STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, DC 20001

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L 000	Initial Comments	L 000		12/5/2022

The Annual Licensure Survey was conducted at this facility on September 11, 2022 to September 26, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 208 and survey sample included 63 residents.

The following complaints were investigated during this survey: DC00010905, DC00010736, DC00010675, DC00010481, DC00010174.

The following facility reported incidents were investigated during this survey: DC00010969, DC00010848, DC00010824, DC00010782, DC00010732, DC00010730, DC00010702, DC00010683, DC00010641. DC00010624, DC00010380, DC00010317, DC00010299, DC00010302, DC00010242, DC00010241, DC00010228, DC00010223, DC00010212, DC00010135.

Federal and Local deficiencies were cited related to the investigation of: DC00010905, DC00010481, DC00010445, DC00010324, DC00010577, DC00010898, DC00010463, DC00010502, DC00010299, DC00010228, DC00010223.

After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations Chapter 32 for Nursing Facilities.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

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L 000	Continued From page 1 AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for house and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C- Discontinue Dl- Deciliter DMH - Department of Mental Health DOH- Department of Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) F - Fahrenheit FR.- French G-tube- Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP- Infection Prevention and Control Program LPN- Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M- minute mL - milliliters (metric system measure of	L 000	Unique Rehabilitation and Health Center makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.	12/5/22

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L 000	Continued From page 2 volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight N/C- nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q- Every RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram The following deficieinces are the results of this survey:	L 000		12/5/22
L 012	3203.2 Nursing Facilties A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director. This Statute is not met as evidenced by:	L 012		

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L 012	Continued From page 3 Based on record review and interview on September 13, 2022, at approximately 3:00 PM, it was determined that facility staff failed to ensure that four (4) of four (4) persons in charge, who are certified food protection managers, obtained a District of Columbia Food Protection Manager Identification Card. The findings included: During a review of dietary records on September 13, 2022, at approximately 3:00 PM, four (4) of four (4) persons in charge did not have the required District of Columbia Food Protection Manager Identification Card. The 2012 District of Columbia Food Code, section 203.3 of Chapter 2 states the following: 2012 District of Columbia Food Code 203 CERTIFICATION AND DISTRICT-ISSUED ID REQUIREMENTS FOOD PROTECTION MANAGER, PERSON IN CHARGE 203.3 A person in charge who is a certified food protection manager as required in §203.1 shall obtain a District-issued Food Protection Manager Identification Card (ID Card), issued by the Department, and shall renew the District-issued ID Card every three (3) years. Employee #14 acknowledged the findings during a face-to-face interview on September 19, 2022, at approximately 3:30 PM.	L 012	**1. CORRECTIVE ACTIONS FOR AFFECTED RESIDENTS:** All food services manager will have the required District of Columbia Food Protection Manager Identification Card by 12/5/2022 **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the ability to be affected. **3. MEASURE TO PREVENT REOCURRENCE** Administrator or Designee will re-educate the Food services Manager that A person in charge who is a certified food protection manager as required in §203.1 shall obtain a District-issued Food Protection Manager Identification Card (ID Card), issued by the Department, and shall renew the District-issued ID Card every three (3) years. **4. MONITORING CORRECTIVE ACTION** The Food Service Manager or designee rounds will audit their files to ensure they have the licensed personnel results will be turned into the to QAPI monthly for for the period of 3 months for recommendations and review. All negative findings will be corrected	12/5/22

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L 051	Continued From page 4	L 051		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observation, record review, resident and staff interview, for three (3) of 63 sampled residents, facility staff failed to: to update one resident's fall and skin care plan focus areas with new goals and interventions after he sustained a fall and when he was observed with a bruise on his right cheek; develop a comprehensive person-centered care plan to address one resident's use of supplemental oxygen; implement one resident's care plan intervention of having a one to one (1:1) supervision while in the courtyard; and ensure that resident's medicaions	L 051	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #20 comprehensive care plan on fall and skin care was reviewed and modified to ensure that it is accurate and interventions are properly implemented on 9/20/2022. Resident head to toe assessment was completed by the licensed nurse on 9/20/22. Resident suffered no negative outcomes. Resident #64 was educated on the on the risk and benefits related to the proper use of oxygen supplement and following the doctor's order. Residents oxygen tubing and nasal cannula was marked with a date and time upon discovery. Staff was educated to check on the resident's oxygen supplement use during resident rounds to ensure that it is set-up properly according to the resident's MD orders and care plan. Resident #64 comprehensive care plan was reviewed to ensure oxygen supplement us in accordance to MD orders and interventions are properly implemented on 9/20/2022. Resident suffered no negative outcomes. Resident #176 comprehensive care plan was reviewed to ensure care plan for s accurate and interventions are properly implemented on 9/28/2022. No negative findings due to this deficient practice. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. ADON/Designee will conduct an audit of five comprehensive care plans to ensure that the fall and skin was	12/5/22

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L 051	Continued From page 5	L 051		12/5/22

were administered using the professional standards of practice. Residents' #20, #64 and #176.

The findings included:

According to the "Long-Term Care Nursing: Medication Pass", " ...pre-pouring medications is unacceptable because the medications: cannot accurately be compared to the Medications Administration Record (MAR) and violates at least two of the seven rights of medication administration (right patient & right medication), dramatically increasing the probability of medication errors ..."

https://ceufast.com/course/long-term-care-nursing-medication-pass

1. Facility staff failed to update Resident #20's fall and skin care plan focus areas with new goals and interventions after he sustained a fall and when he was observed with a bruise on his right cheek.

Resident #20 was admitted to the facility on 04/02/18 with multiple diagnoses that included: Muscle Weakness, Hemiplegia and Hemiparesis, Hypertension and Type 2 Diabetes Mellitus.

Review of Resident #20's medical record revealed the following:

A Quarterly MDS dated 08/25/22 showed facility staff coded: unable to complete the Brief Interview for Mental Status (BIMS); required extensive assistance with one person physical assist for transfers; independent with locomotion on the unit; no functional impairment in upper extremities; functional impairment on one side for

All residents who require 1:1 supervision and residents who use oxygen supplementation have the potential to be affected by this deficient practice. House wide audit will be completed by the Unit managers/Designee on residents with 1:1 supervision and residents on oxygen supplements to ensure that comprehensive care plans are accurate and properly implemented. Any negative findings will be corrected upon discovery.

3. MEASURE TO PREVENT REOCURRENCE

Staff Educator/Designee will educate the Interdisciplinary team regarding the accurate completion of a comprehensive person-centered care plan to ensure that the fall and skin areas are reviewed and modified accurately and timely. Education will be completed by 12/5/2022.

During the weekly risk management meeting, the IDT will review all incidents and accidents and ensure that residents comprehensive care plan are updated accurately and timely including fall and skin incidents. All findings will be corrected upon discovery

During the clinical meeting, all incidents and accidents are reviewed by the IDT team and residents comprehensive care plan are updated accurately and timely including fall and skin incidents. All findings will be corrected upon discovery

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L 051	Continued From page 6 lower extremities; wheelchair for mobility; no falls since admission/entry or reentry or the prior assessment. 09/12/22 at 9:20 PM "Post Fall Huddle ...Specific location of fall: Hallway ... Was a new intervention added to residents care plan ...Yes ..." 09/12/22 at 9:50 PM "Nurses Note ...Resident at 9pm during the staff regular round saw the Resident sitting on the floor beside his wheel chair ..." 09/13/22 at 4:54 PM "Situation Background Assessment Request (SBAR) Communication Tool ... situation- purple discoloration noted at the right chick bone of resident's face ...Resident's face was observed with a purple discoloration at the right chick (sp) bone. Resident complained of pain ...MD (medical doctor) made aware and X ray of facial bones and skull ordered ..." Care plan focus area, "[Resident #20] reported that he fell 2 days ago from the wheelchair, no injury noted" revised on 09/12/22 showed, " ...observed sitting on the floor in the hallway." There was no documented evidence that facility staff updated this care plan with new goals and interventions after the fall on 09/12/22. Care plan focus area, "[Resident #20] is at risk for alteration in skin integrity ..." reviewed on 08/30/22 showed, " ... Observe skin condition ... daily; report abnormalities ..." There was no documented evidence that facility staff updated this care plan to include goals and interventions to address the bruise on Resident #20's right cheek on 09/13/22. During a face-to-face interview conducted on	L 051	Staff Educator/Designee will educate the Interdisciplinary team regarding the accurate completion of a comprehensive person-centered care plan and proper implementation of the care plans on all residents with 1:1 supervision and residents on oxygen supplements. Education will be completed by 12/5/2022. **4. MONITORING CORRECTIVE ACTION** ADON/Designee will conduct an audit of five comprehensive care plans to ensure that the fall and skin areas are reviewed and modified accurately and timely. Any negative findings will be corrected upon discovery. This audit will be conducted weekly times four, then monthly times three to be reviewed during at Quality assessment and Assurance meetings for further recommendations. House wide audit will be completed by the Unit managers/Designee on residents with 1:1 supervision and residents on oxygen supplements to ensure that comprehensive care plans are accurate and properly implemented. Any negative findings will be corrected upon discovery. This will be completed during the 3 month period (August 2022- October 2022), weekly times four, then monthly for three months. Results to be reviewed during at QAPI meetings for further recommendations. All negative findings will be corrected upon discovery.	12/5/22

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L 051	Continued From page 7	L 051		12/5/22

09/19/22 at 3:43 PM, Employee #10 (4th Floor Unit Manager) reviewed both care plan focus areas and made no further comments.

2. Facility staff failed to develop a comprehensive person-centered care plan to address Resident #64's use of supplemental oxygen.

Resident #64 was admitted to the facility on 03/18/22 with multiple diagnoses that included: Atrioventricular Block Second degree, Unspecified Fall, Anemia, and Anxiety Disorder.

During an observation and interview conducted on 09/22/22 at approximately 9:40 AM, Resident #64 was observed with his oxygen tubing and nasal cannula laying on the bed, the tubing was not marked with a date and time and the oxygen was set on 1 liter. Resident #64 stated, "I turn my oxygen on and off and take off the nasal cannula when I don't need it."

Review of the medical record revealed the following:

A Quarterly Minimum Data Set (MDS) dated 06/24/22, showed that the facility staff coded the following: intact cognition; and that oxygen therapy was performed during the last 14 days of assessment.

03/18/22 [Physician's Order] "Staff to Administer Medications"

05/18/22 [Physician's Order] "Oxygen at 2 LPM (Liters Per Minute) via NC (Nasal Cannula) as needed for sob (Shortness of Breath)"

The medical record lacked documented evidence of a care plan that addressed Resident #64's use

1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS**
Resident #176 is supervised at all times while in the courtyard by the courtyard monitor staff upon discovery. Resident #176 signed a social contract on 10/27/22 to abide by the facility policies and conduct including non-consumption of alcohol. Resident #176 comprehensive care plan was reviewed and updated to reflect the appropriate care based on the resident's needs. These interventions are properly implemented. Resident suffered no negative outcomes

2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED**
All residents who require 1:1 supervision and residents who use oxygen supplementation have the potential to be affected by this deficient practice. House wide audit will be completed by the Unit managers/Designee on residents with 1:1 supervision and residents on oxygen supplements to ensure that comprehensive care plans are accurate and properly implemented. Any negative findings will be corrected upon discovery.

3. **MEASURE TO PREVENT REOCURRENCE**

Staff Educator/Designee will educate the Interdisciplinary team regarding the accurate completion of a comprehensive person-centered care plan and proper implementation of the care plans on all residents with 1:1 supervision and residents on oxygen supplements. Education will be completed by 12/5/2022.

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L 051	Continued From page 8 of oxygen as needed for shortness of breath. During a face-to-face interview conducted on 09/22/22 at 1:00 PM, Employee #32 (Charge Nurse 2 south) acknowledged there was no care plan that addressed residents prescribed oxygen treatment and stated, "He (Resident #64) has shortness of breath." 3. Facility staff failed to implement Resident #176's care plan intervention of having 1:1 supervision while in the courtyard. During an observation on 09/22/22 at approximately 4:30 PM on unit 4 South, Resident #176 was observed yelling profanities at facility staff as he wheeled himself past the nurses' station with two security officers behind him. When asked what was going on, Employee #12 (Security Officer) stated, "I saw [Resident #176] coming in from the courtyard (smoking area) with a bottle of alcohol in his lap that was 75% already drunken. I said to him he's not allowed to have that and he started yelling and cussing at me and got in the elevator. I called [Employee #1/Administrator]. The other security officer came with me and we followed him up here." Resident #176 was admitted to the facility on 08/25/15 with diagnoses that included: Alcohol Abuse with Intoxication, Anemia and Atrial Fibrillation. Review of Resident #176's medical record revealed the following: 10/18/21 [physician's order] "Thiamine (supplement) HCl (Hydrochloride) Tablet 100 MG (milligrams) Give 1 tablet by mouth one time a day for Alcohol abuse"	L 051	**4. MONITORING CORRECTIVE ACTION** House wide audit will be completed by the Unit managers/Designee on residents with 1:1 supervision and residents on oxygen supplements to ensure that comprehensive care plans are accurate and properly implemented. Any negative findings will be corrected upon discovery. This will be completed during the 3 month period (August 2022- October 2022), weekly times four, then monthly for three months. Results to be reviewed during at QAPI meetings for further recommendations. All negative findings will be corrected upon discovery.	2/5/22

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L 051	Continued From page 9 06/02/22 at 9:20 AM "Care Plan Meeting Note ...meeting held today, with the IDT (interdisciplinary team) ...The team discussed the drinking issues of resident as a result of his urine toxicology test comes positive for [alcohol]. Resident agreed that he drinks liquor; the team told him that it is against the policy of the facility, and also for his health, he was encouraged to stop drinking. Most time when he drinks he will [curse] all the staff and not in compliant his care and policies ... [Resident #176] verbalized understanding. Resident has the opportunity to go out to the store for couple of hour, which is how he gets the liquor in ... [Resident #176] was informed by the team that if at another time his urine toxicology comes back positive, his privileges' of going to the store will taken, and he will be giving 30 days quit notice from the facility ..." 08/15/22 at 10:00 AM "Physicians Progress Note ...chronic anemia and alcohol abuse has been residing at [Facility name] since 2015 ...The patient is a chronic smoker and alcohol abuser ...The patient has had intermittent verbal aggression towards the staff ..." 08/19/22 [physician's order] "Patient can go to Walmart with facility staff or family member" Care plan focus area, "[Resident #176] has a behavior problem of drinking liquor in the facility r/t (related to) life style" revised on 08/19/22 showed, " ...can go to Walmart with facility staff or family member ...1:1 supervision while in courtyard (initiated 06/08/22) ..." A Quarterly Minimum Data Set (MDS) dated 08/23/22 showed facility staff coded: a Brief	L 051		12/5/22

