day scontinued 07/08/22) , "[Resident #204] has a new e sacrum, fragile, thin skin" showed, "Monitor/document	F 6	86		12/5/2022

Facility ID: JBJ

If continuation sheet Page 106 of 151

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 A APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		LETED
		095036	B. WING				C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC			901 FIRST STREET NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	cm; depth 0.10 cm 7/6/22; [percent] sloug status - new; acquired For Resident #204's s evidence revealed that accurately assess, do skin on 07/03/22 and skin breakdown. Addi notify the physician fo wound was first docur subsequently, when s Practitioner on 07/07/7 measured 10.80 cm b with 30% eschar. During a face-to-face 3:25 PM, Employee # reviewed the shower/7 #204 and stated, "Wh Aide) is giving the res nurse is to go in to do assessment with the 0 documents what she s and nurse] sign the ba Skin" section should a documents the reside issues and anything n resident refuses the s	oms) of infection" "Tissue Analytics gth 10.80 cm; width 9.48 Date wound acquired gh/eschar 30.00; Wound d in house? Yes" acrum area, the above at facility staff failed to: cument on the resident's report signs of worsening tionally, facility staff failed to r 3 days after the sacrum mented as "more wider", een by the wound Nurse 22, the sacral area y 9.48 cm by 0.10 cm deep interview on 09/15/22 at 2 (Director of Nursing/DON) bath sheets for Resident en the CNA (Certified Nurse ident a shower or bath, the the head-to-toe skin CNA present. The nurse sees and they both [CNA ath sheet. The "Condition of always be completed. It nt's current wounds or skin ew that is noted. If the	F	686			12/5/2022
	PM, Employee #6 (Pc	terview on 09/15/22 at 4:34 odiatrist) stated, "I saw ril (2022) as part of regular					

Facility ID: JBJ

If continuation sheet Page 107 of 151

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 MAPPROVED D. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ECONSTRUCTION		PLETED
		095036	B. WING				C 26/2022
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC					
	0.0000000000000000000000000000000000000			V	WASHINGTON, DC 20001	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued from page	107	F	686			12/5/2022
	podiatry services at th			000	·		
		ry, stable, eschar wound on					
	-	dry, eschar area near the					
		to debride the area [right started coming out. The					
	nurse was in there wit	th me. I wrote the					
		os, x-ray, and ultrasound] in e in on May 5th (2022), I					
	•	e in on may stin (2022), i					
		em again and they were					
	09/16/22 at 9:32 AM, Educator/1 north Unit	interview conducted on Employee #7 (Staff Manager) reviewed the censed skin assessments					
	for Resident #204 for "Looking at the reside	April 2022 and stated, nt's feet is part of the skin					
		nt #204] started getting the bot treated after she was					
	seen by the podiatrist	. The staff [nurses and					
	CNAs] did not mention any skin issues on [Re	n to me that they observed esident #204's1 feet "					
	Employee #7 then rev						
	progress notes and the Resident #204 and st	e 07/05/22 SBAR for acted, "The staff documented					
		nents but there's no mention					
	of anything being on h	ner sacrum area until July					
		irst notices the change in o makes the doctor and					
	family aware. The nur						
	doctor immediately fo	r any changes and to					
		gress notes. This SBAR not done properly. Another					
		6th [07/06/22] where the					
	family and doctor were	e notified."					
	Cross Reference DCM	MR 3211.1					
					1		

Facility ID: JBJ

If continuation sheet Page 108 of 151

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 095036 09/26/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 901 FIRST STREET NW UNIQUE REHABILITATION AND HEALTH CENTER LLC WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL CORRECTIVE ACTION SHOULD BE CROSS-PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 12/5/2022 CORRECTIVE ACTION FOR THE 1. F 689 Continued from page 108 F 689 AFFECTED RESIDENTS F 689 Free of Accident Hazards/Supervision/Devices F 689 Resident #3 resident was admitted and SS=G CFR(s): 483.25(d)(1)(2) treated at the hospital on 11/3/21. The resident was stable and was discharged on §483.25(d) Accidents. 11/11/21 Resident returned to the facility on The facility must ensure that -11/11/21. Head to toe assessment was completed on 11/11/21. No new negative §483.25(d)(1) The resident environment remains findings were found. as free of accident hazards as is possible; and Employee #27 was in-serviced on facility §483.25(d)(2) Each resident receives adequate transportation policy to ensure that the resident is safe and secure in the transport supervision and assistance devices to prevent van prior to leaving. Employee is also accidents. encouraged that for any reason she cannot This REQUIREMENT is not met as evidenced validate the resident is secure, the bv: transportation driver is made aware and to escalate the situation to the DON/house Based on observations, record reviews, and staff supervisor or administrator if unable to verify interviews, for three (3) of 63 sampled residents, the resident's safety. facility staff failed to provide adequate supervision and assistance to residents to prevent accidents Resident #505 1:1 supervision is in place as and injury as evidenced by: 1. failure to secure indicated in the care plan. Head to toe Resident #3's wheelchair with the seatbelt in the assessment was completed on 9/28/2022, transportation van; 2. failure to assign a 1:1 Resident suffered no negative outcomes. monitor to Resident #505; and 3. failure to The staffing coordinator and charge nurse provide Resident #176 with 1:1 supervision while will ensure that 1:1 supervision is scheduled without any gaps. in the courtyard. (Residents' #3, #505 and #176) Resident #176 is supervised at all times These failures resulted in actual harm to Resident while in the courtyard by the courtyard monitor staff upon discovery. Resident #176 #3, example #1. signed a social contract on 10/27/22 to abide by the facility policies and conduct including The findings included: non-consumption of alcohol. Resident #176 comprehensive care plan was reviewed and 1. Facility staff failed to provide adequate updated to reflect the appropriate care based on the resident's needs. These supervision to Resident #3, who was not secured interventions are properly implemented. in the transportation van with a seatbelt and Resident suffered no negative outcomes subsequently sustained an injury when he flipped out of his wheelchair during transport to an **IDENTIFICATION OF OTHERS WITH THE** 2. appointment. POTENTIAL TO BE AFFECTED Review of the facility's policy entitled, "Resident All facility residents using transportation Transportation To and From Medical escorts or needing one on one supervision have the potential to be affected. Appointment" (revised 07/2022) documented,

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: JBJ

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL1	TIPLE	CONSTRUCTION	OMB NO	SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· ,			COMPLETED	
		095036	B. WING			09/	/26/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE F	REHABILITATION AND HE	EALTH CENTER LLC			01 FIRST STREET NW VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (E. CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
F 689	(Certified Nursing Aid ensure the resident is secure with the belt van." Resident #3 was re-a 10/04/21 with diagnos Osteomyelitis, Athero of Extremities with Int Leg, Hemiplegia, Spir Cervical Region and 0 Weakness. A Quarterly Minimum 10/29/21 documented severely impaired cog extremity impairment extensive assistance (electrical) wheelchai A facility reported inci received by the State PM documented, ". R morning at about 10:2 Vascular appointment wheelchair accompar a Medicaid transporta on 11/3/2021, the esc resident for the appoi stated, 'When we got ('s) wheelchair was se The car in front of us a left turn, the driver of stop to prevent hitting [Resident #3] fell from floor I then called the	ed Nursing Assistance e/CNA) or designee will a safe and well strapped and while in the transportation dmitted to the facility on ses that included: Acute sclerosis of Native Arteries termittent Claudication Right hal Instabilities of the Generalized Muscle Data Set (MDS) dated d that facility staff coded: gnition; upper and lower on one side; required for transfers; and using an r for mobility. dent (DC00010380) Agency on 11/04/21 at 5:20 esident left the facility this 20 AM, for a scheduled twith his electric hied by the facility escort with ation At about 11:36 AM cort who accompanied the ntment called the facility and into the van, the residents ecured by the van driver. made an illegal stop to make of our van made an abrupt of the car in front of us, and in his chair and landed on the the facility, and the facility t to be transferred to the	F	689	 ADON or designee will audit all retransportation log for appointments accidents log for the past six mont 2022 to October 2022), to ensure were no other residents who were affected by the deficient practice. Unit Managers or DON will conduct wide audit of all resident care plant one on one supervision to ensure properly implemented. All negative will be corrected upon discovery. MEASURE TO PREVENT REOCU Staff Educator/Designee will conduservice/education to transportation facility transportation policy to ensithe resident is safe and secure in the transport van prior to leaving and to escalate the situation to the DON/house supervisor or adminis unable to verify the resident's safe will be completed by 12/5/22. Staff Educator/Designee will educate stafe action of the care plan or supervision to ensure resident as a feducator/designee will educate stafe and secure in the completed by 12/5/22. 	s, and hs (May hat there adversely it a house s requiring that this is findings JRRENCE uct in- aides on ure that he ensure that eason s secure, de aware rator if ty. This ate the e proper 1:1 ety. Staff aff on the residents nonitored	t

If continuation sheet Page 110 of 151

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		STRUCTION		LETED
		095036	B. WING				C 26/2022
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREE	TADDRESS, CITY, STATE, ZIP CODE	00/	
				901 FIF	RST STREET NW		
	EHABILITATION AND HE	ALIH CENTER LLC		WASH	IINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	hospital Per ER (En CT (Computed Tomog contrast and a CT He were completed with the 'Comminuted fracture C1 and anterior and p Nondisplaced fracture C3'" A review of Resident a revealed: 11/03/21 at 5:02 PM, resident had a motor the way to a schedule [Local Hospital] and s Additional Comment facility this morning at scheduled vascular at AM on 11/3/2021, per of us made an illegal driver of our van mad hitting the car in front from his chair and lan immediately told the of so we can attend to [f " During a face-to-face 2:03 PM, Employee # assigned to Resident the resident's wheelcd secured the resident of Employee responded resident, but the drive Normally, I would hav	ent was transported to hergency Room) nurse, "a graphy), spine cervical w/o ad w/o (without) contrast the result showing: s of the right lateral mass of hosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior ring of C1. e of the right lateral mass of wosterior and stop to prevent of us and [Resident #3] fell ded on the floor. I eriver to pull over and stop Resident #3] which he did.' interview on 09/22/22 at 27 (CNA and escort #3) stated, "The driver put n using the lift, and I locked hair." When asked who	F 6		4. MONITORING CORRECT ACTION ADON or designee will audit all resident's transportation log for appointments, and accidents log past six months (May 2022 to Oc 2022), to ensure that there were other residents who were advers affected by the deficient practice Unit Managers or DON will cond house wide audit of all resident of plans requiring one on one supe to ensure that this is properly implemented. All negative finding be corrected upon discovery. Th be completed weekly for four we then monthly for three months. F will be brought to QAPI monthly meeting for further recommenda and review. All negative findings corrected upon discovery.	for the ctober no sely uct a care rvision gs will is will eks Findings tions	12/5/2022