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L 051	Continued From page 10 Interview for Mental Status (BIMS) summary score of 15, meaning intact cognition; no physical or verbal behavioral symptoms directed towards others; independent with activities of daily living (ADLs); required supervision for locomotion off the unit; and used a wheelchair for mobility. Review of the smoke aide schedule for 09/22/22 evening shift 3:00 PM - 11:00 PM showed that two employees were scheduled for the courtyard, Employee #16 and #17, both Smoke Aides. During a face-to-face interview conducted on 09/23/22 at 11:39 AM, when asked if she was aware that Resident #176 required 1:1 supervision at all times when in the courtyard, Employee #16 stated, "No." During a telephone interview conducted on 09/23/22 at 11:45 AM, Employee #17 stated that he also was not aware that Resident #176 required 1:1 supervision while in the courtyard. The evidence showed that facility staff failed to implement the care plan intervention of providing Resident #176 with 1:1 supervision while in the courtyard.	L 051		12/5/22
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 09/26/2022

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L 052	Continued From page 11 contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review and staff interview, for three (3) of 63 sampled residents, facility staff	L 052	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #204 and Resident #253 are discharged. Resident #505 care plan was reviewed on 9/22/2022 with no new negative findings. Head to toe assessment on 9/28/2022, with no negative findings. by licensed nurse. Resident #505 was given a 1:1 monitor on 09/20/22 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All resident has the potential to be affected. House wide skin sweep assessments were completed on 11/16/22 on all residents by licensed nurses to identify any skin issues. No new findings from the skin sweep. 3. **MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will educate the Interdisciplinary team regarding the accurate completion of a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment MDS team will conduct a house wide audit of all new admissions for 3 Months(Aug-October), to ensure that an accurate person-centered comprehensive care plan is in place that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 052	Continued From page 12 failed to ensure that sufficient nursing time was provided to: minimize pressure ulcer development for one (1) resident; ensure that one (1) resident was administered his blood pressure medication as ordered by the physician; and supervise one (1) resident who went missing for 30 minutes in the facility. Residents' #204, #253, and #505. The findings included: Review of the facility's "Wound/Pressure Ulcer Management" policy, revised on 10/01/21 showed, "... Any alteration in skin integrity will be reported to the physician immediately..." Review of the facility's policy titled "Smoking policy" with a revision date of 10/01/21, documented "Residents will be supervised by staff when smoking..." Review of the facility's "Wound Prevention Program" policy (not dated) showed, " ...Weekly skin checks will be conducted by the license nurse. This will be documented in the resident's Electronic Medical Record (EMR). Daily, during routine care, the Certified Nursing Assistant will observe the resident's skin. When abnormalities are noted this will be communicated to the licensed nurse..." Review of the facility's "Treatment/Services to Prevent/Heal Pressure" policy (not dated) showed, "... The facility will ensure that ... a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers ... a resident with pressure ulcers receive necessary treatment and services ... to promote healing, prevent infection and prevent e ulcers from developing ... the nurse will notify the physician anytime the pressure sore is showing	L 052	Staff Educator/Designee will conduct in-service/education to all licensed nursing staff and certified nursing assistants on following MD orders regarding skin assessment, prevention of skin breakdown and communicating skin issues to the licensed nurse to ensure the care plans and treatments are in place. Education will be completed by 12/5/2022. House wide skin sweep were conducted on all residents by licensed nurses from 11/8/2022 to 11/16/2022 The licensed nurses will complete a skin assessment upon admission and the wound nurse/designee will complete a thorough skin assessment within 24-48 post-admission and validate all impaired areas were documented and treatments are ordered, and care plan is initiated. Staff Educator/Designee will conduct in-service/education to all licensed nursing staff and certified nursing assistants on following MD orders regarding skin assessment, prevention of skin breakdown and communicating skin issues to the licensed nurse to ensure the care plans and treatments are in place by 12/5/2022. Staff Educator/Designee will conduct in-service/education to all licensed nurses on their responsibility regarding monitoring the nursing assistants to ensure showers are being given and skin assessment completed timely for residents and turning, and positioning is properly implemented per physician orders by 12/5/2022.	12/5/22

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	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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L 052	Continued From page 13 signs of non-healing or infection ..." Review of the "Medication/Treatment Administration Record and Initials" policy dated February 2022 showed, " ...Prior to administration of medication and treatment, the licenses nurse assigned to the resident must check am validate ... right medication ...dosage ... assessment, evaluation. Licensed nurses will administer medication and treatment to residents following the physician orders ..." Review of the facility's policy entitled, "Resident Transportation To and From Medical Appointment" (revised 07/2022) documented, "The assigned Certified Nursing Assistance (Certified Nursing Aide/CNA) or designee will ensure the resident is safe and well strapped and secure with the belt ...while in the transportation van." 1. Facility staff failed to provide Resident #204 with the necessary care and required services to meet the resident's needs resulting in pressure ulcers first observed at advanced stages. Resident #204 was admitted to the facility on 04/21/16 with multiple diagnoses that included: Mild Protein-Calorie Malnutrition, Dementia, Altered Mental Status, Muscle Weakness and Osteoporosis. Review of a Complaint, DC00010905, received by the State Agency on 07/29/22 showed, "... [Facility Name] failed 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 which resulted in her current hospitalization ..."	L 052	Staff Educator/Designee will conduct an in-service/education to all licensed nurse and certified nursing assistants to ensure that documentation on bath and shower sheets and skin assessments accurately reflect the resident's condition by 12/5/2022. **4. MONITORING CORRECTIVE ACTION** MDS Designee will conduct a house wide audit of comprehensive care plans to ensure that they include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. A house wide audit for the 3 months(Aug- October), weekly times four, then monthly for three months. Results to be reviewed during at QAPI meetings for further recommendations. All negative findings will be corrected immediately. Unit Managers/Designee will conduct a weekly skin assessment ongoing and conduct a bath and shower sheet audit weekly x 4 , then monthly x 3 to ensure that these are completed timely and accurately. All negative findings will be addressed upon discovery. Findings will be brought to QAPI monthly for recommendations and review.	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 052	Continued From page 14 Review of Resident #204's medical record revealed the following: 07/14/21 [physician's order] "Monitor skin for easy bruising (EB), bleeding (B), Skin Discoloration (SD), None (N) every shift and Alert MD with any changes, Resident on Aspirin EC (enteric coated) daily" 08/26/21 [physician's order] "Provide incontinent care with each incontinent episode. Wash peri area with soap and water, pat dry and apply barrier cream every shift and as needed" 03/03/22 [physician's order] "Shower twice a week on Monday and Wednesday and per patient request..." (Discontinued on 04/20/22) An Annual Minimum Data Set (MDS) dated 04/13/22, showed that facility staff coded: A Brief interview for Mental Status (BIMS) summary score of 7, indicating severe cognitive impairment; required total dependence with one to -two persons physical assist for bed mobility, transfers; extensive assistance with one person physical assist for toilet use and personal hygiene; frequently incontinent of urine and bowel; active diagnoses of Anemia; no significant weight loss; at risk for pressure ulcers; and no pressure ulcers, wounds or other skin problems. Skin area #1- right foot: 04/18/22 at 4:28 PM "Nurses Note ...Skin warm to touch and no new skin issues noted. Continued to require total care with all ADL (activities of daily living) cares. Turned and repositioned for pressure relief ..."	L 052	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #253 is discharged 10/14/2021. 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who require a psychological evaluation and residents on Midodrine Medication have the potential to be affected. Unit Managers/Designee will conduct a house wide audit of all the residents who require psychological evaluation and all residents on Midodrine medication to ensure that residents are provided psychiatric evaluation and provided Midodrine as prescribed by the physician by 12/5/22. Any issues found will be corrected upon discovery. 3. **MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will conduct in-service/education to all licensed nursing staff and on following ensuring that MD orders are implemented in a timely manner and the importance of accurate medication administration as ordered by the physician. Education will be completed by 12/5/2022.	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 09/26/2022

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L 052	Continued From page 15 04/19/22 at 5:14 PM "Skin Observation Tool (Licensed Nurse) ... skin is intact, warm and well lubricated. No wound" 04/20/22 [Treatment Administration Record (TAR)] facility staff documented "yes", a check mark (meaning administered), and initialed to indicate that a shower was completed. 04/20/22 [physician's order] "Skin Assessment weekly on shower day by license nurse every day shift every Thu (Thursday)" 04/20/22 [physician's order] "Shower twice a week and per patient request every day shift every Thu, Sat (Saturday)" 04/21/22 (Thursday) [Shower/Bath Sheet] " ...12 (skin intact/no irritation); complete bed bath" 04/21/22 [TAR] - facility staff initialed to indicate that the weekly skin assessment was completed 04/22/22 at 7:34 PM "Social Services Note ... IDT (interdisciplinary team) meeting was held ... No sig. (significant) changes to report resident is stable ..." Care plan focus area, "[Resident #204] has an ADL self-care performance deficit r/t (related to) impaired balance and other conditions", reviewed on 04/22/22 showed, "Provide incontinent care with each incontinent episode. Wash peri area with soap and water, pat dry and apply barrier cream every shift and as needed. The resident requires assistance by staff with bathing/showering routinely and as necessary ...The resident requires assistance by staff for toileting..."	L 052	. **4. MONITORING CORRECTIVE ACTION** Unit Managers/Designee will conduct a house wide audit of all the residents who require psychological evaluation and residents on Midodrine medication weekly times four then three times monthly for three months. Results will be given to QAPI monthly for recommendations to ensure services and medications are provided timely and accurately according to the physician's orders. All negative findings will be corrected upon discovery.	12/5/22

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	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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L 052	Continued From page 16 Care plan focus area, "[Resident #204] has bladder and bowel incontinence r/t deconditioning" reviewed on 04/22/22 showed, "Apply moisture barrier cream to skin after each incontinent care. Calazime (skin protectant paste) cream to buttocks and perineal area with incontinent changes every shift. Incontinent check every two hours and change when soiled and PRN (as needed). Report any signs of skin breakdown." Care plan focus area, "[Resident #204] has potential for impairment to skin integrity r/t fragile skin and Aspirin use" reviewed on 04/22/22 showed, "Keep skin clean and dry. Use lotion on dry skin. Provide incontinent care routinely and as needed ..." Care plan focus area, "[Resident #204] is at risk for pressure ulcer development r/t immobility" reviewed on 04/22/22 showed, "...administer medications as ordered ... administer treatments as ordered ... assess/record/monitor wound healing every shift ... report improvements and declines to the MD." 04/23/22 [TAR] facility staff documented "yes", a check mark, and initialed to indicate that a shower was completed 04/23/22 (Saturday) [Shower/Bath Sheet] "...complete bed bath". There was no licensed nurse signature on the form. 04/26/22 at 11:29 AM "Skin Observation Tool (Licensed Nurse) ...No new skin issues noted" Review of the April 2022 TAR from 04/01/22 to 04/28/22, showed that facility staff documented: "N", meaning no or none, in the area that	L 052	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #505 1:1 supervision is in place as indicated in the care plan. Head to toe assessment was completed on 9/28/2022, Resident suffered no negative outcomes. The staffing coordinator and charge nurse will ensure that 1:1 supervision is scheduled without any gaps. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** Unit Managers or DON will conduct a house wide audit of all resident care plans requiring one on one supervision to ensure that this is properly implemented. All negative findings will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will educate the Interdisciplinary team regarding the proper implementation of the care plan on 1:1 supervision to ensure resident safety.. Education will be completed by 12/5/2022 **4. MONITORING CORRECTIVE ACTION** Unit Managers or DON will conduct a house wide audit of all resident care plans requiring one on one supervision to ensure that this is properly implemented. All negative findings will be corrected upon discovery. This will be completed weekly for four weeks then monthly for three months. Findings will be brought to QAPI monthly meeting for further recommendations and review. All negative findings will be corrected upon discovery.	12/5/22

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	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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L 052	Continued From page 17	L 052		12/5/22

directed, "Monitor skin for easy bruising, bleeding, skin discoloration ...every shift and alert MD (medical doctor) with any changes; no refusal of care behaviors; and that the resident was turned and repositioned every two hours.

04/28/22 at 4:56 PM "Podiatry Note ... Patient is seen bedside for thick, elongated toenails and wound right foot ... Skin: Distal aspect of right hallux with noted sanguinous (sp) scab and eschar (dead tissue) to distal aspect, noted purulence and deep probing sinus ... distal aspect of right 5th toe with noted dry sanguinous scab and eschar to distal aspect ... recommend vascular consult to evaluate for healing potential. Ulcer right 5th toe. Dry eschar right 5th toe ... Ulcer right Hallux. Pain right Hallux. Partial debridement of ulcer to patient tolerance. Noted deep probing and purulence during exam ...Recommen startting antibiotics. Please obtain labs: CBC with Diff, CMP, ESR, CMP. Please obtain x-rays of right foot to rule out osteomyelitis of right hallux..."

04/29/22 at 9:23 AM "Tissue Analytics ... Right heel ...Length: 2.45 cm; width: 2.67 cm; Wound acquired 4/29/22; [percent] epithelialization 100.00; Status - new; Acquired in house? Yes; Etiology- pressure ulcer - Suspected DTI (deep tissue injury)...Dressing change frequency - daily, dressngs- skin prep..."

04/29/22 at 1:55 PM "Tissue Analytics Right great toe ... Length: 1.40 cm, width: 1.60 cm; Wound Acquired 4/28/22, [percent] slough/eschar 100.00 ...Status - New; Acquired in House? Yes; Etiology Arterial ...Dressing change frequency BID (twice a day), cleanse wound with- Normal Saline, dressing- Betadine..."

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L 052	Continued From page 18 04/29/22 at 10:20 AM "Situation Background Assessment Request (SBAR) ...Communication Tool...Situation: skin areas on right great toe red right heel. Date problem or symptom started: 04/29/2022 ... resident had podiatry foot care at the bed side and then was observed with a right arterial area to the right great toe. Reddened area to the right heel. Skin intact. MD and RP (representative) aware. Treatment order in place." 04/29/22 at 11:10 AM "Nurses Note Late Entry ... Resident had Podiatry foot care at the bedside on 4/28/22 and a right great toe ulcer was observed after the podiatry care and Resident has reddened right heel, skin is intact. Responsible party... was made aware. No indication of pain. Right heel elevated on a pillow." 04/29/22 at 2:18 PM "Skin/Wound Note... Comprehensive skin and wound evaluation for consult: right heel, right great toe... Dermatologic - wound(s) present...Right heel DTI. Right great toe arterial ulcer...Patient seen by podiatry 4/28/22. Per podiatry, recommend vascular consultation to evaluate healing potential, recommend x-ray of right foot to rule out osteomyelitis of right hallux..." 04/29/22 at 2:21 PM "Skin/Wound Note Late Entry... MD, R/P... made aware of resident's right heel wound and right great toe (podiatry-caused) wound. Nursing staff aware." 05/02/22 [physician's order] "Right great toe surgical site- Paint with Betadine (antiseptic) and secure with bordered gauze twice daily every day and evening shift for wound healing" 05/02/22 [physician's order] "Right heel DTI - Apply Skin prep and leave open to air daily every	L 052		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, DC 20001

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L 052	Continued From page 19	L 052		12/5/22

day shift for wound healing" (discontinued on 05/09/22)

The evidence showed that the Tissue Analytics documented dressing orders however, there was no physician's orders until 05/02/22, 4 days later. Furthermore, there was no documented evidence that licensed staff performed dressing changes during those 4 days.