Facility ID: JBJ

If continuation sheet Page 111 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION		SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED	
							С	
		095036	B. WING			09/26/202		
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			01 FIRST STREET NW VASHINGTON, DC 20001			
		ATEMENT OF DEFICIENCIES	10	V		011	()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
							12/5/2022	
F 689	Continued from page	111	F	689				
		driver was on his phone and						
		on. I tried to let him [the						
		resident was not secure as continued to ignore me. The						
	next thing I knew, the							
		own out of his wheelchair,						
		e me on the floor of the van.						
	driver then pulled ove	pp, my resident,' The van						
		ow what happened and to						
		eded to be transported to						
	the hospital."							
	Equility staff failed to	ensure that Resident #3 was						
		cure with a seatbelt prior to						
	the transport van beir	•						
		he van drive hit the brakes						
		nt was thrown out of his ined a fracture. These						
	failures resulted in ha							
	2. Facility staff failed t	to provide Resident #505						
	-	09/20/22, subsequently the						
	resident went missing	for 30 minutes in the						
	facility.							
	Resident #505 was a	dmitted to the facility on						
		ses that included: Other						
	Symptoms and Signs	Involving Cognitive						
	Awareness, Altered M	-						
		tive Disorder, Unspecified ioral Disturbance, and						
	Disorientation.	וסימו שוסנעושמווטס, מווע						
	Review of Resident #	505's medical record						
	revealed:							

If continuation sheet Page 112 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		DNSTRUCTION	(X3) DATE COMI	SURVEY PLETED			
		095036	B. WING			C 09/26/2022				
NAME OF P	ROVIDER OR SUPPLIER	1		STR	EET ADDRESS, CITY, STATE, ZIP CODE	, ZIP CODE				
UNIQUE F	REHABILITATION AND HE	EALTH CENTER LLC			FIRST STREET NW SHINGTON, DC 20001					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE			
F 689	documented that facil #505 with a Brief Inte (BIMS) summary sco severely impaired cog (Behaviors), facility st displaying behavior sy pushing, scratching, g screaming, and cursin wandering and intrud 09/02/22 [Physician's consult and treatmen 09/03/22 [Physician O Nursing Supervision f every shift" During a unit tour of 3 09/20/22 at 2:52 PM, Resident #505 was not the observation when #505 was Employee a that she thought the r group activity on the f A second observation approximately 2:53 P #505 was not in the a Employee #34 (Activi the resident was not i During a face-to-face 3:00 PM, when asked on 1:1 monitoring, En "Yes." The surveyor th that at approximately was not observed in h	Minimum Data Set (MDS)] lity staff coded Resident rview for Mental Status re of "07," indicating gnition. Under Section E taff coded the resident for ymptoms of hitting, kicking, grabbing, threatening, ng others, as well as ing on the privacy of others. • Order]: "Psychological t as needed." Order] "Resident on 1:1 for Elopement and Fall Risk 8 North conducted on the surveyor observed that ot in his room. At the time of a asked where Resident #33 (Unit Manager) stated esident was attending a first floor.	F 6	589			12/5/2022			

Facility ID: JBJ

If continuation sheet Page 113 of 151

	-	ID HUMAN SERVICES				FORI	M APPROVED
			()(0) MI II T				D. 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
		095036	B. WING				C /26/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				90	01 FIRST STREET NW		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC		W	VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (E. CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
F 689	this herself. At 3:15 PM on Unit 3 observed Employee # assignment board. E Employee #33 (Unit M assigned as the one t #505] today? " Emplo Employee #35 (Staffin and he told me there for residents on the un It should be noted at 3 Pink-Elopement Risk" #505 was located by 3 North dining room. During a second face 09/20/22 at 3:40 PM, that both Employee # and Employee #35 (St that Resident #505 has and should have calle question. Employee # staff failed to provide and supervision to Resident #176 while i Review of the facility's policy" with a revision	go to the unit to investigate North, the surveyor (2 (DON) checking the unit's mployee #2 then asked Aanager), "Who was o one monitor for [Resident yee #33 replied, "I asked ng Coordinator) about this, was no one to one coverage nit today." 3:20 PM, a "Code ' was initiated and Resident staff at 3:25 PM in the 3 -to-face interview on Employee #2 (DON) stated 33 (3rd Floor Unit Manager) Staffing Coordinator) knew ad orders for 1:1 monitoring, ed her if there was any 2 acknowledged that facility adequate 1:1 monitoring esident #505. to provide 1:1 supervision of n the courtyard. s policy titled "Smoking date of 10/01/21, nts will be supervised by	F	589			12/5/2022
		dmitted to the facility on ses that included: Alcohol on, Anemia and Atrial					

Facility ID: JBJ

If continuation sheet Page 114 of 151

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		LETED
		095036	B. WING				C 26/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				90	1 FIRST STREET NW		
				W	ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued from page Fibrillation.	114	F 6	89			12/5/2022
	Review of Resident # revealed the following						
	behavior problem of or r/t (related to) life style showed, "can go to family member1:1 s courtyard (initiated 06 A Quarterly Minimum 08/23/22 showed faci cognition; no physical symptoms directed to with activities of daily supervision for locom wheelchair for mobility The facility's visitor loo Resident #176 had a	b/08/22)" Data Set (MDS) dated lity staff coded: intact or verbal behavioral wards others; independent living (ADLs); required otion off the unit; and used a					
	#176 was observed y staff as he wheeled h station with two secur asked what was going (Security Officer) state coming in from the co a bottle of alcohol in h drunken. I said to him that and he started ye got in the elevator. I c	M on unit 4 South, Resident elling profanities at facility imself past the nurses' ity officers behind him. When g on, Employee #12 ed, "I saw [Resident #176] urtyard (smoking area) with his lap that was 75% already he's not allowed to have elling and cussing at me and alled [Employee e other security officer came					

If continuation sheet Page 115 of 151

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	G	С
		095036	B. WING		09/26/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE
UNIQUE R	EHABILITATION AND H	EALTH CENTER LLC		901 FIRST STREET NW WASHINGTON, DC 20001	
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION (EACH (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		OULD BE CROSS- COMPLETION APPROPRIATE DATE
F 000					12/5/202
F 689	Continued from page		F 68	89	
		aide schedule for 09/22/22 I - 11:00 PM showed that			
		scheduled for the courtyard,			
		#17, both Smoke Aides.			
	During a face-to-face	interview conducted on			
	•	1, when asked if she was			
	aware that Resident				
	supervision at all time Employee #16 stated	es when in the courtyard, I, "No."			
	During a telephone ir	nterview conducted on			
		1, Employee #17 stated that			
	he also was not awar	e that Resident #176 ion while in the courtyard.			
	required 1.1 Supervis	ion while in the courtyard.			
	-	interview conducted on			
		Employee #2 (Director of			
	•	administration and the IDT vork with Resident #176			
		g alcohol on the premises.			
		pervision, the employee			
E 005	stated, "We don't hav		E of		
F 695 SS=D	CFR(s): 483.25(i)	stomy Care and Suctioning	F 69	95	
	§ 483.25(i) Respirato				
	-	nd tracheal suctioning.			
		ure that a resident who e, including tracheostomy			
		ctioning, is provided such			
	care, consistent with	professional standards of			
		nensive person-centered			
	and 483.65 of this su	nts' goals and preferences, bpart.			
		Γ is not met as evidenced			
	by:				
	Based on observation	on, record review, and staff			

Facility ID: JBJ

If continuation sheet Page 116 of 151

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 095036 09/26/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW UNIQUE REHABILITATION AND HEALTH CENTER LLC WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL CORRECTIVE ACTION SHOULD BE CROSS-PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 12/5/2022 F 695 Continued from page 116 F 695 CORRECTIVE ACTION FOR THE 1 interview, for three (3) of 63 sampled residents, AFFECTED RESIDENTS facility staff failed to ensure that residents Resident #123 had no adverse outcomes received oxygen/respiratory care in accordance due to this deficient practice. Resident will with the physician order. Residents' #123, #132 be checked every 4 hours by the licensed and #185. nurse to ensure that trach mask is properly positioned over his trach and that the oxygen therapy level is set at the ordered level for administration. Resident #123 the tubings The findings included: were replaced and dated appropriately upon discovery. Resident was made aware of risk and Review of the policy entitled "Oxygen benefits related to not changing oxygen Concentrator Utilization" revised 10/01/21 settings on 9/19/2022, Head to toe documented, " ... Procedure and Implementation assessment performed by licensed nurse on ... Weekly change cannula and tubing as to 9/21/2022. Resident suffered no negative reduce the risk of respiratory infections and other outcomes. contamination ... " Resident #132 oxygen therapy was set at the ordered level for administration. Licensed nurse will check oxygen levels Q shift to 1. Facility staff failed to ensure Resident #123's ensure oxygen therapy is set at the ordered level for administration based on physician trach mask was positioned over his trach and that orders. the oxygen therapy level was set at the ordered Resident #132 was made aware of risk and level for administration. benefits related to not changing oxygen settings on 9/19/2022. Head to toe assessment performed by licensed nurse on Resident #123 was admitted to the facility on 9/21/2022. Resident suffered no negative 10/19/20 with diagnoses that included Acute findings. Respiratory Failure, Acute Respiratory Distress Syndrome, Tracheostomy and Cerebral Infarct. Resident #185 was discharged to the hospital on 10/2/22. This deficiency cannot be corrected retroactively. During an observation on 09/19/22, Resident #123's trach mask was observed placed away from the trach area, on the side of the resident's **IDENTIFICATION OF OTHERS WITH THE** 2. POTENTIAL TO BE AFFECTED neck. The humidified oxygen level was noted at 3.5L [Liters]. All residents on Oxygen and tracheostomy, have the ability to be affected. Review of the medical record revealed: A physician's order dated 10/19/20 that directed," O2 (oxygen) via tracheostomy mask at 4L(liters)/min (minute) continuously."