05/05/22 at 6:02 PM "Podiatry Note ...follow-up wound right foot ... Bandage to right heel left intact, deferred to wound care. Distal aspect of right hallux with noted eschar to distal aspect, noted scant purulence however improved since last exam ...distal aspect of right 5th toe with noted dry sanguinous scab and eschar to distal aspect ... recommend vascular to evaluate for healing potential (ordered) ...Discussed with charge nurse as concern for deep infection..."

05/05/22 [physician's order] "Consult for vascular evaluation for healing potential ..."

05/07/22 at 10:23 PM "Radiology Results Note...Date of Test: 5/6/2022. Type of Test: Right foot, complete, 3+ views ... Findings ... No evidence of osteomyelitis ..."

05/24/22 "Report of Consultation ... Vascular consult for wound healing potential ... findings: dry stable gangrene of r (right) hallux ... Diagnosis: toe gangrene ..."

For Resident #204's right foot, the evidence mentioned above revealed that although facility staff documented to implementing the interventions for Resident #204 from 04/01/22 to 04/27/22, the resident was first observed with a right great toe wound at 100 percent eschar and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 09/26/2022

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L 052	Continued From page 20	L 052		12/5/22

Continued From page 20

a right 5th toe wound at 30 percent eschar on 04/28/22. Facility staff failed to have a doctor's order for dressing changes to the right foot for 4 days and failed to obtain ordered labs in a timely manner.

Skin area #2- sacrum:

06/28/22 at 9:30 AM "Skin Observation Tool (Licensed Nurse) ... Site: Right heel. Type -pressure, length 3.79cm, width-4.58cm, depth, 0.0cm, stage -Suspected Deep Tissue Injury; R. (right) great toe site - type - arterial, length-1.28cm, width-0.71cm, depth -0.0cm, stage-N/A. Resident has treatment orders for the sites and is followed by the wound team."

06/29/22 at 12:26 AM "Nurses Note ... Resident is stable and verbally response ...Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Continue monitoring skin wound on right foot. Wound dressing intact on right heel and right great toe. No drainage noted. Paint with Betadine prep on right great toe in this shift. Provide incontinent care with each incontinent episode. Wash peri- area with soap and water, pat dry and apply barrier cream in the evening shift. Extensive assist for ADL care provided ..."

06/30/22 at 3:25 PM "Nurses Note ... Resident is alert and verbally response ...Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Both heels elevated with pillow to prevent pressure ulcer. Right heel and right great toe wound dressing intact, no drainage and redness noted, ADLS and oral hygiene provided by staff ..."

06/30/22 [Shower/Bath Sheet] " ...12 (skin intact/no irritation)"; "condition of skin" section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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L 052	Continued From page 21	L 052		12/5/22

was left blank; "complete bed bath given".

07/01/22 at 8:02 AM "Nurses Note ...skin remain unchanged dry and warm to touch ...Turned and repositioned every two hours... Right heel and right great toe wound dressing intact ..."

07/02/22 [Shower/Bath Sheet] "condition of skin" section showed facility staff documented a line and "12", indicating skin intact/no irritation and "bed bath"

07/02/22 at 11:40 PM "Nurses Note ... Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Continue monitoring skin wound on right foot. Wound dressing intact 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. Extensive assist for ADL care provided ..."

07/03/22 at 7:43 AM "Nurses Note... Turned and repositioned every two hours. Both heels elevated with pillow to prevent pressure ulcer. Right heel and right great toe wound dressing intact..."

07/03/22 at 3:35 PM "Nurses Note...skin dry and warm to touch...Right heel and right big toe wound dressing is changed...ADL provided by staff."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 22	L 052		12/5/22

Continued From page 22

a little wider in the resident's coccyx area. Dressing done..."

There was no documented evidence that further actions such as further assessment of the resident, notifying the physician, or documenting a request for intervention was taken by the licensed staff on 07/03/22.

07/04/22 at 1:57 PM "Nurses Note ... Skin is warm to touch, well moisturized. No skin bruising, No skin bruising and bleeding noted ... Right heel and right great toe wound dressing intact ..."

Care plan focus area, "[Resident #204] has potential for impairment to skin integrity r/t fragile skin and Aspirin use" showed, " ...07/04/22 IDT meeting held. Care plan reviewed and updated ...Patient has an actual wound/sacral DTI."

Although it was discussed at the care plan meeting, there was no documented evidence that further actions such as further assessment of the resident, notifying the physician, or documenting a request for intervention was taken by the IDT on 07/04/22.

07/05/22 at 10:44 PM "SBAR...Communication Tool... Situation Pressure ulcer on coccyx, approx. 10cm*10cm*0.2...Date problem or symptom started 7/3/2022... Identify whether the problem/symptom has gotten worse/better/stayed the same since it started- Worse... Pressure ulcer of coccyx area got wider and worse...Assessment: 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".

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L 052	Continued From page 23	L 052		12/5/22

07/05/22 at 11:09 PM "Nurses Note...Continue monitoring skin wound on right foot and coccyx area. Wound dressing intact on right heel and right great toe ...The pressure ulcer of coccyx area is more 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, skin discoloration ...every shift and alert MD with any changes"; no refusal of care behaviors; a check mark, and initials to indicate that incontinent care was provided with barrier cream applied to peri area every shift; and that the resident was turned and repositioned every two hours, every shift.

From 07/03/22 to 07/05/22 (3 days), there was no documented evidence facility staff notified the physician or requested any intervention for Resident #204's sacral area.

07/06/22 at 3:30 PM "SBAR...Communication Tool... Situation suspected DTI on the sacral ... Date problem/symptom started 07/06/2022 ...Person contacted ... son [RP] ... Provider visit [medical doctor's name] ..."

07/06/22 at 5:04 PM "Skin Observation Tool (Licensed Nurse) ... Site: sacrum. Type- pressure, length- 9.0cm, width-12.0cm, depth-0.0cm, stage- suspected deep tissue injury. Resident has a new area to the sacrum suspected DTI. Thin. Frail skin. Pressure relief mattress. Treatment order in place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, DC 20001

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L 052		L 052		12/5/22

Continued From page 24

Repositioning every 2 hours. Labs and Dietary consult."

07/06/22 [physician's order] "Sacral Wound: Cleanse with normal saline solution; pat dry, apply silver alginate on wound bed and secure with borded (sp) gauge daily and PRN every day shift for skin care" (discontinued 07/08/22)

Care plan focus area, "[Resident #204] has a new wound site DTI on the sacrum, fragile, thin skin" initiated on 07/06/22 showed, "Monitor/document wound... Notify physician as indicated. Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of infection ..."

07/07/22 at 11:22 AM "Tissue Analytics ... Location; sacrum; length 10.80 cm; width 9.48 cm; depth 0.10 cm ... Date wound acquired 7/6/22; [percent] slough/eschar 30.00; Wound status - new; acquired in house? Yes ..."

For Resident #204's sacrum area, the above evidence revealed that facility staff failed to: accurately assess, document on the resident's skin on 07/03/22 and report signs of worsening skin breakdown. Additionally, facility staff failed to notify the physician for 3 days after the sacrum wound was first documented as "more wider", subsequently, when seen by the wound Nurse Practitioner on 07/07/22, the sacral area measured 10.80 cm by 9.48 cm by 0.10 cm deep with 30% eschar.

During a face-to-face interview on 09/15/22 at 3:25 PM, Employee #2 (Director of Nursing/DON) reviewed the shower/bath sheets for Resident #204 and stated, "When the CNA (Certified Nurse Aide) is giving the resident a shower or bath, the nurse is to go in to do the head-to-toe skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, DC 20001

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L 052	Continued From page 25 assessment with the CNA present. The nurse documents what she sees and they both [CNA and nurse] sign the bath sheet. The "Condition of Skin" section should always be completed. It documents the resident's current wounds or skin issues and anything new that is noted. If the resident refuses the shower, bath or skin assessment, it is documented on the form, the progress note and the MD and RP are notified." During a telephone interview on 09/15/22 at 4:34 PM, Employee #6 (Podiatrist) stated, "I saw [Resident #204] in April (2022) as part of regular podiatry services at the facility done every Thursday. I noted a dry, stable, eschar wound on the right 5th toe and a dry, eschar area near the right big toe. I started to debride the area [right big toe] and pus just started coming out. The nurse was in there with me. I wrote the recommendations [labs, x-ray, and ultrasound] in my note. When I came in on May 5th (2022), I saw that none of the recommendations were followed, so I wrote them again and they were finally ordered." During a face-to-face interview conducted on 09/16/22 at 9:32 AM, Employee #7 (Staff Educator/1 north Unit Manager) reviewed the progress notes and licensed skin assessments for Resident #204 for April 2022 and stated, "Looking at the resident's feet is part of the skin assessment. [Resident #204] started getting the wounds on her right foot treated after she was seen by the podiatrist. The staff [nurses and CNAs] did not mention to me that they observed any skin issues on [Resident #204's] feet." Employee #7 then reviewed the July 2022 progress notes and the 07/05/22 SBAR for Resident #204 and stated, "The staff documented to doing skin assessments but there's no mention	L 052		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	**901 FIRST STREET NW WASHINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 26	L 052		12/5/22

of anything being on her sacrum area until July 3rd [2022]. Whoever first notices the change in the skin is the one who makes the doctor and family aware. The nurses know to notify the doctor immediately for any changes and to document it in the progress notes. This SBAR [dated 07/05/22] was not done properly. Another one was done on the 6th [07/06/22] where the family and doctor were notified."

2. Facility staff failed to ensure that Resident #253 was administered his blood pressure medication as ordered by the physician.

Resident #253 was admitted to the facility on 06/07/21 with multiple diagnoses that included: Dependence on Renal Dialysis, Chronic Atrial Fibrillation and Hypertension.

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 at...Dialysis Center ... At 9:10am, Resident was transported out of the facility via a wheelchair ... At 3:40pm, Dialysis Nurse ...called 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 ... resident had elevated HR (heart rate) during dialysis ...right-sided mouth drop, and slow responds to command outside of baseline..."

Review of Resident #253's medical record revealed the following:

07/25/21 [physician's order] "Dialysis on Tuesday, Thursday and Saturday...for End Stage Renal Disease"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 27	L 052		12/5/22

An Admission Minimum Data Set (MDS) dated 07/31/21 showed facility staff coded: severely impaired cognition and received dialysis while a resident.

Care plan focus area, "[Resident #253] has medical diagnosis of Hypotension" reviewed on 08/03/21 showed "...will maintain BP (blood pressure) within acceptable range as determined by MD (medical doctor)... Give medications as ordered..."

08/10/21 [physician's order] "Midodrine (for low blood pressure) HCl (Hydrochloride) Tablet 5 MG (milligrams), give 1 tablet by mouth three times a day every Mon (Monday), Wed (Wednesday), Fri (Friday), Sun (Sunday) for low bp (blood pressure), please hold if SBP (systolic blood pressure) > (greater than) 110 or HR (heart rate) > (greater than) 60"

Medication Administration Record (MAR) for September 2021 showed that facility staff administered Midodrine 5 MG on the following dates:

09/03/21 at 1:00 PM - SBP 125/77 HR 86
09/05/21 at 9:00 AM - SBP 125/67 HR 78
09/05/21 at 1:00 PM - SBP 125/67 HR 78
09/05/21 at 5:00 PM - SBP 128/76 HR 72
09/10/21 at 9:00 AM - SBP 127/68 HR 80
09/10/21 at 1:00 PM - SBP 127/68 HR 80
09/10/21 at 5:00 PM - SBP 114/76 HR 76
09/12/21 at 5:00 PM - SBP 120/78 HR 68
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 - SBP 120/62 HR 66

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ____ B. WING ____	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 28	L 052		12/5/22

Continued From page 28

09/19/21 at 5:00 PM - SBP 122/74 HR 80
09/20/21 at 9:00 AM - SBP 103/62 HR 91
09/20/21 at 1:00 PM - SBP 114/76 HR 87
09/22/21 at 9:00 AM - SBP 128/78 HR 78
09/22/21 at 1:00 PM - SBP 131/76 HR 86
09/24/21 at 9:00 AM - SBP 116/67 HR 70
09/24/21 at 1:00 PM - SBP 116/67 HR 70
09/27/21 at 9:00 AM - SBP 118/75 HR 100
09/27/21 at 1:00 PM - SBP 118/75 HR 100

The evidence showed that facility staff administered Midodrine 5 MG to Resident #253 when the physician's order directed to not do so when the systolic blood pressure was over 110 and the heart rate was over 60.

During a face-to-face interview conducted on 09/22/22 at 11:32 AM, Employee #19 (2nd Floor Unit Manager) stated that education is provided to nurses about medications and following the parameters for administration.

3. Facility staff failed to provide Resident #505 with a 1:1 monitor on 09/20/22, subsequently the resident went missing for 30 minutes in the facility.

During a unit tour of 3 North conducted on 09/20/22 at 2:52 PM, the surveyor observed that Resident #505 was not in his room. At the time of the observation when asked where Resident #505 was Employee#33 (Unit Manager) stated that she thought the resident was attending a group activity on the first floor.

A second observation on 09/20/22 at approximately 2:53 PM revealed that Resident #505 was not in the activity room on the first floor. Employee#34 (Activities Staff), confirmed that the resident was not in attendance for the activity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, DC 20001

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L 052	Continued From page 29	L 052		12/5/22

Resident #505 was admitted to the facility on 09/02/22 with diagnoses that included: Other Symptoms and Signs Involving Cognitive Awareness, Altered Mental Status, Anxiety Disorder, Schizoaffective Disorder, Unspecified Dementia with Behavioral Disturbance, and Disorientation.

Review of Resident #505's medical record revealed:

09/02/22 [Admission Minimum Data Set (MDS)] documented that facility staff coded Resident #505 with a Brief Interview for Mental Status (BIMS) summary score of "07," indicating severely impaired cognition. Under Section E (Behaviors), facility staff coded the resident for displaying behavior symptoms of hitting, kicking, pushing, scratching, grabbing, threatening, screaming, and cursing others, as well as wandering and intruding on the privacy of others.

09/02/22 [Physician's Order]: "Psychological consult and treatment as needed."

09/03/22 [Physician Order] "Resident on 1:1 Nursing Supervision for Elopement and Fall Risk every shift..."