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 117 of 151

CENTER STATEMENT (-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	FORM OMB NC (X3) DATE	D: 11/07/2022 M APPROVED D: 0938-0391 SURVEY PLETED
			A. BUILDING			с
		095036	B. WING			26/2022
	ROVIDER OR SUPPLIER	ALTH CENTER LLC	9	TREET ADDRESS, CITY, STATE, ZIP CODE 01 FIRST STREET NW		
				VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRC REFERENCED TO THE APPROPRIATI DEFICIENCY)	SS-	(X5) COMPLETION DATE
						12/5/2022
F 695	O2 at 4L/min r/t (relat exchange." During a face-to-face time of the observation nurse] stated, "The re trach mask from the p When asked about th prescribed level, the e answer. There was no evidence	tion date of 08/01/22 me] is on oxygen therapy ed to) ineffective gas interview conducted at the n, Employee #45 [charge sident keeps moving the position of the trachea." e oxygen not being at the employee did not provide an ce that facility staff ensure ed the 4 liters of oxygen as	F 695	 Unit Managers/Designee will of house wide audit of all resider oxygen administration, respirat and trach mask. All negative fit will be completed upon discov 3. MEASURE TO PREVENT REOCURRENCE Staff Educator/Designee will of In-service for licensed nurses following Physician orders ens proper oxygen therapy admini proper respiratory care and tracplacement is in its proper plac according to the physician's on Education will be completed b 12/5/2022. 	ts on tory care ndings ery. onduct on sure that stration, uch mask e rders.	12, 5, 2022
	oxygen therapy was administration. Resident #132 was ad 10/19/20 with diagnos Unspecified Asthma, and Acute Respirator According to the Qua dated 08/29/22 the re cognitively intact, require with transferring, with hygiene, had no impa- to upper or lower extra	Chronic Respiratory Failure				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/07/2022 M APPROVED D. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		RUCTION	(X3) DATE COM	E SURVEY PLETED	
		095036	B. WING			C 09/26/2022		
	ROVIDER OR SUPPLIER	EALTH CENTER LLC		901 FIRST	DDRESS, CITY, STATE, ZIP CODE I STREET NW GTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE	
F 695	Continued from page	F 69	95 4.	MONITORING CORRECTIVE		12/5/2022		
	focus: "[Resident nan therapy at 2L/m [liters Respiratory illness" Review of the physici directed, "Continuous cannula every shift for During an observation PM, the resident's ox Liters. During a face-to-face time of the observation (Registered Nurse) st have changed it, I will 3. Facility staff failed per physician's orders "Oxygen Concentrator Resident #185.	n made on 09/13/22 at 2:00 ygen level was noted at 3 interview conducted at the on, Employee #45 tated, "The resident must I educate her." to provide respiratory care is and per the facility's or Utilization" policy for			Unit Managers/Designee will house wide audit of all resider oxygen and trach mask in the months(August 2022-October then weekly for four weeks ar times monthly for three month ensure that resident is admini with the correct oxygen level, respiratory care and trach ma in the appropriate position. Fin be brought to QAPI monthly for recommendations and review negative findings will be correct discovery.	nts on past 3 2022), ad three is. To stered proper sk placed ndings will or . All		
Resident #185 was lying in bed of humidified oxygen via nasal humidifier bottle and nasal can date of "09/11/22" and no initia nursing staff who changed the humidifier bottle.		via nasal cannula. The nasal cannula tubing had a d no initials of the last nged the tubing or						
	05/07/21 with diagnos	dmitted to the facility on ses that included: Acute and Failure, Diastolic Congestive						

If continuation sheet Page 119 of 151

	-	ID HUMAN SERVICES				FORI	M APPROVED
		MEDICAID SERVICES				1	D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY PLETED
			A. BUILDI	NG	B		
							С
		095036	B. WING	r		09/	/26/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			901 FIRST STREET NW		
					WASHINGTON, DC 20001		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (E		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		CORRECTIVE ACTION SHOULD BE CRC REFERENCED TO THE APPROPRIAT		COMPLETION DATE
170			IAO		DEFICIENCY)	-	
							12/5/2022
F 695	Continued from page	110	E	69	5		12/3/2022
1 000				09			
		ctive Sleep Apnea, and					
	Obesity.						
	Review of Resident #	185's medical record					
	revealed:						
	An Annual Minimum I	Data Set (MDS) dated					
		lity staff coded: intact					
	cognition. Under Sect	tion O (Special Treatments),					
	requiring oxygen ther	apywhile a resident within					
	the past 14 days.						
		order]: "Change humidifier					
	humidification."	ight shift every Friday for					
	numumcation.						
	06/15/22 [physician's	order]: "Change and replace					
		filter weekly every night shift					
	every Friday."	, , , ,					
		order]: "Change oxygen					
		ht shift every Friday for					
	infection prevention."						
	00/40/00 [above is is a la						
	tubing and humidifier	order]: "Date and initial					
	tubing and numiumer	bollie, as needed.					
	08/18/22 [physician's	order]: "Oxygen at 3 LPM					
		nasal cannula continuously					
	every shift for SOB (s						
		,					
	The Treatment Admir	istration Record (TAR) from					
		showed that facility staff					
		at Resident #185's nasal					
	-	numidification bottle were					
	changed.						
	Although foolity of the	do our on to d that the our ward					
		documented that they were					
	changing the hasal ca	annula tubing and humidifier					

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	= CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					С
		095036	B. WING		09/26/2022
NAME OF P	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE	00/20/2022
			901	FIRST STREET NW	
UNIQUE F	REHABILITATION AND H	EALTH CENTER LLC	WA	SHINGTON, DC 20001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (E. CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS- COMPLETION
					12/5/202
F 695	Continued from page	120	F 695		
		-			
F 700	4:55 PM, Employee # stated, "I spoke with t and left supplies. Eve supposed to change happened."		F 700		
F 726 SS=D			F 726		
	the appropriate comp provide nursing and r resident safety and a practicable physical, well-being of each re- resident assessments and considering the r diagnoses of the facil	e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care			
	licensed nurses have and skill sets necess needs, as identified th assessments, and de §483.35(a)(4) Providi	escribed in the plan of care.			
		evaluating, planning and nt care plans and responding			

Facility ID: JBJ

If continuation sheet Page 121 of 151

	-	D HUMAN SERVICES					FORM	M APPROVED	
		MEDICAID SERVICES						D. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN				COMF	E SURVEY PLETED	
		095036	B. WING				C 09/26/2022		
NAME OF PR	ROVIDER OR SUPPLIER			SI	FREET AD	DRESS, CITY, STATE, ZIP CODE	-		
				90	1 FIRST	STREET NW			
UNIQUE R	EHABILITATION AND HE	EALIH CENTER LLC		W	ASHING	GTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
								12/5/2022	
F 726	Continued from page	121	F 7	26					
	§483.35(c) Proficienc	y of nurse aides.							
		ire that nurse aides are able			1.	CORRECTIVE ACTION FOR T AFFECTED RESIDENTS	ΉE		
	techniques necessary	to care for residents'				Desident #004 is discharged an	_		
	needs, as identified th					Resident #204 is discharged or 7/23/22. This deficiency canno			
	-	scribed in the plan of care.				retroactively corrected and resi			
		is not met as evidenced				cannot be reassessed.			
	by: Based on record rovi	ow and staff interview for							
		ew and staff interview,for I residents, facility staff							
		censed nurses had the			2.	IDENTIFICATION OF OTHERS	S WITH		
	competency and skill				2.	THE POTENTIAL TO BE AFFI	-		
		d document. Resident							
	#204.					All resident has the potential to			
						affected. House wide skin swee			
	The findings included	:				assessments were completed of 11/16/22 on all residents by lice nurses to identify any skin issue	ensed		
	-	e in Condition/Notification of ible Party" policy revised on				new findings from the skin swe			
	immediately consul								
		responsible party/appointed							
		is a significant change in							
	•	l, mental, or psychosocial							
	status a need to alt	er treatment significantly							
	(that is, a need to disc	continue or change existing							
	form of treatment"								
	Review of the "Wound Management" policy,								
	•	ation in skin integrity will be							
	04/21/16 with multiple Mild Protein-Calorie N	dmitted to the facility on diagnoses that included: Malnutrition, Dementia, Muscle Weakness and							
	Osteoporosis.								

		MEDICAID SERVICES				OMB NO	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDIN	NG			
		005000					C
		095036	B. WING			09/	26/2022
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE F	REHABILITATION AND HE	EALTH CENTER LLC			01 FIRST STREET NW		
	-			W	VASHINGTON, DC 20001		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION (E		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
					3. MEASURE TO PREVENT		12/5/202
F 726	Continued from page	122	F 7	726	REOCURRENCE:		, 0, _0_
		nt, DC00010905, received by					
	the State Agency on (House wide skin sweep asses		
		to provide the proper care			were completed on 11/16/22, f residents by licensed nurses to		
	and appropriate care				any skin issues. No new findin		
	resident [Resident	#204] was neglected and			the skin sweep.	gonom	
		physical injuries over an				la (a. a.	
		h resulted in her current			The licensed nurses will comp skin assessment upon admiss		
	hospitalization"				the wound nurse/designee will		
					complete a thorough skin asse		
	Review of Resident #				within 24-48 post-admission a		
	revealed the following	g:			validate all impaired areas wer		
					documented and treatments a	-	
		Data Set (MDS) dated			ordered and care plan is initiat	ed.	
		at facility staff coded: severe				a a du at ia	
	÷ .	required total dependence			Staff Educator/Designee will construction to all license		
		ons' physical assist for bed tensive assistance with one-			staff and certified nursing assis		
	_	for toilet use and personal			following MD orders regarding		
		icontinent of urine and			assessment, prevention of skir		
		ses of Anemia; no significant			breakdown and communicating		
	-	r pressure ulcers; and no			issues to the licensed nurse to		
	-	nds or other skin problems.			the care plans and treatments		
					place. Education will be compl 12/5/2022.	eted by	
	04/28/22 at 4:56 PM	Podiatry Note Patient is					
		k, elongated toenails and					
		kin: Distal aspect of right					
	5	guineous (sp) scab and					
		to distal aspect, noted					
		probing sinus distal aspect					
		oted dry sanguineous scab					
	and eschar to distal a						
		aluate for healing potential.					
	Ulcer right 5th toe. Dr	y eschar right 5th toe					
	Ulcer right Hallux. Pa	in right Hallux. Partial					
		to patient tolerance. Noted					
	deep probing and pur	-					
		g antibiotics. Please obtain					
		blood count) with Diff					
	(differential), ESR (er	vthrocyte sedimentation					

Facility ID: JBJ

If continuation sheet Page 123 of 151

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 095036 09/26/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW UNIQUE REHABILITATION AND HEALTH CENTER LLC WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL CORRECTIVE ACTION SHOULD BE CROSS-PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Staff Educator/Designee will conduct in-12/5/2022 service/education to all licensed nurses F 726 Continued from page 123 F 726 on their responsibility regarding rate), CMP (complete metabolic panel). Please monitoring the nursing assistants to obtain x-rays of right foot to rule out osteomyelitis ensure showers are being given and of right hallux ... " skin assessment completed timely for residents and turning, and positioning is 04/29/22 at 1:55 PM "Tissue Analytics Right great properly implemented per physician orders. Completed by 12/5/22. toe ... Length: 1.40 cm, width: 1.60 cm; Wound Acquired 4/28/22, [percent] slough/eschar 100.00 Staff Educator/Designee will conduct an ...Status - New; Acquired in House? Yes; Etiology in-service/education to all licensed Arterial ... Dressing change frequency BID (twice nurse and certified nursing assistants to a day), cleanse wound with-Normal Saline, ensure that documentation on bath and dressing-Betadine ... " shower sheets and skin assessments accurately reflect the resident's 04/29/22 at 2:21 PM "Skin/Wound Note Late condition. This will be completed by Entry... MD, R/P... made aware of resident's right 12/5/2022 heel wound and right great toe (podiatry-caused) MONITORING CORRECTIVE ACTION 4 wound. Nursing staff aware." Unit Managers/Designee will conduct an audit of the bath and shower sheet 05/02/22 [physician's order] "Right great toe weekly x 4, then monthly x 3 and will surgical site- Paint with Betadine (antiseptic) and continue with the weekly skin secure with bordered gauze twice daily every day assessment to ensure that these are and evening shift for wound healing" completed timely and accurately. All negative findings will be addressed 05/02/22 [physician's order] "Right heel DTI upon discovery. Findings will be Apply Skin prep and leave open to air daily every brought to QAPI monthly for recommendations and review. day shift for wound healing" 06/08/22 at 10:04 PM "Laboratory Note Results. Date of test: 6/8/2022. Type of test ... CBC W/Diff ... Actions/New Orders: Waiting for doctor's review ..." 07/03/22 at 11:35 PM "Nurses Note ... Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Continue monitoring skin wound on right foot. Changed wound dressing on right heel and right great toe ... Provide incontinent care with each incontinent episode. Wash peri- area with soap and water, pat dry and apply barrier cream in the evening shift. The pressure ulcer is

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: JBJ

If continuation sheet Page 124 of 151

CENTER	S FOR MEDICARE &	D HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC	D: 11/07/2022 MAPPROVED D. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·				PLETED
		095036	B. WING				26/2022
NAME OF PR	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC			11 FIRST STREET NW ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued from page	124	F 7	26			12/5/2022
	a little wider in the res Dressing done"						
	skin and Aspirin use"	nt to skin integrity r/t fragile showed, "07/04/22 IDT an reviewed and updated					
	Tool Situation Press approx. 10cm*10cm*0 symptom started 7/3/2 problem/symptom has the same since it star of coccyx area got wid worseAssessment: I need active pressure Further review of this licensed nurse comple name listed under the instead of the RP or m	0.2Date problem or 2022 Identify whether the s gotten worse/better/stayed ted- Worse Pressure ulcer der and In my opinion, residents ulcer treatment and care" document showed that the eting the form was also the section "person contacted" nedical doctor's name.					
	Tool Situation susper Date problem/sympto Person contacted [medical doctor's name	son [RP] Provider visit e]"					
	cm; depth 0.10 cm	gth 10.80 cm; width 9.48 Date wound acquired gh/eschar 30.00; Wound					
	staff documented to in	ealed that although facility					

Facility ID: JBJ

If continuation sheet Page 125 of 151

		MEDICAID SERVICES	-		OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		095036	B. WING		C 09/26/2022
AME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
NIQUE R	EHABILITATION AND	HEALTH CENTER LLC		FIRST STREET NW SHINGTON, DC 20001	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIA DEFICIENCY)	OSS- COMPLETIC
F 700					12/5/202
F 726	Continued from pag		F 726		
		ent was first observed with a			
		d at 100 percent eschar and			
	-	d at 30 percent eschar on			
		aff failed to have a doctor's			
		hanges to the right foot for 4			
	manner.	btain ordered labs in a timely			
	For Resident #204's	s sacrum area, the above			
		hat facility staff failed to:			
		document on the resident's			
		d report signs of worsening			
	skin breakdown. Ad	ditionally, facility staff failed to			
	notify the physician	for 3 days after the sacrum			
	wound was first doo	cumented as "more wider",			
	subsequently, when	seen by the wound Nurse			
	Practitioner on 07/0	7/22, the sacral area			
	measured 10.80 cm	h by 9.48 cm by 0.10 cm deep			
	with 30% eschar.				
	During a face-to-fac	e interview conducted on			
		I, Employee #7 (Staff			
		nit Manager) reviewed the July			
		s and the 07/05/22 SBAR for			
		stated, " The staff			
		g skin assessments but			
		of anything being on her Jy 3rd [2022]. Whoever first			
		in the skin is the one who			
	-	nd family aware. The nurses			
		octor immediately for any			
	-	ument it in the progress			
		dated 07/05/22] was not done			
		ne was done on the 6th			
		e family and doctor were			
	notified."	-			
F 755	Pharmacy Srvcs/Pro	ocedures/Pharmacist/Records	F 755		
SS=E	CFR(s): 483.45(a)(b				

Facility ID: JBJ

If continuation sheet Page 126 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			(X3) DATE COMF	SURVEY PLETED
		095036	B. WING				C /26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREETAD	DRESS, CITY, STATE, ZIP CODE		
UNIQUE F	EHABILITATION AND HE	EALTH CENTER LLC			STREET NW		
				WASHING	TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
							12/5/2022
F 755	Continued from page	126	F 755	5			
	drugs and biologicals them under an agreer §483.70(g). The facil personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedurer pharmaceutical service that assure the accurat dispensing, and admin biologicals) to meet the §483.45(b) Service Cor- must employ or obtain pharmacist who- §483.45(b)(1) Provide aspects of the provision the facility. §483.45(b)(2) Establist receipt and disposition sufficient detail to ena- reconciliation; and §483.45(b)(3) Determo- order and that an accu- is maintained and per This REQUIREMENT by: Based on record revi	ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed er drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and he needs of each resident. onsultation. The facility in the services of a licensed es consultation on all on of pharmacy services in shes a system of records of n of all controlled drugs in able an accurate hines that drug records are in ount of all controlled drugs iodically reconciled. is not met as evidenced ew and staff interviews, for ursing units, the facility staff he receipt, usage,		1.	CORRECTIVE ACTION FOR AFFECTED RESIDENTS Narcotic count completed and narcotics were presented and accounted for on 9/12/2022. N residents had any negative fine related to this deficient practice Resident #188 narcotic medica properly administered on 9/14/ however the failure to docume narcotic log cannot be retroact corrected. Resident #188 was assessed head to toe by the lie nurse on 9/20/22. Resident su negative findings as a result of deficiency. IDENTIFICATION OF OTHER THE POTENTIAL TO BE AFF All residents receiving narcotic the potential to be affected. And designee will conduct house w of all narcotic counts and will a narcotic count matches the log negative issues will be corrected discovery.	all do dings e. ation was (22, nt in the ively censed ffered no f this S WITH ECTED is have DON or ride audit udit the ure the js. Any	

If continuation sheet Page 127 of 151

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938- STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED 095036 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			ID HUMAN SERVICES					APPROVED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMF	SURVEY PLETED
			095036	B. WING			09/	26/2022
UNIQUE REHABILITATION AND HEALTH CENTER LLC 901 FIRST STREET NW WASHINGTON, DC 20001			EALTH CENTER LLC		901 FIRST	STREET NW		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CORRECTIVE ACTION SHOULD BE CROSS-	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE	SS-	(X5) COMPLETION DATE
F 755 Continued from page 127 The findings included: Review of the "Receiving Controlled Substances" policy revised August 2020 showed, "The following information is completedupon receipt of the controlled substance, name of resident drug name, strength and dosage, date received, quarity received, name of person receiving medication Staff Educator/Designee will conduct Inservice for licensed nurses on the policy to ensure accurate nancotic counting the standards of practice. Education will be completed by 12/5/2022. Review of the "Controlled Substances" policy revised August 2020 showed, " Accurate inventory of all controlled Gubstances" administering the medication is maintained t all times. When a controlled substance is administering the medication nimediately enters the following information on the accountability record date and time of administering the dose" MONITORING CORRECTIVE ACTION 1. A review of the Shift Count Narcotic records on Unit 3 North was completed on September 12, 2022, at approximately 9:10 Au, and it showed the following attrix is mane nurse signed coming on and going off duty 8/14/2022 11-7 shift same nurse signed coming on and going off duty 8/14/2022 11-7 shift same nurse signed coming on and going off duty 8/14/2022 11-7 shift same nurse signed coming on and going off duty 8/20/2022 11-7 shift same nurse signed coming on and going off duty 8/20/2022 11-7 shift same nurse signed coming on and going off duty 8/20/2022 11-7 shift same nurse signed coming on and going off duty 8/21/2022 7-3 shift on nurse signed coming on and going off duty 8/21/2022 7-3 shift on nurse signed coming on and going off duty 8/21/2022 7-3 shift on nurse signed coming on and going off duty 8/21/2022 7-3 shift on nurse signed coming on and going off duty 8/21/2022 7-3 shift on nurse signed comin	F 755	The findings included Review of the "Receive policy revised August following information is of the controlled subs drug name, strength a quantity received, nar medication Review of the "Contro revised August 2020 s inventory of all contro maintained t all times substance is administer immediately enters th the accountability rece administration; amour quantity, signature of administering the dos 1. A review of the Shif Unit 3 North was com 2022, at approximate the following activity in record for the followin 8/4/2022 11-7 shift s on and going off duty 8/16/2022 7-3 shift on and going off duty 8/20/2022 11-7 shift on and going off duty	 ving Controlled Substances" 2020 showed, " The is completed upon receipt stance: name of resident and dosage, date received, me of person receiving bled Substances" policy showed, " Accurate illed medications is . When a controlled tered, the licensed nursing ing the medication the following information on ord date and time of nt administered, remaining the nursing personnel ise" ft Count Narcotic records on upleted on September 12, ly 9:10 AM, and it showed in the Narcotic reconciliation ag dates: same nurse signed coming duty same nurse signed coming same nurse signed coming 	F 75	3.	REOCURRENCE Staff Educator/Designee will or In-service for licensed nurses of policy to ensure accurate narch counts are reconciled per the s of practice. Education will be of by 12/5/2022. During shift change, the outgoid will complete a narcotic count/reconciliation with the intern nurse and both nurses will sign narcotic count log book validat the narcotic count is accurate. MONITORING CORRECTIVE ADON or designee will conduct wide audit of all narcotic count audit the narcotic count log boo ensure the narcotic count match logs weekly for four (4) weeks monthly times three (3), to ens facility staff reconcile controlled medications per the standards practice findings will be brough QAPI monthly for recommenda and review. All negative finding	on the otic standards ompleted ng nurse coming n the ing that ACTION t house s and will ok to shes the and ure d of at to ations	

Facility ID: JBJ

If continuation sheet Page 128 of 151

		MEDICAID SERVICES			OMB NO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		095036	B. WING		C 09/26/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
UNIQUE R	EHABILITATION AND H	EALTH CENTER LLC		901 FIRST STREET NW			
	-			WASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF CORRECTIVE ACTION SHO REFERENCED TO THE A DEFICIENC	DULD BE CROSS- COMPLETION APPROPRIATE DATE		
					12/5/202		
F 755			F 75	5			
		same nurse signed coming					
	on and going off duty						
	on and going off duty	same nurse signed coming					
		one nurse signed coming on					
	and going off duty wa						
		count and nurse coming on					
	duty left blank and or duty	ne nurse signed going off					
	•	ame nurse signed coming on					
	and going off duty	5 5					
		me nurse signed coming on					
	and going off	no purpo signed coming on					
	and going off	me nurse signed coming on					
		same nurse signed coming					
	2. A review of the Sh	ift Count Narcotic records on					
		npleted on September 12,					
		ely 9:30 AM, and it showed in the Narcotic reconciliation					
	record for the following						
	8/2/2022 3-11 shift on and going off duty	same nurse signed coming					
		same nurse signed coming					
		arse coming on duty left					
		signed going off duty					
	duty and going off du	e nurse signed coming on ity was left blank					
		ft same nurse signed					
	coming on duty and g	-					
	on duty and going off						
		same nurse signed coming					
	on duty and going off	fduty					
	8/18/202211-7 shift	same nurse signed coming					