During a face-to-face interview on 09/20/22 at 3:00 PM, when asked if Resident #505 was still on 1:1 monitoring, Employee #2 (DON) stated "Yes" The surveyor then informed Employee #2 that at approximately 2:55 PM, Resident #505 was not observed in his room, or in the activity group on the first floor. The Employee then stated that she would go to the unit to investigate this herself.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	**901 FIRST STREET NW WASHINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 30 At 3:15 PM on Unit 3 North, the surveyor observed Employee #2 (DON) checking the unit's assignment board. Employee #2 then asked Employee #33 (Unit Manager), "Who was assigned as the one to one monitor for [Resident #505] today? " Employee #33 replied, "I asked Employee #35 (Staffing Coordinator) about this, and he told me there was no one to one coverage for residents on the unit today." It should be noted at 3:20 PM, a "Code Pink-Elopement Risk" was initiated and Resident #505 was located by staff at 3:25 PM in the 3 North dining room. During a second face-to-face interview on 09/20/22 at 3:40 PM, Employee #2 (DON) stated that both Employee #33 (3rd Floor Unit Manager) and Employee #35 (Staffing Coordinator) knew that Resident #505 had orders for 1:1 monitoring, and should have called her if there was any question. Employee #2 acknowledged that facility staff failed to provide adequate 1:1 monitoring and supervision to Resident #505.	L 052		12/5/22
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4.	L 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 31 This Statute is not met as evidenced by: Based on record review and staff interview, facility staff failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per day for seven (7) of 25 days and sixth tenths (0.6) Advance practiced reregistered nurse per resident per day for 17 of 25 days reviewed in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings included: According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. A review of the nurse staffing was conducted on 09/23/22, at approximately 1:00 PM, and of the 25 days reviewed, seven (7) of the days the facility staff failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day and 17 of the days the facility failed to provide a minimum daily average of six tenths (0.6) hours of advanced practiced registered nurse or Registered nurse care as follows: Hours of direct care per resident per day: 03/02/22, showed that the facility provided direct nursing care per resident at a rate of (4.0).	L 056	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** No Resident was affected by this deficient practice 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. 3. **MEASURE TO PREVENT REOCURRENCE** Administrator/Designee will in service the Staffing Coordinator, DON an HR of the need to maintain State mandated PPD Staffing needs to be updated PPD will be evaluated daily by the Staffing coordinator and leadership team Weekly Labor meeting on recruitment will be conducted with Corporate HR, Facility HR. Hiring bonuses approved and implemented. Attendance bonuses approved and implemented.	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 32 03/04/22, showed that the facility provided direct nursing care per resident at a rate of (4.0). 03/05/22, showed that the facility provided direct nursing care per resident at a rate of (3.7). 03/06/22, showed that the facility provided direct nursing care per resident at a rate of (3.3). 04/17/22, showed that the facility provided direct nursing care per resident at a rate of (3.4). 04/18/22, showed that the facility provided direct nursing care per resident at a rate of (3.8). 09/11/22, showed that the facility provided direct nursing care per resident at rate of (4.0). Hours of advanced practiced registered nurse or registered nurse care per resident per day: 03/01/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.53). 03/02/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.44). 03/03/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.57). 03/05/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.36). 03/06/22, showed that the facility provided advanced practiced or registered nurse care per	L 056	4. **MEASURE TO PREVENT REOCURRENCE** Administrator/Designee will conduct weekly audits of staffing issues and Human resources will conduct weekly report on vacancies and hires to Administrator	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 33 resident at a rate of (0.36). 03/07/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.48). 04/17/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.34). 04/18/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.45). 04/19/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.53). 07/04/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.59). 07/05/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.59). 09/06/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.59). 09/09/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.58). 09/12/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.58).	L 056		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 34 09/13/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.58). 09/14/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.50). 09/15/22, showed that the facility provided advanced practiced or registered nurse care per resident at a rate of (0.54). During a face-to-face interview conducted on 09/23/22 at approximately 5:30 PM, Employee #2 (Director of Nursing) acknowledged the findings and made no further comment.	L 056	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #123- Care Plan Updated. Resident was made aware of the risk and benefits related to not changing Oxygen settings on 9/19/2022, Head to toe assessment performed by licensed nurse on 9/21/2022, with no negative findings.	12/5/22
L 076	3215.4 Nursing Facilities As appropriate, ventilator care personnel shall be competent in the following: (a)The fundamentals of cardiopulmonary physiology and of fluids and electrolytes; (b)The recognition, interpretation and recording of signs and symptoms of respiratory dysfunction and medication side effects, particularly those that require notification of a physician; (c)The initiation and maintenance of cardiopulmonary resuscitation and other related life-support procedures; (d)The mechanics of ventilation and ventilator function; (e)The principles of airway maintenance, including endotracheal and tracheotomy care;	L 076	Resident #132 oxygen therapy was set at the ordered level for administration. Licensed nurse will check oxygen levels Q shift to ensure oxygen therapy is set at the ordered level for administration based on physician orders. Resident #132 was made aware of risk and benefits related to not changing oxygen settings on 9/19/2022. Head to toe assessment performed by licensed nurse on 9/21/2022. Resident suffered no negative findings. Resident #185 was discharged to the hospital on 10/2/22. This deficiency cannot be corrected retroactively. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents on Oxygen and tracheostomy have the potential to be affected	

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	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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L 076	Continued From page 35 (f)The effective and safe use of equipment for administrative oxygen and other therapeutic gases and providing humidification, nebulization, and medication; (g)Pulmonary function testing and blood gas analysis when these procedures are performed within the ventilator care unit; (h)Methods that assist in the removal of secretions from the bronchial tree, such as hydration, breathing and coughing exercises, postural drainage,therapeutic percussion and vibration, and mechanical clearing of the airway through proper suctioning technique; (i)Procedures and observations to be followed during and after extubation; and (j)Recognition of and attention to the psychosocial needs of residents and their families. This Statute is not met as evidenced by: Based on observation, record review, and staff interview, for three (3) of 63 sampled residents, facility staff failed to ensure that residents received oxygen/respiratory care in accordance with the physician order. Residents' #123, #132 and #185. The findings included: Review of the policy entitled "Oxygen Concentrator Utilization" revised 10/01/21 documented, " ...Procedure and Implementation ... Weekly change cannula and tubing as to	L 076	Unit Managers/Designee will conduct a house wide audit of all residents on oxygen administration, respiratory care and trach mask. All negative findings will be completed upon discovery. 3. **MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will conduct In-service for licensed nurses on following Physician orders ensure that proper oxygen therapy administration, proper respiratory care and trach mask placement is in its proper place according to the physician's orders. Education will be completed by 12/5/2022. 4. **MONITORING CORRECTIVE ACTION** Unit Managers/Designee will conduct a house wide audit of all residents on oxygen and trach mask in the past 3 months(August 2022-October 2022), then weekly for four weeks and three times monthly for three months. To ensure that resident is administered with the correct oxygen level, proper respiratory care and trach mask placed in the appropriate position. Findings will be brought to QAPI monthly for recommendations and review. All negative findings will be corrected upon discovery.	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 09/26/2022

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L 076	Continued From page 36	L 076		12/5/22

reduce the risk of respiratory infections and other contamination..."

1. Facility staff failed to ensure Resident #123's trach mask was positioned over his trach and that the oxygen therapy level was set at the ordered level for administration.

Resident #123 was admitted to the facility on 10/19/20 with diagnoses that included Acute respiratory Failure, Acute Respiratory Distress Syndrome, Tracheostomy and Cerebral Infarct.

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 neck. The humidified oxygen level was noted at 3.5L [Liters].

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."

Care plan with a revision date of 08/01/22 showed, "[resident name] is on oxygen therapy O2 at 4L/min r/t (related to) ineffective gas exchange."

During a face-to-face interview conducted at the time of the observation, Employee #45 [charge nurse] stated, "The resident keeps moving the trach mask from the position of the trachea." When asked about the oxygen not being at the prescribed level, the employee did not provide an answer.

There was no evidence that facility staff ensure Resident #123 received the 4 liters of oxygen as

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	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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L 076	Continued From page 37	L 076		12/5/22

prescribed by the physician.

2. Facility staff failed to ensure Resident #132's oxygen therapy was set at the ordered level for administration.

Resident #132 was admitted to the facility on 10/19/20 with diagnoses that included Unspecified Asthma, Chronic Respiratory Failure and Acute respiratory Failure.

According to the Quarterly Minimum Data Set dated 08/29/22 the resident was coded as being cognitively intact, required extensive assistance with transferring, with dressing and personal hygiene, had no impartment with range of motion to upper or lower extremities, uses a wheel chair for mobility and was receiving oxygen therapy.

Review of the care plan initiated 02/24/22 showed focus: "[Resident name] is on continuous oxygen therapy at 2L/m [liters per minute] r/t (related to) Respiratory illness..."

Review of the physician's order dated 06/09/22 directed, "Continuous oxygen 2L via nasal cannula every shift for Hypoxia"

During an observation made on 09/13/22 at 2:00 PM, the resident's oxygen level was noted at 3 Liters.

During a face-to-face interview conducted at the time of the observation, Employee #45 (Registered Nurse) stated, "The resident must have changed it, I will educate her."

3. Facility staff failed to provide respiratory care per physician's orders and per the facility's "Oxygen Concentrator Utilization" policy for

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L 076	Continued From page 38 Resident #185. During an observation on 09/19/22 at 4:30 PM, Resident #185 was lying in bed, receiving 3 liters of humidified oxygen via nasal cannula. The humidifier bottle and nasal cannula tubing had a date of "09/11/22" and no initials of the last nursing staff who changed the tubing or humidifier bottle. Resident #185 was admitted to the facility on 05/07/21 with diagnoses that included: Acute and Chronic Respiratory Failure, Diastolic Congestive Heart Failure, Obstructive Sleep Apnea, and Obesity. Review of Resident #185's medical record revealed: An Annual Minimum Data Set (MDS) dated 03/21/22 showed facility staff coded: intact cognition. Under Section O (Special Treatments), requiring oxygen therapy...while a resident within the past 14 days. 06/15/22 [physician's order]: "Change humidifier bottle weekly every night shift every Friday for humidification." 06/15/22 [physician's order]: "Change and replace oxygen concentrator filter weekly every night shift every Friday." 06/15/22 [physician's order]: "Change oxygen tube weekly every night shift every Friday for infection prevention." 08/18/22 [physician's order]: "Date and initial tubing and humidifier bottle, as needed."	L 076		12/5/22

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L 076	Continued From page 39 08/18/22 [physician's order]: "Oxygen at 3 LPM (liters per minute) via nasal cannula continuously every shift for SOB (shortness of breath)." The Treatment Administration Record (TAR) from 09/01/22 to 09/15/22 showed that facility staff initialed to indicate that Resident #185's nasal cannula tubing and humidification bottle were changed. Although facility staff documented that they were changing the nasal cannula tubing and humidifier bottle weekly, the resident's nasal cannula tubing and humidifier bottle were dated on 09/11/22 (more than a week prior to the surveyor's observation on 09/19/22). During a face-to-face interview on 09/19/22 at 4:55 PM, Employee #38 (Weekend Supervisor) stated, "I spoke with the Charge Nurse last night and left supplies. Every Sunday night shift, we are supposed to change it. I am not sure what happened."	L 076	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The following items were corrected upon discovery by the Food Service Manager: 1) 16 of 16 six-inch half-pans were and placed on the dry in rack shelf, ready for use. 2) Two (2) of two (2) convection ovens, two (2) of two (2) grease fryers, one (1) of one (1) meat slicer, and six (6) of seven (7) cutting boards were immediately cleaned upon discovery. 3) Dishwashing machine was repaired immediately upon discovery, and the daily temperature logs are now reflecting the final rinse temperature of at least 180 degrees Fahrenheit. 4) Six (6) of six (6) fire suppression nozzle covers located above the gas stove and the fryers were cleaned and free from grease and lint. 5) Breakfast and lunch food temperatures are adequate and are now testing above 135 degrees Fahrenheit, based on a test tray and food temperature log **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected	12/5/22
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to prepare, serve, and distribute foods under sanitary conditions as evidenced by 16 of 16 six-inch half-pans that were stored wet and ready for use, soiled equipment such as two (2) of two (2) convection ovens, two (2) of two (2) grease fryers, one (1) of one (1) meat slicer, and	L 099		

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L 099	Continued From page 40 six (6) of seven (7) cutting boards, dishwasher temperature logs that were improperly documented, six (6) of six (6) stained fire suppression nozzle covers , and food temperatures that tested below 135 degrees Fahrenheit on two (2) of two (2) food trays assessment. The findings include: 1. 16 of 16 six-inch half-pans were stored wet, on a shelf, ready for use. 2. Two (2) of two (2) convection ovens, two (2) of two (2) grease fryers, one (1) of one (1) meat slicer, and six (6) of seven (7) cutting boards were soiled throughout with food deposits. 3. Dishwashing machine daily temperature logs were improperly documented and failed to show a final rinse temperature of at least 180 degrees Fahrenheit (F) from January 2022 to present. 4. Six (6) of six (6) fire suppression nozzle covers located above the gas stove and the fryers were soiled with grease and lint. 5. Breakfast and lunch food temperatures were inadequate and failed to test above 140 degrees Fahrenheit (F) 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 observations. Employee #14 acknowledged the findings during	L 099	**3. MEASURE TO PREVENT REOCURRENCE** Food Services Manager or designee will conduct an in-service to all dietary staff on the preparation, storage, distribution and serving resident meals in accordance with professional and regulatory standards. Food Service Manager will in-service all dietary staff to ensure equipment in the kitchen is in sanitary conditions. All equipment will be assessed daily for proper functioning and if repair is required it will be communicated immediately. Food Services Manager will conduct an in- service to Food Service staff to take food temperatures before putting it on the food truck and log it. All negative findings will be addressed immediately. All findings will be discussed at the QAPI meeting monthly. 4. **MONITORING CORRECTIVE ACTION** Food Services Manager or designee will conduct a house wide audit on all equipment weekly for four weeks and monthly for 3 months, then will also do an audit of temperature of food when it arrives on the unit weekly for 4 weeks. Negative findings will be addressed immediately, and all other findings will be discussed at the QAPI meeting monthly.	12/5/22

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	HFD02-0010	A. BUILDING: ___ B. WING ___	C 09/26/2022

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L 099	Continued From page 41 a face-to-face interview on September 19, 2022, at approximately 3:30 PM.	L 099		12/5/22
L 109	3220.3 Nursing Facilities If a resident refuses food, appropriate substitutions of comparable nutritive value shall be offered at the same mealtime. This Statute is not met as evidenced by: Based on observations, record reviews, and staff and resident interviews for two (2) of 63 sampled residents, facility staff failed to provide food that reflected the resident's food preferences and failed to ensure that the residents' menu was current and posted in plain sight for a resident to review and failed to make a reasonable effort to provide Resident #152 with double portions of food. Residents' #199 and #152. The findings included: 1.Facility staff failed to provide Resident #199 with foods of her choice/preference. Resident #199 was admitted to the facility on 05/15/22 with diagnoses including Obesity, Diabetes Type 2 Without Complications, Sick-Euthyroid Syndrome, Dysphagia, and Gastroesophageal Reflux Disease. During a face-to-face interview on 09/11/22 at 8:57 AM with Resident #199's she stated, "I have to call the kitchen just about every day. I don't eat scrambled eggs because sometimes they upset my stomach. I have asked for two hard-boiled eggs instead. I am also supposed to get fresh fruit like oranges for breakfast, and I hardly ever get them."	L 109	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #199 Double portions provided as requested per preference on 9/11/2022. No negative finding as a result of this deficient practice. Psych Evaluation on 9/27/2022 with no negative findings. Resident's menu is current and posted in plain sight of the resident for viewing. Resident #152 Double portions provided as requested per preference on 9/11/2022. No negative findings as a result of this deficient practice. Psych Evaluation on 10/14/2022, with No negative finding. Resident's menu is current and posted in plain sight of the resident for viewing. 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. 3. **MEASURE TO PREVENT REOCURRENCE** Food Services Manager or designee will audit menu preferences and portions twice weekly times four for one month then weekly for three months to ensure menu of the provided food reflected the resident's food preferences and also ensure that the residents' menu was current and posted in plain sight for all resident. Findings will be brought to QAPI monthly for recommendations and review. All negative findings will be corrected upon discovery.	

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L 109	Continued From page 42 At the time of the interview, an observation of Resident #199's breakfast tray was conducted. The resident's breakfast tray contained the following items: two scrambled eggs, one slice of whole wheat bread, one sausage patty, grits, one cup of hot tea, and no fruit. A copy of the resident's menu was also on the resident's tray. The menu indicated that the resident had ordered an orange (missing from the tray) and two hard-cooked (scrambled) eggs. A review of Resident #199's medical record revealed: A Quarterly Minimum Data Set dated 08/21/22 showed that facility staff coded the resident as having intact cognition. 09/07/21 [Physician's Order: "NAS (No Added Salt) diet. Regular texture diet. Thin liquids consistency" During an interview on 09/21/22 at 12:40 PM, Employee #40, Assistant Director of Food Services acknowledged the findings and said she conducted an in-service training this morning after hearing that the residents complained about not receiving their food choices. 2. Facility staff failed to ensure the resident menu was current and posted in plain sight for a resident to review and failed to make a reasonable effort to provide Resident #152 with double portions of food. Resident #152 was admitted to the facility on 05/03/22 with multiple diagnoses that included: Pressure-Induced Deep Tissue Damage to Left Heal, Acute Kidney Failure, and Anemia.	L 109	**4. MONITORING CORRECTIVE ACTION** Food Services Manager or designee will audit menu preferences and portions twice weekly for one month then weekly for three months to ensure provided menu reflected the resident's food preferences and failed to ensure that the residents' menu was current and posted in plain sight for a resident. Findings will be brought to QAPI monthly for recommendations and review. All negative findings will be corrected immediately	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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L 109	Continued From page 43	L 109		12/5/22

Continued From page 43

Review of the Quarterly Minimum Data Set (MDS) dated 08/09/22, revealed that the facility staff coded: intact cognition. In section K (Swallowing/Nutritional Status) Resident #152 was coded as having a therapeutic diet and no signs or symptoms of swallowing disorder.

During a face-to-face interview conducted on 09/20/22 at approximately 3:15 PM, Employee #31 (Licensed Nutritionist) regarding the process for residents to get double portions of food. Employee #31 stated, "The nutritionists input the meal tickets and then its up to the tray line staff to make sure the residents get double portions. A double portion is two entrée and two vegetables and two starches."

During a tour of Unit 1 South on 9/20/22 at approximately 3:15 PM the menus were observed posted on a wall behind an activities calendar, and the posted menu was for a previous month. The menu was not accessible to the residents and the print font was small. Employee #31 was asked if Resident #152 received double portions. Employee #31 stated that Resident #152 was not getting the double portions or food alternatives and acknowledged the concerns regarding the food menu was not in plan sight for the resident to review.

An observation and resident interview were conducted on 09/21/22 at approximately 9:40 AM, Resident #152 stated, "I am supposed to get double portions and I have not been getting them, they do not follow the menu and yesterday I got a cup of beans for dinner." At this time, a review of Resident # 152's menu that was located on resident tray documented "2X" which indicates resident is to get a double portion. However, the resident had a single portion of food on his

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L 109	Continued From page 44 breakfast tray. During an interview on 09/21/22 at 12:40 PM, Employee #40, Assistant Director of Food Services acknowledged the findings and said she conducted an in-service training this morning after hearing that the residents complained about not receiving their food choices.	L 109		12/5/22
L 117	3222.2 Nursing Facilities Documentation of the food purchased shall be retained for ninety (90) days. This Statute is not met as evidenced by: Based on record review, resident, and staff interview for three (3) of 63 sampled residents, facility staff failed to: investigate an unusual incident in which a resident was found unresponsive; and to take necessary corrective actions after a resident-to-resident incident. Residents' #53, #148, and #505. The findings included: Review of the facility's policy entitled, "Prohibition of Abuse" revised 02/2022, read: "...Policy: Sexual abuse is non-consensual sexual contact of any type with a resident includes but is not limited to sexual harassment coercion or sexual assault. Procedure ...E. Protection ...3. In the case of a resident abusing another resident, the facility will separate the resident (s) as appropriate during the investigation ...F. Reporting 1.All alleged violations, the Administrator, Director of Nursing, or designee shall notify the Department of Health [State Agency] via the Event Reporting System	L 117	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #53 was admitted to the hospital on 5/31/22 and returned on 6/2/22 in stable condition. Head to toe assessment completed on 6/3/2022, by licensed nurse and suffered no negative outcomes. Resident #148 was discharged 9/27/22. This deficiency cannot be corrected retroactively. Resident #505 was assessed head to toe by licensed nurse on 9/28/22. Resident suffered no negative outcomes. Resident #505 was moved on 9/14/22 to ensure resident safety. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements it's policy on properly investigating any unusual incident; and to take necessary corrective actions after a resident-to-resident incident in a timely manner.	

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	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, DC 20001

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L 117	Continued From page 45 electronically ...within two (2) hours if serious bodily injury occurred or there is an allegation of abuse..." 1.The facility staff failed to investigate an unusual occurrence in which Resident #53 was found unresponsive after going to the courtyard to smoke and subsequently required Naloxone (Opiate antagonists) and transport to the hospital. Resident #53 was admitted to the facility on 12/10/19, with multiple diagnoses that included: Tobacco Use, Hemiplegia and Hemiparesis Following Cerebral Infarction, History of Falling, Cataract, Other Psychoactive Substance Abuse and Cognitive Communication Deficit. Review of the medical record revealed the following: 03/22/22 [Quarterly Minimum Data Set (MDS)] showed that the facility staff coded: intact cognition. Resident has no impairment in the upper or lower extremity, and uses a wheelchair and walker for mobility. Review of the physicians' orders revealed the following: 05/31/22 [Physician Order] "Send the resident to the nearest ER (emergency room) due to change in mental status one time only ..." 05/31/22 at 5:04 PM [Nursing Progress] " ...Resident returned from courtyard with suspected ingestion of opioids around 2:40 PM with clinical characteristics of unresponsiveness, slow breathing, sleepiness and sweating. Resident (has a) is a history of psychoactive substance abuse ...notified DR (Doctor) ...and	L 117	**3. MEASURE TO PREVENT REOCURRENCE** Education/ Designee will in-service all staff and leadership on the Abuse Policy and procedures to ensure the facility implements its policy on properly investigating any unusual incident; and to take necessary corrective actions after a resident-to-resident incident in a timely manner. This will be completed 12/5/2022. Incidents and accidents are discussed during the clinical meetings to ensure the facility implements it's policy on investigating incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. Any negative findings will be corrected upon discovery if applicable. **4. MONITORING CORRECTIVE ACTION** LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements it's policy on investigating incident of alleged abuse, take necessary corrective actions after a resident-to-resident incident and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner, weekly for four weeks and monthly for three months. Results of finding will be forward to QAPI for review and recommendations.	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, DC 20001

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L 117	Continued From page 46	L 117		12/5/22

naloxone (opiate antagonists) 2 doses of 0.4mg/ml is administered at 2:50 pm and 3:00 pm intramuscular to reverse Opioid overdose. After the injection the resident is still unresponsive and breathing is low and shallow ...911 took the resident to (hospital) for further treatment and left the facility at 3:58 pm ..."

05/31/22 at 5:50 PM [Nursing Progress] " ...Resident is a smoker and was observed around 2.45pm when he returned from smoking in the court yard to have a change in his mental and physical status, sweating profusely. Resident was assisted to his bed and a complete head to toe assessment done, pupils were fixed and dilated, sweating profusely and could not answer questions, skin was warm to touch, breathing was shallow-respiratory. Oxygen started at 2 liters a minute via nasal cannula ...Resident had vital signs but still not responding to touch and voice ..."

The medical record lacked any documented evidence that the facility investigated resident's episode of becoming unresponsive on 05/31/22.

During a face-to-face interview conducted on 09/21/22 at approximately 5:00 PM, Employee #2 (Director of Nursing) when asked if the facility investigated the resident's episode of unresponsiveness that occurred on 05/31/22, Employee #2 stated, "We do not have it."

2. Facility staff failed to take the necessary corrective action of separating Residents' #505 and #148 after a resident-to-resident incident.

On 09/06/22 at 7:42 PM the facility submitted a Department of Health (DOH) Complaint/ Incident Report Form that documented the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, DC 20001

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L 117	Continued From page 47	L 117		12/5/22

following:..."Aggressive Behavior (Resident to Resident) [Resident #505] ...Aggressor ... Victim ...[Resident #148]... [Resident #505] oriented to self, otherwise very confused. On 1:1 Nursing supervision...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 #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 documented that facility staff coded: severely impaired cognition; displayed behavior symptoms of hitting, kicking, pushing, scratching, grabbing, threatening, screaming, and cursing others, wandering, and intruding on the privacy of others.

09/02/22 [Care Plan]: "[Resident #505] has potential to be physically aggressive r/t (related to) Dementia...Goal:[Resident #505] will not harm self or others...Interventions: Modify environment..."

09/03/22 [Physician Order]: "Resident on 1:1 Nursing Supervision for Elopement and Fall Risk every shift ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, DC 20001

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L 117	Continued From page 48	L 117		12/5/22

SBAR [Situation, Background, Assessment/Appearance, and Request Communication Tool] dated 09/06/22 documented: " Situation: Pushing another resident to the floor ...pushed the resident [Resident # 148], who was coming from the bathroom to the floor...Resident [#505] was redirected and taking (taken) to his room by 5 (five) nursing staff..."

1B. Resident #148 was admitted to the facility on 07/28/22 with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Seizures, and History of Falling.

Review of Resident #148's medical record revealed:

An Admission Minimum Data Set (MDS) dated 08/03/22 documented that facility staff coded: intact cognition; not steady; and only able to stabilize with staff assistance when moving on or off the toilet and from seated to standing.

09/06/22 [Situation, Background, Assessment/Appearance, and Request (SBAR] documented, "... [Resident #148], was pushed by another resident to the floor with no injury ...complained of lower back pain, [with a pain rating] of 3/10...order given for lumbar and vertebra X-ray to R/O (rule out) fracture due to fall ..."

09/08/22 [Physician Order]: "Transfer resident to the nearest ER (Emergency Room) for further evaluation of rib pain."

Review of the facility's alpha census on 09/20/22 showed that Resident #505 and Resident #148 remained on the same unit after the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 117	Continued From page 49 During a face-to-face interview on 09/20/22 at 2:06 PM, Employee #30, Night Supervisor, stated that he received a call from Employee #31, Charge Nurse on the Second Floor, that Resident #505 had pushed Resident # 148 down. Staff separated the two residents and redirected Resident #505 to his room. Resident #148 did not want to be moved at first and seemed to be in pain. The resident said she called the police, so I called 911 for an ambulance to have her evaluated and transferred to the hospital. The employee then stated, "After speaking with the Director of Nursing (DON) today, I understand that I should have also called the police." He added that Resident #505 remained on 1:1 monitoring, but both residents remained on the same unit until their quarantine periods were over.	L 117		12/5/22
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications;	L 128	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Narcotic count completed and all narcotics were presented and accounted for on 9/12/2022. No residents had any negative findings related to this deficient practice. 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. 3. **MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will conduct In-service for licensed nurses on narcotic counts reconcile controlled medications per the standards of practice by 12/5/2022. 4. **MONITORING CORRECTIVE ACTION** ADON or designee will conduct house wide audit all narcotic counts, weekly for four months, to ensure Facility staff reconcile controlled medications per the standards of practice findings will be brought to QAPI monthly for recommendations and review. All negative findings will be corrected immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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L 128	Continued From page 50	L 128		12/5/22

(d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and

(e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled.
This Statute is not met as evidenced by:
Based on record review and staff interviews, for four (4) of eight (8) nursing units, the facility staff failed to account for the receipt, usage, disposition, and reconciliation of controlled medications.

The findings included:

Review of the "Receiving Controlled Substances" policy revised August 2020 showed, " ...The following information is completed ...upon receipt of the controlled substance: name of resident ... drug name, strength and dosage, date received, quantity received, name of person receiving medication ...

Review of the "Controlled Substances" policy revised August 2020 showed, " ... Accurate inventory of all controlled medications is maintained t all times. When a controlled substance is administered, the licensed nursing personnel administering the medication immediately enters the following information on the accountability record ... date and time of administration; amount administered, remaining quantity, signature of the nursing personnel administering the dose ..."