Facility ID: JBJ

If continuation sheet Page 129 of 151

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE	. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMP	LETED
		095036	B. WING			C 26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
UNIQUE R	EHABILITATION AND H	EALTH CENTER LLC		901 FIRST STREET NW		
				WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR CORRECTIVE ACTION SHO REFERENCED TO THE A DEFICIENCY	ULD BE CROSS- PPROPRIATE	(X5) COMPLETION DATE
		100		_		12/5/202
F 755	Continued from page		F 75	5		
	on and going off duty	same nurse signed coming				
	on and going off duty	v				
	8/19/2022 3-11 shift	same nurse signed coming				
	on and going off duty					
	on and going off duty	same nurse signed coming				
		same nurse signed coming				
	on and going off duty					
	8/22/2022 3-11 shift of duty and going off du	one nurse signed coming on				
		same nurse signed coming				
	on and going off duty					
		same nurse signed coming				
	on and going off duty 8/25/2022 11-7 shift (coming on duty was left				
	blank and one nurse					
		ne nurse signed coming on				
	duty and going off du					
	on duty and going off	same nurse signed coming				
		one nurse signed coming on				
	duty and going off du					
	on duty and going off	same nurse signed coming				
		same nurse signed coming				
	on and going off duty					
		same nurse signed coming				
	on and going off duty 9/5/2022 3-11 shift sa	ame nurse signed coming on				
	and going off duty					
	The review of the abo	ove-mentioned dates				
	showed that the Shift	Count Narcotic on the Unit				
		uth was missing the two (2)				
	nurse's signatures (in the space allotted for	dicating it was not done) in				
	-	another nurse to sign going				
		on/ going off spaces allotted				

Facility ID: JBJ

If continuation sheet Page 130 of 151

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 11/07/2022 A APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		LETED
		095036	B. WING			C 26/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC	-	01 FIRST STREET NW		
				ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 755	Continued from page	130	F 755			12/5/2022
		natures were left blank [no	1 700			
	Narcotic Count Policy Controlled Drug Count directed, "Shift count must be verified by the nurse going off duty a The evidence showed failed to adhere to an practice to reconcile t substances on the afor shifts. A face-to-face intervie Employees #2 (Direct (Assistant Director of 2022, at approximate acknowledged the find 3. Facility staff failed to	d Drug Record to the Actual states, "Reconciliation at Verification Form" sheet for Narcotics balance e nurse coming on duty and t each change of shift". If that licensed nursing staff acceptable standard of he verification of controlled orementioned dates and we was conducted with for of Nursing) and #3 Nursing) on September 23, by 3:00 PM. They dings.				
	 (2) observations on ut 3A. During an observations AM on unit 4 south, th Verification Form" shot AM"; correct drug countries coming on duty balance verified by nut 	nit 4 south. ation on 09/11/22 at 6:12 ne Controlled Drug Count owed: "9/11/22"; shift "7:00 int "yes"; balance verified by - this area was blank;				

Facility ID: JBJ

If continuation sheet Page 131 of 151

		ID HUMAN SERVICES					FORM	M APPROVED
		MEDICAID SERVICES				1		0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,					E SURVEY PLETED
			A. BUILDI	NG				с
		095036	B. WING					26/2022
NAME OF PI	ROVIDER OR SUPPLIER			I	STREET ADDRESS, CITY, STATE, ZIP CODE		03/	20/2022
					901 FIRST STREET NW			
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC			WASHINGTON, DC 20001)1		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ON (EAC	н	(X5)
PREFIX			PREFI		CORRECTIVE ACTION SHOULD BE		S-	COMPLETION DATE
TAG	REGULATORTORI	SC IDENTIFYING INFORMATION)	TAG		REFERENCED TO THE APPROP DEFICIENCY)	RIATE		
								12/5/2022
F 755	Continued from page	131		751	5			12/5/2022
1755	1.3		Г	75	5			
	09/11/22 at 6:12 AM c	ed medication count on						
		noted that there was one						
		abalin (for nerve pain) and						
		Lorazepam (antianxiety) in						
	•	that were not logged into the						
	"Controlled Drug Cou	nt Verification Form".						
		interview conducted at the						
		ons, Employee #20 stated, "I rcotic count with myself so I						
		/ today. The supervisor was						
		as going to give him the						
	keys." When asked is							
	-	controlled medications,						
	Employee #20 stated	, "No." Regarding the two						
		s not logged into the count,						
		, "These medications were						
	•	forgot to log them into the						
	book."							
	4. Facility staff failed	to reconcile controlled						
	-	tandards of practice in one						
	observation on unit 4	north.						
		administration observation						
		ximately 1:53 PM on unit 4						
	north, Resident #188 Phenobarbital (anti-se							
	i nenobarbitai (anti-st							
	Resident #188 was a	dmitted to the facility on						
		e diagnoses that included:						
	Seizures, Encephalor							
	Disorder with Delusio	ns.						
		188's medical record						
	showed a physician's	order starting on 09/03/21						

Facility ID: JBJ

If continuation sheet Page 132 of 151

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
					С	
		095036	B. WING		09/26/20	22
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
UNIQUE R	EHABILITATION AND	HEALTH CENTER LLC		901 FIRST STREET NW		
				WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIE	(STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL CORRECTIVE ACTION SHO REFERENCED TO THE / DEFICIENC	OULD BE CROSS- COM	(X5) IPLETIOI DATE
					12/5	5/202
F 755	Continued from pa	ige 132	F 75	5		
	that directed, "Phe	nobarbital Solution 20 MG				
	(milligrams)/5ML (i	milliliters), give 7.5 ml by mouth				
		Seizures" with administration				
	times of 5:00 AM,	1:00 PM and 9:00 PM.				
	Poviow of the Son	tember 2022 Medication				
		cord (MAR) showed that facility				
		a check mark and then initialed				
	to indicate that the	Phenobarbital was				
	administered as or	dered to Resident #188 at 1:00				
	PM on 09/14/22. H	lowever, review of Resident				
	-	for the Phenobarbital showed				
		M 7.5 ml, [Nurse signature],				
	9/14/21 [at] 9 PM,	[Nurse signature]"				
	The evidence show	wed that although it was				
		Iministered, facility staff failed				
		a dose was taken out on				
	09/14/22 at 1:00 P	M in the narcotic log.				
		ace interview conducted on				
		kimately 2:00 PM, Employee t Manager) reviewed the				
		de no further comment.				
F 770	Laboratory Service		F 77	0		
	CFR(s): 483.50(a)					
	§483.50(a) Labora	tory Services.				
	§483.50(a)(1) The	facility must provide or obtain				
		s to meet the needs of its				
		lity is responsible for the quality				
	and timeliness of t					
		vides its own laboratory				
		ces must meet the applicable aboratories specified in part 493				
	of this chapter.	aboratories specified in part 435				
		NT is not met as evidenced				
	by:					

Facility ID: JBJ

If continuation sheet Page 133 of 151

	MENT OF HEALTH AN S FOR MEDICARE & I					FOR	D: 11/07/2022 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTR	RUCTION	(X3) DATE COMF	SURVEY PLETED
		095036	B. WING				C /26/2022
	ROVIDER OR SUPPLIER	ALTH CENTER LLC		901 FIRST	DDRESS, CITY, STATE, ZIP CODE STREET NW GTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (E/ CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
F 770	Based on record revit two (2) of 63 sampled failed to provide labors manner to meet reside and #204. The findings included: 1. Resident #158 was 06/30/20 with multiple Sarcoidosis, Hyperter failure, Diabetes Melli Disorder, and Genera Review of Resident # revealed the following Care plans focus area diagnosis of painful un on 04/30/22 at 3:41 PM of pain in vagina whe out to [MD name] to r to increase fluids and condition changes afte 04/30/22 [physician's shift complain of burn every shift for burning call MD with updates [Started 4/30/22 end 5 05/20/22 at 13:26 [1:2 New order given to U/A (urinalysis) C&S urine out stat"	ew and staff interview, for residents, facility staff atory services in a timely ent needs. Residents' #158 admitted to the facility on e diagnoses including hsion, Chronic respiratory tus, Major Depressive lized Anxiety Disorder. 158's medical record transformed at the service (service) and the service of the service of the service (service) and the service of the service of the service (service) and the service of the service of the service of the service (service) and the service of	F7		CORRECTIVE ACTION FOR AFFECTED RESIDENTS Resident #158 resident was di to the hospital and treated on 7 Returned on 7/13/22 with read Head to toe assessment perfor licensed nurse completed on 1 Resident suffered no negative outcomes. Resident #204 is discharged o 7/23/22. This deficiency cannot retroactively corrected, and resident be reassessed.	scharge 7/7/2022. mission. med by 0/12/22. n ot be sident S WITH ECTED I to be ill audit igust provide manner sues will	12/5/2022

If continuation sheet Page 134 of 151

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING			PRINTED: 11/07/202 FORM APPROVEI OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C	
		095036	B. WING			09/:	26/2022
	Rovider or supplier	ALTH CENTER LLC		901 FIRST	DRESS, CITY, STATE, ZIP CODE STREET NW STON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 770	Diamond lab technicia 6:15 PM. Will follow u 05/20/22 at 23:44 [11: U/A C&S unable to pro- gathered, urine was v re -collect and re-subr 05/20/22 [Physician's may in and out cath for (urinary tract infection UTI (urinary tract infection UTI (urinary tract infection OT/A C&S for possil out stat to the Lab. on 05/21/22 [Physician 's may in and out cath for every night" 05/28/22 at 15:48 [3:4 Preventionist Note " done 5/23/22 and rest 5/27/22. Her Urinalysi moderate blood, large negative nitrate, mode culture revealed 50,00 Mirabilis" The evidence showed were ordered on 04/30 obtained until 05/27/2 2. Resident #204 was 04/21/16 with multiple Mild Protein-Calorie M	taining x3 staff members an obtained specimen at p on results." 44 PM] Nurses notes " ocess due to urine level ery cloudy with "feces" will mit." order] "Please obtain urine or U/A C&S for possible UTI a) one time only for possible ction). Please [Physician ' s urine may in and out cath ble UTI every night" urine e time only for lab" s order] "Please obtain urine or U/A C&S for possible UTI b) One time only for lab" s order] "Please obtain urine or U/A C&S for possible UTI e time only for lab" s order] "Please obtain urine or U/A C&S for possible UTI e time only for lab"	F 77() 3. 4.	REOCURRENCE Staff Educator/Designee will co In-service for licensed nurses o ensuring laboratory services are provided in a timely manner to r resident needs. This will be con by 12/5/22. During the clinical morning mee clinical team will review all lab o ensure that labs are obtained in timely manner as ordered by th physician and results are report the physician timely and familie notified to meet resident needs.	n e meet npleted eting the orders to a e ted to s are ACTION coratory to four (4) onths to were r the will be	

Facility ID: JBJ

If continuation sheet Page 135 of 151

	-	ID HUMAN SERVICES				FOR	M APPROVED
		MEDICAID SERVICES				-	D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION		E SURVEY PLETED
AND I LAN OF	F CORRECTION IDENTIFICATION NUMBER:		A. BUILDI	NG .	i		
							С
		095036	B. WING			09	/26/2022
NAME OF PR	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
				9	901 FIRST STREET NW		
	EHABILITATION AND HE			1	WASHINGTON, DC 20001		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (E	ACH	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	х	CORRECTIVE ACTION SHOULD BE CRO	SS-	COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ξ	DATE
							12/5/2022
F 770	Continued from page	135	F	770	0		
	Review of a Complair	nt (DC00010905) received					
	by the State Agency of	on 07/29/22 showed, "					
		to provide the proper care					
	and appropriate care	owed to its long-term					
	resident [Resident	#204] was neglected and					
	sustained significant	physical injuries over an					
	unknown period whic	h resulted in her current					
	hospitalization"						
	Review of Resident #						
	revealed the following	g:					
	0						
		n, "[Resident #204] has					
		' reviewed on 04/22/22					
	showed, "laborator	y lesis as ordered					
	05/05/22 at 6:02 PM '	Podiatry Notefollow-up					
		ease obtain labs order has					
		obtain X-rays of right foot to					
		of right hallux (noted order					
	has been placed)"						
	, , ,						
	05/05/22 [physician's	order] "CBC (complete					
	blood count) with Diff						
		tation rate), CRP (c-reactive					
	protein) next lab day"						
		I "Laboratory Note Results.					
		2. Type of test CBC W/Diff					
		s: Waiting for doctor's					
	review"						
		"Nurse Practitioner Progress					
	NoteLabs and medi	ications reviewed."					
	The evidence chows	d that Resident #204's labs					
		5/22 however, they were not					
		22, 34 days after they were					
I		2, or days aller they were					

Facility ID: JBJ

If continuation sheet Page 136 of 151

	MENT OF HEALTH AN					FORM	D: 11/07/2022 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
		095036	B. WING				C 26/2022
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE F	REHABILITATION AND HE	ALTH CENTER LLC			11 FIRST STREET NW ASHINGTON, DC 20001		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	•••	PROVIDER'S PLAN OF CORRECTION (EA	сн	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	¢	CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F 770	Continued from page ordered.	136	F 7	70			12/5/2022
F 803 SS=D	09/16/22 at 10:45 AM Nursing) acknowledge #204's labs were not the facility had switch time and that quite a missed. Menus Meet Residem CFR(s): 483.60(c)(1) §483.60(c) Menus and Menus must- §483.60(c)(1) Meet th residents in accordan guidelines.; §483.60(c)(2) Be prep §483.60(c)(2) Be prep §483.60(c)(3) Be follo §483.60(c)(4) Reflect, reasonable efforts, the ethnic needs of the re- input received from re- groups; §483.60(c)(5) Be upd §483.60(c)(6) Be revio dietitian or other clinic professional for nutriti §483.60(c)(7) Nothing	d nutritional adequacy. e nutritional needs of ce with established national pared in advance; wed; based on a facility's e religious, cultural and sident population, as well as esidents and resident ated periodically; ewed by the facility's cally qualified nutrition onal adequacy; and g in this paragraph should be resident's right to make	F8	903			

Facility ID: JBJ

If continuation sheet Page 137 of 151

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES						M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	1				OMB NC	0. 0938-0391
-	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN					PLETED
		095036	B. WING _					C /26/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REETAD	DRESS, CITY, STATE, ZIP CODE		
	EHABILITATION AND HE			90 [.]	1 FIRST S	STREET NW		
		EALTH CENTER LLC		W	ASHING	TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
								12/5/2022
F 803	Continued from page	137	F 8	303				
		is not met as evidenced						
	by:	ns, record reviews, and staff			1.	CORRECTIVE ACTION FOR T AFFECTED RESIDENTS	ΉE	
	and resident interview	vs for two (2) of 63 sampled						
		failed to provide food that				Resident #199 Double portions provided as rea	hoteour	
		s food preferences and				per preference on 9/11/2022. N		
		ne residents' menu was				negative finding as a result of the	nis	
		plain sight for a resident to nake a reasonable effort to				deficient practice. Psych Evaluation		
		2 with double portions of				9/27/2022 with no negative find		
	food. Residents' #199	•				Resident's menu is current and in plain sight of the resident for		
						in plain signt of the resident for	viewing.	
	The findings included	:				Resident #152 Double portions provided as rea		
	1.Facility staff failed to with foods of her choi	o provide Resident #199 ce/preference.				per preference on 9/11/2022. N negative findings as a result of deficient practice. Psych Evalua	this	
						10/14/2022, with No negative fi		
		dmitted to the facility on				Resident's menu is current and		
	05/15/22 with diagnos Diabetes Type 2 With					in plain sight of the resident for	viewing.	
	Sick-Euthyroid Syndro				2.	IDENTIFICATION OF OTHERS	: wiтн	
	Gastroesophageal Re				2.	THE POTENTIAL TO BE AFFE		
	8:57 AM with Resider to call the kitchen just scrambled eggs beca my stomach. I have a eggs instead. I am als	interview on 09/11/22 at ht #199's she stated, "I have about every day. I don't eat use sometimes they upset sked for two hard-boiled so supposed to get fresh reakfast, and I hardly ever				All residents have the potential affected. Food Services Manag designee will audit menu prefer and portions to ensure that resi are provided with food of their choice/preference. Any negativ will be corrected upon discover	er or ences dents e issues	
	Resident #199's brea The resident's breakfa following items: two s	crambled eggs, one slice of ne sausage patty, grits, one						

If continuation sheet Page 138 of 151

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 A APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		JCTION		LETED
		095036	B. WING				C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREETAD	DRESS, CITY, STATE, ZIP CODE	00,	
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC	9	01 FIRST S	STREET NW		
			v	VASHING	TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
_							12/5/2022
F 803	Continued from page		F 803				
		also on the resident's tray. That the resident had ordered					
	an orange (missing fro hard-cooked (scramb	om the tray) and two		3.	MEASURE TO PREVENT REOCURRENCE		
	A review of Resident a revealed:				Food Services Manager or desi will audit menu preferences and portions twice weekly times four month then weekly for three mo ensure menu of the provided fo	f for one onths to	
	-	Data Set dated 08/21/22 aff coded the resident as n.			reflected the resident's food preferences and also ensure the residents' menu was current an in plain sight for all residents. Fi	at the d posted	
	09/07/21 [Physician's Salt) diet. Regular tex consistency"	Order: "NAS (No Added ture diet. Thin liquids			will be brought to QAPI monthly recommendations and review. All negative findings will be corr upon discovery.	for	
	Employee #40, Assist Services acknowledge conducted an in-servi	ed the findings and said she ce training this morning residents complained about					
	was current and poster resident to review and reasonable effort to pri double portions of foo Resident #152 was ac 05/03/22 with multiple	I failed to make a rovide Resident #152 with d. dmitted to the facility on e diagnoses that included: ep Tissue Damage to Left					

If continuation sheet Page 139 of 151

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 A APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _				PLETED
		095036	B. WING				C 26/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREETAD	DRESS, CITY, STATE, ZIP CODE	00,	
	EHABILITATION AND HE		9	01 FIRST	STREET NW		
			v	VASHING	TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 803	Continued from page	100	E 000				12/5/2022
F 003	Continued from page Review of the Quarter		F 803				
		2, revealed that the facility					
	staff coded: intact cog	nition. In section K					
	· · · ·	al Status) Resident #152					
	signs or symptoms of	a therapeutic diet and no swallowing disorder.		4.	MONITORING CORRECTIVE	ACTION	
	olghe er cymptellie er	enale ming alcordon			Food Services Manager or des	ignee	
					will audit menu preferences twi	ce	
	-	interview conducted on			weekly for one (1) month then for three (3) months to ensure p		
		ately 3:15 PM, Employee onist) regarding the process			menu reflected the resident's for		
	for residents to get do				preferences and to ensure that		
		, "The nutritionists input the			residents' menu was current an in plain sight for resident. Findir		
		it's up to the tray line staff to nts get double portions. A			be brought to QAPI monthly for		
		entrées and two vegetables			recommendations and review. negative findings will be correct		
	and two starches."				discovery.		
	During a tour of Unit 1						
		M the menus were observed					
		nd an activities calendar, was for a previous month.					
		cessible to the residents					
		small. Employee #31 was					
		2 received double portions.					
		that Resident #152 was not tions or food alternatives					
	• • ·	he concerns regarding the					
		plain sight for the resident					
	to review.						
	An observation and re	esident interview were					
		2 at approximately 9:40 AM,					
		, "I am supposed to get					
	-	have not been getting them, menu and yesterday I got a					
		er." At this time, a review of					
	Resident # 152's men						

If continuation sheet Page 140 of 151

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONS	TRUCTION	(X:		. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,				COMPI	
							C)
		095036	B. WING				09/26/2022	
NAME OF PI	ROVIDER OR SUPPLIER				ADDRESS, CIT	Y, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND H	EALTH CENTER LLC			NGTON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		CORRECT	R'S PLAN OF CORRECTION (EACH IVE ACTION SHOULD BE CROSS- ENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
- 000								12/5/202
F 803	Continued from page	e 140 ented "2X" which indicates	F 80	03				
		puble portion. However, the						
	resident had a single breakfast tray.	portion of food on his				ECTIVE ACTION FOR THE TED RESIDENTS	E	
						owing items were corrected ately by Food Service Man		
	•	on 09/21/22 at 12:40 PM,			1)	16 of 16 six-inch half-pan	าร	
	Employee #40, Assis	itant Director of Food jed the findings and said she			,	were and placed on the c	dry in	
	conducted an in-serv				rack shelf, ready for use.			
	after hearing that the			2)	Two (2) of two (2) convec	ction		
	not receiving their for				,	ovens, two (2) of two (2)		
F 812 SS=E	Food Procurement, S CFR(s): 483.60(i)(1)(Store/Prepare/Serve-Sanitary 2)	F 8 ⁻	12		grease fryers, one (1) of (1) meat slicer, and six (6)	6) of	
	6 400 00(i) F a a dia afa					seven (7) cutting boards immediately cleaned upo		
	§483.60(i) Food safe The facility must -	ty requirements.				discovery.		
	§483.60(i)(1) - Procu	re food from sources						
		red satisfactory by federal,						
	state or local authorit	ties. food items obtained directly						
		, subject to applicable State						
	and local laws or reg	ulations.						
		es not prohibit or prevent						
	•	roduce grown in facility ompliance with applicable						
		d-handling practices.						
		es not preclude residents						
	from consuming food	ls not procured by the facility.						
		prepare, distribute and						
	serve food in accorda	ance with professional ervice safety.						
		Γ is not met as evidenced						
	by:							
	Based on observation	ons and staff interview, facility						