1. A review of the Shift count Narcotic records on Unit 3 North was completed on September 12,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ____ B. WING ____	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 128	Continued From page 51 2022, at approximately 9:10 AM, and it showed the following activity in the Narcotic reconciliation record for the following dates: 8/4/2022 11-7 shift same nurse signed coming on and going off duty 8/14/2022 11-7 shift same nurse signed coming on duty and going off duty 8/16/2022 7-3 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 one nurse signed coming on and going off duty was left blank 8/27/2022 11-7 shift same nurse signed coming on and going off duty 8/30/2022 7-3 shift same nurse signed coming on and going off duty 8/31/2022 7-3 shift one nurse signed coming on and going off duty was left blank 8/31/2022 11-7 shift count and nurse coming on duty left blank and one nurse signed going off duty 9/4/2022 11-7 shift same nurse signed coming on and going off duty 9/8/2022 7-3 shift same nurse signed coming on and going off 9/9/2022 7-3 shift same nurse signed coming on and going off 9/10/2022 11-7 shift same nurse signed coming on and going off 2. A review of the Shift count Narcotic records on Unit 3 South was completed on September 12, 2022, at approximately 9:30 AM, and it showed the following activity in the Narcotic reconciliation record for the following dates: 8/2/2022 3-11 shift same nurse signed coming on and going off duty	L 128		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 128	Continued From page 52 8/6/2022 3-11 shift same nurse signed coming on and going off duty 8/6/2022 11-7 shift nurse coming on duty left blank and one nurse signed going off duty 8/7/2022 7-3 shift one nurse signed coming on duty and going off duty was left blank 8/14/2022 3-11 shift same nurse signed coming on duty and going off duty 8/15/2022 11- 7 shift same nurse signed coming on duty and going off duty 8/16/2022 3-11 shift same nurse signed coming on duty and going off duty 8/18/202211-7 shift same nurse signed coming on and going off duty 8/19/2022 7-3 shift same nurse signed coming on and going off duty 8/19/2022 3-11 shift same nurse signed coming on and going off duty 8/19/2022 11-7 shift same nurse signed coming on and going off duty 8/20/2022 3 -11 shift same nurse signed coming on and going off duty 8/22/2022 3-11 shift one nurse signed coming on duty and going off duty was left blank 8/23/2022 3-11 shift same nurse signed coming on and going off duty 8/25/2022 3-11 shift same nurse signed coming on and going off duty 8/25/2022 11-7 shift coming on duty was left blank and one nurse signed going off duty 8/26/2022 7-3 shift one nurse signed coming on duty and going off duty was left blank 8/28/2022 3-11 shift same nurse signed coming on duty and going off duty 8/29/2022 7- 3 shift one nurse signed coming on duty and going off duty was left blank 8/29/2022 3-11 shift same nurse signed coming on duty and going off duty 9/1/2022 3-11 shift same nurse signed coming on and going off duty	L 128		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ___ B. WING ___	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 53 9/3/2022 3-11 shift same nurse signed coming on and going off duty 9/5/2022 3-11 shift same nurse signed coming on and going off duty The review of the above-mentioned dates showed that the Shift count Narcotic on the Unit 3North and Unit 3South was missing the two (2) nurse's signatures (indicating it was not done) in the space allotted for one (1) nurse to sign coming on duty and another nurse to sign going off duty, and coming on/ going off spaces allotted for two (2) nurses signatures were left blank [no signatures]. A review of the facility Shift Verification of Accuracy of Controlled Drug Record to the Actual Narcotic Count Policy states, "Reconciliation Controlled Drug Count Verification Form" directed, "Shift count sheet for Narcotics balance must be verified by the nurse coming on duty and nurse going off duty at each change of shift". The evidence showed that licensed nursing staff failed to adhere to an acceptable standard of practice to reconcile the verification of controlled substances on the aforementioned dates and shifts. A face-to-face interview was conducted with Employees #2 (Director of Nursing) and #3 (Assistant Director of Nursing) on September 23, 2022, at approximately 3:00 PM. They acknowledged the findings. 3. Facility staff failed to reconcile controlled medications per the standards of practice in two (2) observations on unit 4 south. 3A. During an observation on 09/11/22 at 6:12	L 128		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 128		L 128		

Continued From page 54

AM on unit 4 south, the Controlled Drug Count Verification Form" showed: "9/11/22"; shift "7:00 AM"; correct drug count "yes"; balance verified by nurse coming on duty - this area was blank; balance verified by nurse going off duty - "[Employee #20's (Licensed Practical Nurse) " signature.

3B. During a controlled medication count on 09/11/22 at 6:12 AM on Unit 4 south with Employee #20, it was noted that there was one blister packet of Pregabalin (for nerve pain) and one blister packet of Lorazepam (antianxiety) in the narcotic lock box that were not logged into the "Controlled Drug Count Verification Form".

During a face-to-face interview conducted at the time of the observations, Employee #20 stated, "I cross checked the narcotic count with myself so I can leave a little early today. The supervisor was going to sign, and I was going to give him the keys." When asked is this the standard of practice for counting controlled medications, Employee #20 stated, "No." Regarding the two controlled medications not logged into the count, Employee #20 stated, "These medications were delivered last night. I forgot to log them into the book."

4. Facility staff failed to reconcile controlled medications per the standards of practice in one observation on unit 4 north.

During a medication administration observation on 09/16/22 at approximately 1:53 PM on unit 4 north, Resident #188 was administered Phenobarbital (anti-seizure) Solution.

Resident #188 was admitted to the facility on 08/21/96 with multiple diagnoses that included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 55 Seizures, Encephalopathy and Psychotic Disorder with Delusions. Review of Resident #188's medical record showed a physician's order starting on 09/03/21 that directed, "Phenobarbital Solution 20 MG (milligrams)/5ML (milliliters), give 7.5 ml by mouth every 8 hours for Seizures" with administration times of 5:00 AM, 1:00 PM and 9:00 PM. Review of the September 2022 Medication Administration Record (MAR) showed that facility staff documented a check mark and then initialed to indicate that the Phenobarbital was administered as ordered to Resident #188 at 1:00 PM on 09/14/22. However, review of Resident #188's narcotic log for the Phenobarbital showed "... 9/14/21 [at] 5 AM 7.5 ml, [Nurse signature], 9/14/21 [at] 9 PM, [Nurse signature]..." The evidence showed that although it was documented as administered, facility staff failed to document that a dose was taken out on 09/14/22 at 1:00 PM in the narcotic log. During a face-to-face interview conducted on 09/16/22 at approximately 2:00 PM, Employee #10 (4th Floor Unit Manager) reviewed the document and made no further comment.	L 128		12/5/22
L 142	3226.2 Nursing Facilities Each dose of medication shall be properly and promptly recorded and initiated in the resident's medical record by the person who administers it. This Statute is not met as evidenced by: Based on record review and staff interview, in one (1) of one (1) observation, facility staff failed to properly and promptly record and initial in the	L 142		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 142	Continued From page 56 resident's medical record by the person who administered the medication. Resident #188. The findings included: During a medication administration observation on 09/16/22 at approximately 1:53 PM on unit 4 north, Resident #188 was administered Phenobarbital (anti-seizure) Solution. Resident #188 was admitted to the facility on 08/21/96 with multiple diagnoses that included: Seizures, Encephalopathy and Psychotic Disorder with Delusions. Review of Resident #188's medical record showed a physician's order starting on 09/03/21 that directed, "Phenobarbital Solution 20 MG (milligrams)/5ML (milliliters), give 7.5 ml by mouth every 8 hours for Seizures" with administration times of 5:00 AM, 1:00 PM and 9:00 PM. Review of the September 2022 Medication Administration Record (MAR) showed that facility staff documented a check mark and then initialed to indicate that the Phenobarbital was administered as ordered to Resident #188 at 1:00 PM on 09/14/22. However, review of Resident #188's narcotic log for the Phenobarbital showed "... 9/14/21 [at] 5 AM 7.5 ml, [Nurse signature], 9/14/21 [at] 9 PM, [Nurse signature]..." The evidence showed that although it was documented as administered, facility staff failed to document that a dose was taken out on 09/14/22 at 1:00 PM in the narcotic log. During a face-to-face interview conducted on 09/16/22 at approximately 2:00 PM, Employee #10 (4th Floor Unit Manager) reviewed the	L 142	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Narcotic count completed and all narcotics were presented and accounted for on 9/12/2022. No residents had any negative findings related to this deficient practice. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. Resident #188 narcotic medication was properly administered on 9/14/22, however the failure to document in the narcotic log cannot be retroactively corrected. Resident suffered no negative findings as a result of this deficiency. **3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will conduct In-service for licensed nurses on narcotic counts reconcile controlled medications per the standards of practice by 12/5/2022. **4. MONITORING CORRECTIVE ACTION** ADON or designee will conduct house wide audit all narcotic counts, weekly for four months, to ensure Facility staff reconcile controlled medications per the standards of practice findings will be brought to QAPI monthly for recommendations and review. All negative findings will be corrected immediately.	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 142	Continued From page 57 document and made no further comment.	L 142		12/5/22
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a)The date, time, and description of the incident; (b)The name of the witnesses; (c)The statement of the victim; (d)A statement indicating whether there is a pattern of occurrence; and (e)A description of the corrective action taken. This Statute is not met as evidenced by: Based on record review, resident, and staff interview for three (3) of 63 sampled residents, facility staff failed to: investigate an unusual incident in which a resident was found unresponsive; and to take necessary corrective actions after a resident-to-resident incident. Residents' #53, #148, and #505. The findings included: Review of the facility's policy entitled, "Prohibition of Abuse" revised 02/2022, read: "...Policy: Ssexual abuse is non-consensual sexual contact of any type with a resident includes but is not limited to sexual harassment coercion or sexual assaulI. Procedure ...E. Protection ...3. In the case of a resident abusing another resident, the	L 204	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #53 was assessed head to toe on 9/20/22 by the licensed nurse. Resident suffered no negative outcomes. Resident #148 is discharged. Resident # 505 received psychological evaluation and is stable. Psych evaluation on 10/7/22 and 10/11/22. Head to toe assessment completed 9/28/2022 by licensed nurse, with no negative findings. 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements it's policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner 3. **MEASURE TO PREVENT REOCURRENCE** Education/ Designee will in-service all staff and leadership to ensure the facility implements it's policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. This will be completed by 12/5/22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 09/26/2022

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L 204	Continued From page 58 facility will separate the resident (s) as appropriate during the investigation ...F. Reporting 1.All alleged violations, the Administrator, Director of Nursing, or designee shall notify the Department of Health [State Agency] via the Event Reporting System electronically ...within two (2) hours if serious bodily injury occurred or there is an allegation of abuse..." 1. The facility staff failed to investigate an unusual occurrence in which Resident #53 was found unresponsive after going to the courtyard to smoke and subsequently required Naloxone (Opiate antagonists) and transport to the hospital. Resident #53 was admitted to the facility on 12/10/19, with multiple diagnoses that included: Tobacco Use, Hemiplegia and Hemiparesis Following Cerebral Infarction, History of Falling, Cataract, Other Psychoactive Substance Abuse and Cognitive Communication Deficit. Review of the medical record revealed the following: 03/22/22 [Quarterly Minimum Data Set (MDS)] showed that the facility staff coded: intact cognition. Resident has no impairment in the upper or lower extremity, and uses a wheelchair and walker for mobility. Review of the physicians' orders revealed the following: 05/31/22 [Physician Order] "Send the resident to the nearest ER (emergency room) due to change in mental status one time only ..." 05/31/22 at 5:04 PM [Nursing Progress] "	L 204	Incidents and accidents are discussed during the clinical meetings to ensure the facility implements it's policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. Any negative findings will be corrected upon discovery if applicable. 4. **MONITORING CORRECTIVE ACTION** LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements it's policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner, weekly for four weeks and monthly for three months. Results of finding will be forward to QAPI for review and recommendations.	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 204	Continued From page 59	L 204		12/5/22

Continued From page 59

...Resident returned from courtyard with suspected ingestion of opioids around 2:40 PM with clinical characteristics of unresponsiveness, slow breathing, sleepiness and sweating. Resident (has a) is a history of psychoactive substance abuse ...notified DR (Doctor) ...and naloxone (opiate antagonists) 2 doses of 0.4mg/ml is administered at 2:50 pm and 3:00 pm intramuscular to reverse Opioid overdose. After the injection the resident is still unresponsive and breathing is low and shallow ...911 took the resident to (hospital) for further treatment and left the facility at 3:58 pm ..."

05/31/22 at 5:50 PM [Nursing Progress] " ...Resident is a smoker and was observed around 2.45pm when he returned from smoking in the court yard to have a change in his mental and physical status, sweating profusely. Resident was assisted to his bed and a complete head to toe assessment done, pupils were fixed and dilated, sweating profusely and could not answer questions, skin was warm to touch, breathing was shallow-respiratory. Oxygen started at 2 liters a minute via nasal cannula ...Resident had vital signs but still not responding to touch and voice ..."

The medical record lacked any documented evidence that the facility investigated resident's episode of becoming unresponsive on 05/31/22.

During a face-to-face interview conducted on 09/21/22 at approximately 5:00 PM, Employee #2 (Director of Nursing) when asked if the facility investigated the resident's episode of unresponsiveness that occurred on 05/31/22, Employee #2 stated, "We do not have it."

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	HFD02-0010	A. BUILDING: ___ B. WING ___	C 09/26/2022

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L 204	Continued From page 60	L 204		

2. Facility staff failed to take the necessary corrective action of separating Residents' #505 and #148 after a resident-to-resident incident.

On 09/06/22 at 7:42 PM the facility submitted a Department of Health (DOH) Complaint/ Incident Report Form that documented the following:..."Aggressive Behavior (Resident to Resident) [Resident #505] ...Aggressor ...Victim ...[Resident #148]... [Resident #505] oriented to self, otherwise very confused. On 1:1 Nursing supervision...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 #148] down to the floor while she was coming out of her bathroom...."

Resident #505:

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 documented that facility staff coded: severely impaired cognition; displayed behavior symptoms of hitting, kicking, pushing, scratching, grabbing, threatening, screaming, and cursing others, wandering, and intruding on the privacy of others.

09/02/22 [Care Plan]: "[Resident #505] has

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	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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L 204		L 204		

Continued From page 61

potential to be physically aggressive r/t (related to) Dementia...Goal:[Resident #505] will not harm self or others...Interventions: Modify environment..."

09/03/22 [Physician Order]: "Resident on 1:1 Nursing Supervision for Elopement and Fall Risk every shift ..."

SBAR [Situation, Background, Assessment/Appearance, and Request Communication Tool] dated 09/06/22 documented: " Situation: Pushing another resident to the floor ...pushed the resident [Resident # 148], who was coming from the bathroom to the floor...Resident [#505] was redirected and taking (taken) to his room by 5 (five) nursing staff..."

Resident #148:

Resident #148 was admitted to the facility on 07/28/22 with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Seizures, and History of Falling.

Review of Resident #148's medical record revealed:

An Admission Minimum Data Set (MDS) dated 08/03/22 documented that facility staff coded: intact cognition; not steady; and only able to stabilize with staff assistance when moving on or off the toilet and from seated to standing.