Facility ID: JBJ

If continuation sheet Page 141 of 151

		D HUMAN SERVICES MEDICAID SERVICES						FOR	D: 11/07/2022 M APPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRU	CTION			PLETED
		095036	B. WING						C /26/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	TREETADD	RESS, CITY	, STATE, ZIP CODE		
				90	01 FIRST S	TREET NW	I		
UNIQUE F	EHABILITATION AND HE	ALTH CENTER LLC		w	ASHING1	TON, DC	20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			CORRECTIV	S PLAN OF CORRECTION (EA /E ACTION SHOULD BE CROS NCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 812	under sanitary conditi 16 six-inch half-pans f ready for use, soiled e of two (2) convection grease fryers, one (1) six (6) of seven (7) cut temperature logs that documented, six (6) o suppression nozzle co temperatures that tes Fahrenheit on two (2) assessment. The findings included 1. 16 of 16 six-inch ha a shelf, ready for use. 2. Two (2) of two (2) of two (2) grease fryers, slicer, and six (6) of sever soiled throughout with 3. Dishwashing mach were improperly docu final rinse temperature of Fahrenheit (F) from Ja 4. Six (6) of six (6) fire located above the gas soiled with grease and lint. 5. Breakfast and lunct	, serve, and distribute foods ons as evidenced by 16 of that were stored wet and equipment such as two (2) ovens, two (2) of two (2) of one (1) meat slicer, and tting boards, dishwasher were improperly f six (6) stained fire overs, and food ted below 135 degrees of two (2) food trays : alf-pans were stored wet, on convection ovens, two (2) of one (1) of one (1) meat n (7) cutting boards were	F	812	2.	THE PO All reside affected designee audit on	Dishwashing machine repaired immediately discovery, and the da temperature logs are of reflecting the final rins temperature of at leas degrees Fahrenheit. Six (6) of six (6) fire suppression nozzle co located above the gas and the fryers were clu and free from grease a Breakfast and lunch for temperatures are ader and are now testing all degrees Fahrenheit, b a test tray and food temperature log. FICATION OF OTHERS TENTIAL TO BE AFFI ents have the potential . Food Services Manage e will conduct a house of all identified equipment 22. Any issues will be concovery.	upon ily how e t 180 overs stove eaned and lint. ood quate bove 135 ased on S WITH ECTED to be ler or wide t by	

If continuation sheet Page 142 of 151

CENTER		MEDICAID SERVICES	1			OMB NO.	. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTR		(X3) DATE S COMPL	
		095036	B. WING			09/2	; 26/2022
NAME OF P	ROVIDER OR SUPPLIER	1		STREETAD	DDRESS, CITY, STATE, ZIP CODE		
UNIQUE F	REHABILITATION AND HI	EALTH CENTER LLC			STREET NW STON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (I CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETIC N DATE
F 812 Continued from page 142 or more during food trays assessment on September 11, 2022, 9:10 AM and on September 13, 2022, at approximately 1:30 PM on seven (7) of 12		F 81	12 3 .	MEASURE TO PREVENT REOCURRENCE Food Services Manager or de conduct an in-service to all die	signee will	12/5/202	
					on the preparation, storage, d and serving resident meals in accordance with professional regulatory standards by 12/5/2 Food Service Manager will in-	and 22.	
F 842 SS=D	Resident Records - Io CFR(s): 483.20(f)(5),	dentifiable Information			dietary staff to ensure equipm kitchen is in sanitary condition equipment will be assessed d proper functioning and if repai	ent in the is. All aily for ir is	
	(i) A facility may not resident-identifiable to	release information that is o the public. elease information that is			required it will be communicat immediately. In service will be by 12/5/22		
	accordance with a co agrees not to use or o except to the extent to to do so.	ntract under which the agent disclose the information he facility itself is permitted			Food Services Manager will c in- service to Food Service sta food temperatures before putt the food truck and log it. All ne findings will be addressed imm All findings will be discussed a	aff to take ing it on egative nediately.	
	•				meeting monthly. Education w completed by 12/5/2022.	ill be	
	(ii) Accurately docum (iii) Readily accessibl (iv) Systematically or	e; and					
	all information contain regardless of the form records, except when (i) To the individual, o						

Facility ID: JBJ

If continuation sheet Page 143 of 151

		D HUMAN SERVICES MEDICAID SERVICES			FORM	0: 11/07/2022 1 APPROVED 0: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		LETED
		095036	B. WING			C 26/2022
UNIQUE R	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 901 FIRST STREET NW WASHINGTON, DC 20001	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF CORRECTIVE ACTION SHOU REFERENCED TO THE AP DEFICIENCY)	ILD BE CROSS- PROPRIATE	(X5) COMPLETION DATE
F 842	 (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506; (iv) For public health a neglect, or domestic wattivities, judicial and law enforcement purp purposes, research purposes, record information again authorized use. §483.70(i)(3) The facine (ii) Five years from the there is no requirement (iii) For a minor, 3 year legal age under State §483.70(i)(5) The me (i) Sufficient information (ii) A record of the rese (iii) The comprehensive provided; (iv) The results of any and resident review endeterminations condure (v) Physician's, nurse professional's progrese (vi) Laboratory, radiologies (vi) Laboratory, radiologies (vi) Laboratory, radiologies (vi) Comprehensive provides (vi) Comprehensive provides (vi) Comprehensive professional's progrese (vi) Laboratory, radiologies (vi) Laboratory,	went, or health care ed by and in compliance activities, reporting of abuse, violence, health oversight administrative proceedings, oses, organ donation urposes, or to coroners, ineral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or urs after a resident reaches law. dical record must contain- on to identify the resident; ident's assessments; we plan of care and services preadmission screening valuations and cted by the State; 's, and other licensed	F 842	 4. MONITORING CORF Food Services Manage will conduct a house of equipment weekly for monthly for 3 months an audit of temperatur arrives on the unit we Negative findings will upon discovery, and a will be discussed at the monthly. F842 1. CORRECTIVE ACTION AFFECTED RESIDEN Resident #102 Residen checked for accuracy Resident was assess licensed nurse on 9/2 service to be completed by Staff Development ensure that blood pret the proper arm as orcophysician. Resident s negative outcome from practice. 2. IDENTIFICATION OF THE POTENTIAL TO All residents on dialysis potential to be affected Managers/Designee of audit for all dialysis pat the blood pressure is and documented accor physician order by 12 negative findings will discovery. 	ger or designee wide audit on all four weeks and , then will also do re of food when it wekly for 4 weeks. be addressed all other findings ne QAPI meeting ON FOR THE NTS ent order was c ed head to toe by 20/22. Staff in- ted by 12/5/2022 t/Designee to ssure is taken on dered by the uffered no m this deficient FOTHERS WITH DE AFFECTED sis have the ed. Unit will conduct an atients to ensure to being taken ording to the 2/5/22. Any	

Facility ID: JBJ

If continuation sheet Page 144 of 151

	CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	PLE CONST G	RUCTION	(X3) DATE SURVE COMPLETED		
		095036	B. WING			C 09/26/2022		
	ROVIDER OR SUPPLIER	EALTH CENTER LLC		901 FIRS	ADDRESS, CITY, STATE, ZIP CODE ST STREET NW IGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE	
F 842	Based on record revi one (1) of 63 sampled failed to accurately do Resident #102's blood The findings included Review of the policy " Nursing Notes" revise the responsibility of lit that information releve resident is recorded . Resident #102 was at 11/19/20 with diagnos Renal Disease (ESRI Dialysis. Review of Resident # revealed the following A Quarterly Minimum 07/21/22 showed faci cognition and receive 09/04/22 [physician's no blood draw, no fing procedure on right up (arteriovenous) graft s Review of the Septen Resident #102 showe the following blood pr 09/04/22 at 1:36 PM of mercury); Lying r (1 09/04/22 at 2:28 PM	 iew and staff interview, for d residents, facility staff boument the location where d pressure was being taken. I: I'Charting/Documentation ed 0n 10/02/21 showed, "It is censed nurses to make sure ant to the care of the " dmitted to the facility on ses that included: End Stage D) and Dependence on I'102's medical record g: Data Set (MDS) dated lity staff coded: intact d dialysis while a resident. order] "No blood pressure, ger stick, no invasive oper arm because of the AV site every shift" nber 2022 vital signs for ed facility staff documented ressure readings: 132/79 mmHg (millimeters 	F 8	42 3	 MEASURE TO PREVENT REOCURRENCE Staff Educator/Designee will In-service for licensed nurses following Physician orders for blood pressure on the approp Education will be completed In 12/5/2022. MONITORING CORRECTIVE Unit Managers/Designee will an audit for all dialysis patient ensure that blood pressure is taken and documented accur the residents' charts per phys orders, weekly for four (4) we monthly for three months' find be brought to QAPI monthly for recommendations and review All negative findings will be of upon discovery. 	s on r taking priate sites. by E ACTION conduct ts on to being rately in sician eeks then dings will for	12/5/202	