09/06/22 [Situation, Background, Assessment/Appearance, and Request (SBAR) documented, "... [Resident #148], was pushed by another resident to the floor with no injury ...complained of lower back pain, [with a pain

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L 204	Continued From page 62 rating] of 3/10...order given for lumbar and vertebra X-ray to R/O (rule out) fracture due to fall ..." 09/08/22 [Physician Order]: "Transfer resident to the nearest ER (Emergency Room) for further evaluation of rib pain." Review of the facility's alpha census on 09/20/22 showed that Resident #505 and Resident #148 remained on the same unit after the incident. During a face-to-face interview on 09/20/22 at 2:06 PM, Employee #30, Night Supervisor, stated that he received a call from Employee #31, Charge Nurse on the Second Floor, that Resident #505 had pushed Resident # 148 down. Staff separated the two residents and redirected Resident #505 to his room. Resident #148 did not want to be moved at first and seemed to be in pain. The resident said she called the police, so I called 911 for an ambulance to have her evaluated and transferred to the hospital. The employee then stated, "After speaking with the Director of Nursing (DON) today, I understand that I should have also called the police." He added that Resident #505 remained on 1:1 monitoring, but both residents remained on the same unit until their quarantine periods were over.	L 204		12/5/22
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of	L 206		

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L 206	Continued From page 63 occurrence. This Statute is not met as evidenced by: Based on observation, record review, resident and staff interviews, for three (3) of 63 sampled residents the facility staff failed to: report an incident of alleged staff of resident abuse/mistreatment the State Agency; report an unusual incident in which a resident was found unresponsive after going into the courtyard; and to report resident allegation of abuse [sexual] to the state Department in a timely manner. Residents' #193, #53, and #191. The findings included: Review of the facility's policy titled "Prohibition of Abuse" revised on 02/22, stated "...Anyone who has knowledge of any kind of abuse should report immediately to their immediate Supervisor. During the Weekend Administrator or Manager on Duty ... or in his/her absence, the Nursing Supervisor or his/her designee. Staff will complete an incident/accident form for any unusual occurrences and submit it to the Director of Nursing or designee. ...All alleged violations, the administrator, Director of Nursing or designee shall notify the Department of Health, via the Event Reporting System electronically or by phone in the event the electronic system being unavailable within twenty four (24) hours of knowledge of the alleged incident and within two (2) hours if serious bodily injury has occurred or there is an allegation of abuse..." 1. The facility's staff failed to report an incident of alleged abuse that Resident #193 made to staff to the State Agency. Resident #193 was admitted to the facility on 05/18/22, with multiple diagnoses that included	L 206	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #193 was assessed by Licensed nurse on 9/20/22. Skin Assessment and S-Bar completed, and found not to be in distress. Resident #53 was assessed head to toe on 9/20/22 by the licensed nurse. Resident suffered no negative outcomes. Resident #191 was separated from Resident #148 to ensure resident safety. Resident #191 was assessed head to toe on 9/20/22 by licensed nurse. Resident suffered no negative outcomes. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements it's policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. **3. MEASURE TO PREVENT REOCURRENCE** Education/ Designee will in-service all staff and leadership to ensure the facility implements it's policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. This will be completed by 12/5/22.	12/5/22

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L 206	Continued From page 64 the following: Diabetes Mellitus Without Complications Type 2, Hemiplegia Affecting Left Nondominant Side, Post Traumatic Stress Disorder and Major Depressive Disorder. An observation and resident interview were conducted on 09/13/22 at 3:00 PM, with Resident #193, he stated "An aide gets angry with me in the morning because I have diarrhea, she told me she is not going to change me in the morning. While in the room she talks loud on her phone and curses and uses explicit language." Resident #193 went on to explain that the aide was in the room with another staff who he said was from "speech" (Speech language pathologist) and the other staff observed what occurred. Review of the medical record revealed the following: A Quarterly Minimum Data Set (MDS) dated 08/19/22, showed that the facility's staff coded the following: intact cognition; totally dependent for toilet use and personal hygiene requiring one (1) staff assist; bathing resident was totally dependent on staff and requiring the support of two (2) staff; impairment on both sides for both the upper and lower extremities. Review of the facility's grievance folder showed no documented evidence of the allegation of abuse/neglect that Resident #193 made concerning the incident with the aide and there was no evidence in the medical record of a report made to the State Agency as of 09/15/22. During a face-to-face interview conducted on 09/13/22 at 4:07 PM, Employee #2 (Director of Nursing) was questioned by the Surveyor and asked if the facility conducted an investigation	L 206	Incidents and accidents are discussed during the clinical meetings to ensure the facility implements it's policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. Any negative findings will be corrected upon discovery if applicable. 4. **MONITORING CORRECTIVE ACTION** LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements it's policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner, weekly for four weeks and monthly for three months. Results of finding will be forward to QAPI for review and recommendations. .	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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L 206	Continued From page 65	L 206		

and reported Resident #193's allegation of abuse to the State Agency. Employee #2 stated, "He never reported any of this to me." Employee #2 also stated that they had not reported this to the state agency.

During a face-to-face interview conducted on 09/15/22 at 3:14 PM, Employee #25 (Speech language pathologist) stated "He (Resident #193) communicated many things about his care to me. I was there when he was refused care by a CNA (Certified Nurse Aide) due to her needing to deal with other residents. It was very unprofessional, dismissive, inconsiderate tone, harsh, critical and not respectful. I spoke to my supervisor and reported this ..."
Employee #25 went on to explain that the incident happened on Monday 09/12/22, and she said that she reported this to her supervisor that day.

During a face-to-face interview conducted on 09/15/22 at approximately 3:30 PM, Employee #48 (Director of Rehab) stated "(Employee #25) told me on that day of a conversation that resident had with staff, and he asked staff to change his diaper. Employee #48 went on to explain that Employee #25 described the CNA's behavior as rude and that he did not tell anyone about it.

2. Facility staff failed to report an unusual incident where Resident #53 was found unresponsive after going into the courtyard to smoke.

Resident #53 was admitted to the facility on 12/10/19, with multiple diagnoses that included: Tobacco Use, Hemiplegia and Hemiparesis Following Cerebral Infarction, History of Falling, Cataract, Other Psychoactive Substance Abuse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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L 206	Continued From page 66 and Cognitive Communication Deficit. Review of the medical record revealed the following: 03/22/22 [Quarterly Minimum Data Set (MDS)] showed that the facility staff coded: intact cognition. Resident has no impairment in the upper or lower extremity, and uses a wheelchair and walker for mobility. Review of the physicians' orders revealed the following: 05/31/22 [Physician Order] "Send the resident to the nearest ER (emergency room) due to change in mental status one time only ..." 05/31/22 at 5:04 PM [Nursing Progress] " ...Resident returned from courtyard with suspected ingestion of opioids around 2:40 PM with clinical characteristics of unresponsiveness, slow breathing, sleepiness and sweating. Resident (has a) is a history of psychoactive substance abuse ...notified DR (Doctor) ...and naloxone (opiate antagonists) 2 doses of 0.4mg/ml is administered at 2:50 pm and 3:00 pm intramuscular to reverse Opioid overdose. After the injection the resident is still unresponsive and breathing is low and shallow...911 took the resident to (hospital) for further treatment and left the facility at 3:58 pm ..." 05/31/22 at 5:50 PM [Nursing Progress] " ...Resident is a smoker and was observed around 2.45pm when he returned from smoking in the court yard to have a change in his mental and physical status, sweating profusely. Resident was assisted to his bed and a complete head to toe assessment done, pupils were fixed and dilated,	L 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 206	Continued From page 67	L 206		

sweating profusely and could not answer questions, skin was warm to touch, breathing was shallow-respiratory. Oxygen started at 2 liters a minute via nasal cannula ...Resident had vital signs but still not responding to touch and voice ..."

The medical record lacked any documented evidence that the facility reported to the State Agency, the unusual occurrence in which Resident #53 became unresponsive and was given Naloxone and sent to the hospital.

During a face-to-face interview conducted on 09/21/22 at approximately 5:00 PM, Employee #2 (Director of Nursing) she acknowledged the findings and stated "Do I need to submit to DOH (Department of Health) (State Agency) for unresponsiveness?"

3. Facility staff failed to follow its policy evidenced by failure to report Resident #191's allegation of abuse [sexual] to the state Department in a timely manner.

Resident #191 was admitted to the facility on 06/09/21 with multiple diagnoses including Depressive Disorder, Anxiety Disorder, Schizoaffective Disorder, Hyperlipidemia, Hypertension Diabetes Mellitus, Anemia, and Chronic Renal Disease.

During a face-to-face interview conducted with Resident #191on 09/12/22 at 2:00 PM, when asked about being abused she stated, "My roommate came to my bed at night, take my blanket off, try to have sex with me. I reported her and call the police on her."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 206	Continued From page 68	L 206		

Review of the DOH Complaint/Incident Report form showed facility submitted it to the state agency on: 08/10/22 at 10:23 AM documented, "[Resident name] ... admitted on 06/09/2021with a Brief Interview for Mental Status (BIMS) summary score of 15...Resident verbalized that during night shift of 08/09/22 that, "My roommate was making sexual request towards me. She called the police who then called the charge nurse and upon initial investigation, roommate was soundly asleep at the time of report and police therefore decided not to continue the investigation. Both resident assessments done and benign at this time Resident were separated and [Resident name] is in room alone, investigation in progress, final report to follow."

Review of the Situation, Background, Assessment, Result Form signed and dated on 08/09/22 by Employee #2 [Director of Nursing] showed, "... at approximately 3 AM, received call from police department about resident reported to them that room-mate had made sexual request[s] to her. Writer put police female police on hold to find out what is going on ...writers ' findings to police, is room-mate was fast asleep and not aware of what patient was talking about. Then the police said okay "Thanks". Writer upon assessment to resident, she denied pain, skin intact with no new skin issues noted, vital signs stable and recorded."

The evidence showed the alleged sexual abuse was reported to the night charge nurse on 08/09/22 at 3:00 AM by a phone call from the police who call[ed] the facility. The DOH Complaint/Incident Report form was submitted on: 08/10/2022 at 10:23 AM, 28 hours later, instead of within 2 hours for an allegation of abuse [sexual abuse].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, DC 20001

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L 206	Continued From page 69 A face-to-face interview was conducted with Employee #2 [DON], on 9/23/22 at 3:00 PM concerning reporting alleged abuse on time to the state agency, she acknowledged the findings.	L 206	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #505 was assessed head to toe by licensed nurse on 9/28/22. Resident suffered no negative outcomes. Resident #505 was moved on 9/14/22 to ensure resident safety. Resident #148 was moved on 9/12/22 to ensure resident safety. Resident #148 was discharged on 9/27/22. The resident cannot be assessed retroactively. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022 to ensure the facility implemented it's "Prohibition of Abuse Policy", "Dealing with Combative Resident Policy", and reporting of allegation of abuse [sexual] to the applicable authorities in a timely manner. Any negative findings will be corrected upon discovery if applicable. This will be completed by 12/5/22. **3. MEASURE TO PREVENT REOCURRENCE** Education/ Designee will in-service all staff and leadership to ensure the facility implements it's "Prohibition of Abuse Policy", "Dealing with Combative Resident Policy", and reporting of allegation of abuse [sexual] to the applicable authorities in a timely manner. This will be completed by 12/5/22.	12/5/22
L 207	3232.5 Nursing Facilities Incidents of abuse or neglect resulting in injury to a resident, or incidents of misappropriation of a resident's funds, shall be reported immediately to the appropriate agencies, including the Department of Health, the Metropolitan Police Department, the Long Term Care Ombudsman and Adult Protective Services. This Statute is not met as evidenced by: Based on record reviews and staff and resident interviews, for two (2) of 63 sampled residents, facility staff failed to report a resident-to-resident altercation to the Metropolitan Polce Department. Residents' #505 and #148. The findings included: On 09/06/22 at 7:42 PM the facility submitted a Department of Health (DOH) Complaint/ Incident Report Form that documented the following:..."Aggressive Behavior (Resident to Resident) [Resident #505] ...Aggressor ...Victim ...[Resident #148]... [Resident #505] oriented to self, otherwise very confused. On 1:1 Nursing supervision...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 #148] down to the floor while she was coming out of her bathroom...." Resident #505:	L 207		

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L 207	Continued From page 70 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 documented that facility staff coded: severely impaired cognition; displayed behavior symptoms of hitting, kicking, pushing, scratching, grabbing, threatening, screaming, and cursing others, wandering, and intruding on the privacy of others. 09/02/22 [Care Plan]: "[Resident #505] has potential to be physically aggressive r/t (related to) Dementia...Goal:[Resident #505] will not harm self or others...Interventions: Modify environment..." 09/03/22 [Physician Order]: "Resident on 1:1 Nursing Supervision for Elopement and Fall Risk every shift ..." SBAR [Situation, Background, Assessment/Appearance, and Request Communication Tool] dated 09/06/22 documented: " Situation: Pushing another resident to the floor ...pushed the resident [Resident # 148], who was coming from the bathroom to the floor...Resident [#505] was redirected and taking (taken) to his room by 5 (five) nursing staff..."	L 207	Incidents and accidents are discussed during the clinical meetings to ensure that facility implements it's "Prohibition of Abuse Policy", "Dealing with Combative Resident Policy", and reporting of allegation of abuse [sexual] to the applicable authorities in a timely manner. Any negative findings will be corrected upon discovery if applicable. 4. **MONITORING CORRECTIVE ACTION** LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements it's "Prohibition of Abuse Policy", "Dealing with Combative Resident Policy", and reporting of allegation of abuse [sexual] to the applicable authorities in a timely manner, weekly for four weeks and monthly for three months. Results of finding will be forward to QAPI for review and recommendations.	12/5/22

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L 207	Continued From page 71	L 207		

Resident #148:

Resident #148 was admitted to the facility on 07/28/22 with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Seizures, and History of Falling.

Review of Resident #148's medical record revealed:

An Admission Minimum Data Set (MDS) dated 08/03/22 documented that facility staff coded: intact cognition; not steady; and only able to stabilize with staff assistance when moving on or off the toilet and from seated to standing.

09/06/22 [Situation, Background, Assessment/Appearance, and Request (SBAR] documented, "... [Resident #148], was pushed by another resident to the floor with no injury ...complained of lower back pain, [with a pain rating] of 3/10...order given for lumbar and vertebra X-ray to R/O (rule out) fracture due to fall ..."

09/08/22 [Physician Order]: "Transfer resident to the nearest ER (Emergency Room) for further evaluation of rib pain."

The above evidence showed that faciity staff failed to call and file a complaint with Metropolitan Police Department (MPD) after the incident.

During a face-to-face interview on 09/20/22 at 2:06 PM, Employee #30, Night Supervisor, stated that he received a call from Employee #31, Charge Nurse on the Second Floor, that Resident #505 had pushed Resident # 148 down. Staff separated the two residents and redirected Resident #505 to his room. Resident #148 did not

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L 207	Continued From page 72 want to be moved at first and seemed to be in pain. The resident said she called the police, so I called 911 for an ambulance to have her evaluated and transferred to the hospital. The employee then stated, "After speaking with the Director of Nursing (DON) today, I understand that I should have also called the police."	L 207		12/5/22
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by ceiling vent coves that were soiled throughout on six (6) of eight (8) resident care units, and ceiling tiles that were stained on five (5) of eight resident care units. The findings include: During an environmental walkthrough of the facility on September 12, 2022, between 10:00 AM and 1:00 PM the following were observed: 1. Ceiling vent covers were soiled with dust in common areas including: Three (3) of five (5) in the hallway on 4 South Three (3) of three (3) in the hallway on 4 North Four (4) of four (4) in the hallway on 3 South Seven (7) of seven (7) in the dayroom on 3 South Three (3) of three (3) in the hallway on 3 North	L 410	**1. CORRECTIVE ACTIONS FOR AFFECTED RESIDENTS** Facility Maintenance Director or Designee addressed the following to ensure that housekeeping services were provided to maintain a safe, clean, comfortable environment by cleaning: the identified six ceiling vent covers and replaced identified five stained ceiling tiles upon discovery. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** No residents were found to have been adversely affected. Maintenance director performed a house wide audit of all ceiling tiles and ceiling vent covers. No other issues were identified. Any issues if found will be corrected upon discovery. . **3. MEASURE TO PREVENT REOCURRENCE** The Maintenance Director or Designee will re-educate the maintenance associates on conducting rounds to ensure that the ceiling tiles and vents covers are clean to maintain a safe, clean, comfortable environment for the residents by 12/5/2022.	