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	0: 11/07/2022 1 APPROVED 0: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		LETED
		095036	B. WING			C 26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/	20/2022
				001 FIRST STREET NW		
UNIQUE F	EHABILITATION AND HE	EALTH CENTER LLC		WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued from page	145	F 880	1. CORRECTIVE ACTION FOR T AFFECTED RESIDENTS	ΉE	12/5/2022
F 880 SS=D	09/10/22 at 2:09 PM - 09/14/22 at 3:31 PM - 09/16/22 at 10:26 AM 09/16/22 at 10:26 AM 09/16/22 at 7:49 AM - 09/17/22 at 1:32 AM - 09/18/22 at 8:18 PM - 09/19/22 at 2:30 AM - 09/19/22 at 2:30 AM - 09/19/22 at 5:18 PM - During a face-to-face 09/21/22 at 2:48 PM, Unit Manager) review stated, "It's a docume know not to take the k Infection Prevention & CFR(s): 483.80(a)(1)0 §483.80 Infection Cor The facility must estal infection prevention a designed to provide a comfortable environm development and tran diseases and infection §483.80(a) Infection p program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di	124/67 mmHg; Lying r/arm 139/79 mmHg; Lying r/arm 130/70 mmHg; Lying r/arm 131/73 mmHg; Sitting r/arm 127/73 mmHg; Lying r/arm 128/78 mmHg; Lying r/arm 122/74 mmHg; Lying r/arm 121/83 mmHg; Lying r/arm 131/83 mmHg; Lying r/arm 131/83 mmHg; Lying r/arm 131/83 mmHg; Lying r/arm 131/83 mmHg; Lying r/arm 14100 conducted on Employee #10 (4th floor ed the vital signs and ntation error. The nurses blood in that resident's arm." A Control (2)(4)(e)(f) htrol blish and maintain an nd control program safe, sanitary and ent and to help prevent the ismission of communicable ns. brevention and control blish an infection prevention IPCP) that must include, at ring elements: m for preventing, identifying, g, and controlling infections seases for all residents, prs, and other individuals		 Employee #21 was in-serviced infection control policy which imappropriate footwear. 9/11/2022 employee corrected this deficie practice, with proper shoe wear Employee #22 was in-serviced disinfect the glucose monitor min between residents; and performing between residents; and performing between residents; and performing the Staff Development/Designer 2. IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFE All facility residents have the pot to be affected. House wide aud conducted by IP, Unit managers department heads on monitorin staff to ensure proper hand was techniques are demonstrated by doffing and while providing care residents, ensuring that blood gmonitor machines are cleaned/disinfected before, duri after resident use, and to ensur are always wearing proper footh during resident care. All negative findings will be corrected upon discovery. 	cluded 2 nt c on how achine orm hand will be incted by e. S WITH ECTED otential it will be s and g facility shing efore e to plucose ing and e staff wear	
	arrangement based u	to §483.70(e) and following				

If continuation sheet Page 146 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 11/07/2022 APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		CONSTRUCTION	(X3) DATE S COMPL	LETED
		095036	B. WING			09/2	26/2022
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	ALTH CENTER LLC		90	01 FIRST STREET NW		
				w	ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued from page accepted national star		F	880	3. MEASURE TO PREVENT REOCURRENCE ADON or designee will conduct	in	
	§483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveill possible communicab- infections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and tran- to be followed to preve- (iv)When and how iso resident; including but (A) The type and dura- depending upon the ir involved, and (B) A requirement that least restrictive possib- circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste identified under the fa corrective actions take §483.80(e) Linens. Personnel must handl	standards, policies, and ogram, which must include, lance designed to identify ole diseases or can spread to other in possible incidents of se or infections should be assission-based precautions ent spread of infections; lation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable in lesions from direct is or their food, if direct ne disease; and procedures to be followed rect resident contact.			ADON or designee will conduct services with the facility staff to the facility infection prevention a control program is designed to p safe, sanitary and comfortable environment and to help preven development and transmission of communicable diseases and infection All staff will be educated on prop hand washing techniques before and while providing care to reside proper handling of blood glucos monitor machines ensuring that are cleaned/disinfected before, and after resident use, and to el staff are always wearing proper footwear during resident care Education will be completed by 12/5/2022.	ensure and provide a t the of ections. per e doffing dents, e they during nsure	

If continuation sheet Page 147 of 151

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 11/07/2022 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095036	B. WING		C 09/26/2022	
NAME OF PROVIDER OR SUPPLIER UNIQUE REHABILITATION AND HEALTH CENTER LLC		90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 FIRST STREET NW VASHINGTON, DC 20001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
F 880	IPCP and update their This REQUIREMENT by: Based on observation facility staff failed to for infection control pract contamination and sp failure to wear the app sanitize the blood glue residents. The reside survey was 208. The findings included 1. Facility staff failed to practices when admin During an observation Employee #21 (Regis passing medications of sandals. The employee surveyor. In an interview condu- observation, the employed stated, "I broke my too to put shoes on. Even gave the doctor's lette Resources). They said sandals."	view. uct an annual review of its ir program, as necessary. T is not met as evidenced In and staff interview, the follow accepted standards of tices to prevent potential propriate shoe and failed to cose machine between ent census on the first day of I: to follow infection control histering medications. In on 09/11/22 at 9:28 AM, stered Nurse) was observed while wearing open toe ee was stopped by the Interview on 09/11/22 at interview on 09/11/22 at its was okay to wear	F 880	4. MONITORING CORRECTIVE House wide audit will be cond IP, Unit managers and depart heads on monitoring facility st ensure proper hand washing techniques are demonstrated doffing and while providing ca residents, ensuring that blood monitor machines are cleaned/disinfected before, du after resident use, and to ensu are always wearing proper foo during resident care. All negat findings will be corrected upor discovery. ADON or designee will condu rounds and audit a sample of to ensure the facility is practic infection control surveillance of hygiene and glucometer clear between residents to prevent spread of communicable dises infections. This will be conducted 4 times then 3 times monthly and find be brought to QAPI monthly for recommendations and review negative findings will be addre upon discovery	ucted by ment aff to before re to glucose uring and ure staff otwear tive n ct random residents ing of hand hing the ases or s weekly ings will or	

If continuation sheet Page 148 of 151

DEPART CENTER	FORM	0: 11/07/2022 1 APPROVED 0: 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
095036		B. WING			C 26/2022	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIQUE F	EHABILITATION AND HE	EALTH CENTER LLC		01 FIRST STREET NW VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	open toe shoes. It's ir She [Employee #21] I wear those shoes [op	148 The facility's policy is no a the Employee Handbook. knows she's not supposed to en toe sandals]. HR never lo so. We are addressing it	F 880			
	 2. Facility staff failed to follow hand hygiene and standard infection control practices while conducting blood glucose testing. During an observation on 09/20/22 at 5:15 PM on unit 1 north, the following was observed: Employee #22 (RN) exited room 107 after checking the resident in Bed-A's blood glucose using a handheld glucose monitor. The employee doffed her gloves and put them in the trash receptacle. Employee #22 then walked into room 109 Bed-B, donned gloves and was about to check that resident's blood glucose levels when the surveyor stopped her. Employee #22 failed to: perform hand hygiene after doffing gloves in room 107 (Resident in bed-A); disinfect the glucose monitor machine in between residents; and perform hand hygiene before donning gloves to obtain the blood glucose level of the resident in room 109 Bed-B. During a face-to-face interview conducted at the time of the observations, Employee #22 stated, "I usually use the alcohol hand rub. I just forgot." When asked why she didn't disinfect the glucose monitor machine in between residents, the employee made no comments but proceeded to use an alcohol prep pad to wipe down the machine. The employee was then asked to step 					

Facility ID: JBJ

If continuation sheet Page 149 of 151

					(X3) DATE	0. 0938-039	
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095036			. ,	PLE CONSTRUCTION G	. ,	PLETED	
						С	
		B. WING			09/26/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
	EHABILITATION AND HI			901 FIRST STREET NW			
				WASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION REFERENCED TO DEFICI	SHOULD BE CROSS- THE APPROPRIATE	(X5) COMPLETIOI DATE	
			F 908			12/5/202	
F 880	Continued from page 149 out of the resident's room. Now at the medication cart, Employee #22 was asked what is the standard infection control practice for medical equipment that is shared, the employee pulled				ACTION FOR THE		
				AFFECTED RES	SIDEN I S		
				The following ite	ms were corrected		
					Food Service Manager:		
				(1) 16 of 16 oix	inch half nana wara		
	out a container of "Super Sani-Cloth Germicidal Disposable Wipe" and stated, "We are supposed				-inch half-pans were on the dry in rack		
	to use this."			shelf, ready			
F 908 SS=E	Essential Equipment,	Safe Operating Condition					
	CFR(s): 483.90(d)(2)				wo (2) convection (2) of two (2) grease		
					(1) of one (1) meat		
	§483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.			slicer, and s	ix (6) of seven (7)		
					ds were immediately		
		is not met as evidenced		cleaned upo	on discovery.		
	by:			3) Dishwashin	g machine was		
	Based on observatio	ns and staff interview, facility			mediately upon		
		n essential equipment in			and the daily		
		denced by one (1) of one (1)			e logs are now reflecting se temperature of at		
	•	e that did not reach 180			grees Fahrenheit.		
		and failed to complete the fill one (1) of six (6) steam well			-		
		e, four (4) of six (6) steam			(6) fire suppression		
		se handle, one (1) of eight			rs located above the nd the fryers were		
	(8) unsecured baffle f				free from grease and		
	•	of four (4) curtains from the		lint.	5		
	dishwasher that were	marred.					
					nd lunch food es are adequate and		
	The findings included	ŀ			ting above 135 degrees		
	The indings included			Fahrenheit,	based on a test tray		
				and food ter	mperature log		
		nse temperatures failed to					
	-	ahrenheit on numerous					
	consecutive cycles.						
	2. The dishwasher fai	iled to automatically					
		e during start-up. Staff was					
	observed filling the						

Facility ID: JBJ

If continuation sheet Page 150 of 151

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/07/2022 A APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
095036		095036	B. WING				C 09/26/2022	
NAME OF PROVIDER OR SUPPLIER				STRE	ETADI	DRESS, CITY, STATE, ZIP CODE		
UNIQUE R	EHABILITATION AND HE	EALTH CENTER LLC						
				WAS	HING	TON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG			PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000		450						12/5/2022
F 908	Continued from page machine manually		F 90	38	2.	IDENTIFICATION OF OTHERS W	TH THE	
	machine manually	with water.				POTENTIAL TO BE AFFECTED All residents have the potential to b		
	3. One (1) of six (6) s				affected. Food Services Manager o	or		
	missing a handle and well pans cover				designee will conduct a house wide all identified equipment by 12/5/202	22. Any		
	had a loose handle				issues will be corrected upon disco	very.		
	4. One (1) of eight (8) baffles form the kitchen			3.	3.	MEASURE TO PREVENT REOCU	RRENCE	
		ne fryers was hanging loose				Food Services Manager or designe	nee will	
	 due to a missing locking pin. 5. Four (4) of four (4) dishwasher curtains were stained throughout. Employee #14 acknowledged the findings during 					conduct an in-service to all dietary the preparation, storage, distributio	staff on n and	
						serving resident meals in accordan professional and regulatory standard		
						12/5/22.		
						Food Service Manager will in-service		
						dietary staff to ensure equipment in kitchen is in sanitary conditions. All		
	a face-to-face intervie at approximately 3:30	ew on September 19, 2022,) PM.				equipment will be assessed daily for functioning and if repair is required communicated immediately. In service be completed by 12/5/22	or proper it will be	
						Food Services Manager will conduct service to Food Service staff to take temperatures before putting it on the truck and log it. All negative finding addressed immediately. All findings discussed at the QAPI meeting mod Education will be completed by 12/	e food le food s will be s will be nthly.	
					4.	MONITORING CORRECTIVE ACT	ION	
						Food Services Manager or designe conduct a house wide audit on all e weekly for four weeks and monthly months, then will also do an audit o temperature of food when it arrives unit weekly for 4 weeks. Negative fi will be addressed upon discovery, a other findings will be discussed at t meeting monthly.	equipment for 3 of on the indings and all	

Facility ID: JBJ

If continuation sheet Page 151 of 151