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L 410	Continued From page 73 Four (4) of five (5) in the Rehab Department on 3 North One (1) of two (1) in the dayroom on 3 North One (1) of two (2) in the hallway on 2 South One (1) of one (1) in the dayroom on 2 South One (1) of one (1) in the hallway on 1 South 2. Ceiling tiles were stained in common areas including: Two (2) in the dining room on 4 North One (1) in the hallway on 4 North Five (5) in the hallway on 4 South Two (2) in the hallway on 2 South One (1) in the hallway on 2 North One (1) in the hallway on 1 South These findings were acknowledged by Employee #15 on September 12, 2022, at approximately 4:00 PM.	L 410	Maintenance Director will perform a House wide audit, monthly of all ceiling tiles and vents covers. All negative findings will be corrected upon discovery. **4. MONITORING CORRECTIVE ACTION** Maintenance Director will perform a full house wide audit and then monthly of all ceiling tiles and vents covers X 3 Months. The results from the observations and rounds will be reviewed during the monthly QAPI meeting and then re-evaluated to determine if further monitoring is indicated.	12/5/22
L 521	3269.1d Nursing Facilities (d) To be treated with respect and dignity and assured privacy during treatment and when receiving personal care; This Statute is not met as evidenced by: Based on observation, record review, resident, and staff interviews, for one (1) of 63 sampled residents, the facility's staff failed to ensure that a resident was treated with respect and dignity and assured privacy when receiving personal care by staff. Resident #193. The findings included:	L 521	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #193 was assessed by Licensed nurse on 9/20/22. Resident suffered no negative outcomes. Staff was in-serviced upon discovery to ensure that Resident #193's privacy curtain is left closed while receiving personal care including bed baths to maintain dignity and privacy. Staff #24 was in-serviced by Staff educator on 9/19/22 to ensure residents maintain privacy and dignity at all times.	

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L 521	Continued From page 74 The facility staff failed to ensure that Resident #193 was provided dignity and privacy as evidenced by staff exiting the room and leaving the privacy curtain open while resident was partially naked and receiving a bed bath. Resident #193 was admitted to the facility on 05/18/22, with multiple diagnoses that included the following: Hemiplegia Affecting Left Nondominant Side, Post Traumatic Stress Disorder and Major Depressive Disorder. A Quarterly Minimum Data Set (MDS) dated 08/19/22, showed that the facility's staff coded the following: intact cognition; totally dependent for toilet use and personal hygiene requiring 1 staff assist; totally dependent on staff and requiring the support of 2 staff. 05/18/22 [Physician Order] "Shower twice a week per patient request ..." On 09/19/22 at approximately 10:15 AM, Resident #193 was observed receiving a bad bath which was performed by two staff. Employee #24 (Certified Nurse Aide) was observed leaving residents bedside and opening the privacy curtain and then exiting the room without closing the privacy curtain while Resident #193 was partially nude in the bed. During a face-to-face interview conducted on 09/19/22 at approximately 11:00 AM, Employee #24 (Certified Nurse Aide) acknowledged the findings and stated, "I was supposed to close the curtain."	L 521	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the ability to be affected by this practice. Social Work Director or designee will conduct a house wide audit to ensure that resident privacy and dignity are maintained during bed baths and entering resident rooms. **3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/designee will provide an in-service all Staff on Resident rights including maintaining privacy and dignity completed by 12/5/2022. During grand rounds, staff will conduct a house wide audit to ensure that resident privacy and dignity are maintained during care and in resident room entries. All negative findings will be corrected upon discovery. **4. MONITORING CORRECTIVE ACTION** Social Work Directors or designee will conduct a house wide audit to ensure that resident privacy and dignity are maintained. This audit will be completed weekly times four and monthly times three. Negative findings will be corrected upon discovery. All findings to be reported to the monthly QAPI for further recommendations.	12/5/22

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L 534	Continued From page 75	L 534	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS**	12/5/22
L 534	3270.1 Nursing Facilities A transfer or discharge of a resident from a nursing facility shall be done in accordance with the Nursing Home and Community Residence Facility Residents' Protection Act of 1985, effective April 18, 1986 (D.C. Law 6-108; D.C. Official Code §§ 44-1003.01, et seq. (2005 Repl. & 2011 Supp.)). This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 63 sampled residents, facility staff failed to provide Resident #253's responsible party (RP) written notice of the bed-hold policy when he was transferred to the hospital. The findings included: Resident #253 was admitted to the facility on 06/07/21 with multiple diagnoses that included: Dependence on Renal Dialysis, Chronic Atrial Fibrillation and Hypertension. 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 at...Dialysis Center ... At 9:10am, Resident was transported out of the facility via a wheelchair ... At 3:40pm, Dialysis Nurse ...called 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	L 534	. Resident #253, did not have negative outcomes as a result of failure to provide a bed hold policy to the resident or resident representative. Resident was discharged on 10/14/21. This cannot be corrected retroactively. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents discharged have the ability to be affected by this practice. Social worker /Designee will conduct a house wide audit for the past 3 months (Aug-October) of residents who are discharged or transferred to the hospital to ensure that resident and responsible parties are notified and provided with a copy of the bed hold policy. Any negative findings will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/designee will provide an in-service to the Social Services and licensed nurses on providing residents and/or resident representatives with a written Bed Hold Policy upon discharge from the facility. Medical records clerk will attach the bedhold policy to all hospital transfer packages. Education will be completed by 12/5/2022.	

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L 534	Continued From page 76 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 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's admission ..." There is no documented evidence that facility staff provided Resident #253's RP with the bed hold policy. 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 further comments.	L 534	**4. MONITORING CORRECTIVE ACTION** Social worker /Designee will conduct a house wide audit for the past 3 months (Aug- October), of residents who are transferred or discharged to the hospital 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 3 months, weekly times four and monthly times three. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery.	12/5/22
L 537	3270.2b Nursing Facilities (b) If the resident is likely to be discharged within six (6) months after the discharge assessment, a discharge plan. This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 63 sampled residents, facility staff failed to develop a discharge care plan for Resident #402 that addressed her needs for	L 537	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #402 was discharged from the facility on 8/11/22. This cannot retroactively be corrected. 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who discharge home have the potential to be affected by this deficient practice.	

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L 537	Continued From page 77 discharge back to the community. The findings included: Resident #402 was admitted to the facility on 10/14/21 with multiple diagnoses that included: Multiple Sclerosis, Difficulty in Walking, Heart Failure and Hypertension. Review of a Complaint, DC00010481, received by the State Agency on 12/30/21 documented, " ... [Resident #402] has been trying to get discharged and service assistance since 09/24/21 ..." Review of Resident #402's medical record revealed the following: 10/14/21 at 5:29 PM "Social Services Assessment Admission" showed, Section E (Discharge Assessment/Planning) was left blank; Section F (Care Planning) was left blank. An Admission Minimum Data Set (MDS) dated 10/20/21 showed facility staff coded: moderately impaired cognition; required extensive assistance to total dependence with one person physical assist for bed mobility, transfer, dressing, eating toilet use and personal hygiene; expected to be discharged to the community; discharge plan already occurring; referral to the contact agency not needed. 11/18/21 at 3:46 PM "Care Plan Meeting Note... Discharge meeting...was done today ... The IDT (interdisciplinary team) present ... [Representatives]... [Resident #402] refused to be part of the meeting ...The family friend said that [Resident #402] has been given 20hrs by [Home Agency] ...social worker said she will call...to ask them for exactly what benefit resident has been	L 537	SW or designee team will conduct a house wide audit of all discharges for the past three months (August 2022 – October 2022), to ensure discharge planning care plan and meeting were completed and the needs of the residents are met for a successful discharge back to the community. Any negative findings will the corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will educate the Interdisciplinary team regarding the accurate completion of a discharge care plan to ensure that it addresses resident needs for discharge back to the community. Education will be completed by 12/5/2022. During UR meeting and clinical meeting, discharge planning will be discussed by the clinical team to ensure that discharge care plan is accurate and meet the needs of the resident. Any issues found will be corrected and family members will be notified to ensure that the resident has a successful and safe discharge back to the community.	

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L 537	Continued From page 78 given... resident has a neurology and cardiovascular appointment coming up. The neurology appointment is coming up in January [2022], and the cardiology is in progress ...The discharge date was not agreed on yet as the social worker made the team know that resident has to stay for 90 days before the department of aging and another group can assist in the ramp building in the resident's house to facilitate easy going out and coming in of resident with stairs." 11/18/21 at 6::32 PM "Social Work Progress Note Late Entry ... [Representative] wants the resident to be discharged and they were informed that it has to be a safe discharged. They have to have a doctor's order and she must has services in the home... [Representative] is asking that the resident have a ramp placed on her home so that she can get in and out the house... Social Worker will call DC (District of Columbia) Office of Aging to find out about the ramp..." 01/14/22 at 10:17 AM "Social Services Assessment Quarterly Review" showed, Section E (Discharge Assessment/Planning) was left blank; Section F (Care Planning) was left blank. 04/20/22 at 4:47 PM "Social Work Progress Note Late Entry...Social Worker was called to the floor to meet with... care manager for the resident in the community. She stated that the Home Health Agency that will provide care for the resident is [Name of Agency] ...will notify nursing when the PCA (personal care aide) services will be placed in the home. Then a discharge planning meeting will be scheduled." 06/07/22 at 12:56 PM "Social Work Progress Note... IDT Meeting was held on behalf of resident to discuss his status and discharge. IDT	L 537	**4. MONITORING CORRECTIVE ACTION** SW or designee team will conduct a house wide audit of all discharges for the past three months (August 2022 – October 2022), to ensure discharge planning care plan and meeting were completed and the needs of the residents are met for a successful discharge back to the community. Any negative findings will the corrected upon discovery. This audit will be conducted weekly times four, then monthly times three to be reviewed during at QAPI meetings for further recommendations. All negative findings will be corrected upon discovery.	

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L 537	Continued From page 79	L 537		

Team met with resident and attorney. Her son participated by phone... Resident is alert and requires max assistance. She expressed a desire to return to her home in the community. Resident has been connected to the safe at home program to do renovations to her home. Resident needs the renovations so that she can return home safely. [Community Transition Specialist] DC Office on Aging and Community Services...has been coordinating her services. There is no date to start the renovations but the assessment has been completed. The meeting has been continued to Monday, June 13, 2022 at 1PM via conference call..."

06/13/22 at 7:47 AM "Social Work Progress Note Late Entry...Discharge Planning ... Meeting was held on behalf of resident to plan her discharge. IDT Team met with resident and her brother. Community Transition Specialist...participated by phone. The discharge planning meeting was postponed to 6/27/2022 at 1:30PM because repairs to the resident's home have not been done by the Safe At Home program. Resident has 15 hours of PCA Services; however, nursing feels she needs 24 hours care. Nursing will meet with the Attending Physician for her opinion. The agency who has verbally accepted resident's PCA hours states they do not have the nursing staff to provide her services. RP may need to select another agency."

07/14/22 at 4:35 PM "Social Work Progress Note... [Home Care Agency Name] has accepted resident's PCA hours (15) per 7 days a week. Today, resident completed assessment..."

07/15/22 at 7:30 AM "Social Work Progress Note Late Entry... Discharge IDT meeting was held via conference call on behalf of resident to discuss

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	HFD02-0010	A. BUILDING: ______ B. WING ______	C 09/26/2022

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UNIQUE REHABILITATION AND HEALTH CENTER LL	901 FIRST STREET NW WASHINGTON, DC 20001

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L 537	Continued From page 80	L 537		

the services in place and to set a discharge date ... Safe At Home has already completed the necessary modifications in the home. Hospital bed and wheelchair has already been delivered ...Resident is supposed to be discharged on 7/21/2022..."

08/11/22 at 11:33 AM "Social Work Progress Note Discharge Summary: Resident was discharged to home. She was escorted by her mother and sister. Resident will received 15 hours of PCA Services for 7 days a week... Nursing Services will be provided...for PT (physical therapy) and OT (occupational therapy) services also medication management. Resident will be monitored in the community by Community Transition Specialist, DC Office on Aging and Community Services... Case Worker... will also follow resident in the community..."

Review of the comprehensive care plan lacked documented evidence that facility staff developed a discharge care plan with goals and interventions to address Resident #402's discharge needs.

During a face-to-face interview conducted on 09/16/22 at 3:02 PM, Employee #5 (Social Worker) stated, "For the area "Care Planning" of the Social Services Assessment, if it was filled out, it would have automatically generated a care plan in PCC (Point Click Care). Regardless, social services are responsible to initiating the discharge care plan."

L 550	3271.1d Nursing Facilities	L 550		

(d) Mental health; and

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L 550	Continued From page 81 This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 63 sampled residents, facility staff failed to ensure one resident was provided mental health services in a timely manner. Residents' #194 The findings included: Resident #194 was admitted to the facility on 12/02/19 with diagnoses that included: Sequelae of Cerebral Infarction, Aphasia and Major Depressive Disorder. Review of a Facility Reported Incident (FRI), DC00010299, received by the State Agency on 10/02/21 documented, " ... [Resident #36] was in the dining room area while waiting for banking ...jumped the line ...she (Resident #194) reacted by putting her hand on [Resident #36] first..." Review of Resident #194's medical record revealed the following: A Quarterly Minimum Data Set (MDS) dated 08/17/21 where facility staff coded: severe cognitive impairment; no physical or verbal behaviors directed towards others; supervision for walking in the corridor; independent with locomotion off the unit; no impairment in range of motion; and used a walker for mobility. 10/01/21 at 3:45 PM "Situation Background Assessment Request (SBAR) ...Communication Tool... Situation: Resident to resident altercation...At around 10:45 AM per [Resident #194] ...while she was in the area of the main dining room for banking resident stated that a male resident known to be the resident in room 408B (Resident #36), came in front of her and	L 550	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #194 received her psychological evaluation. Psych evaluation and medications review was completed on 9/29/22 and 10/25/22. Resident was determined to be appropriate with the current medications. Psychiatrist stated that the resident does not require any immediate changes in her psychiatric care. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who require a psychological evaluation have the potential to be affected. Unit Managers/Designee will conduct a house wide audit of all the residents who require psychological evaluation to ensure that residents are provided psychiatric evaluation, as prescribed by the physician by 12/5/22. Any issues found will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will conduct in-service/education to all licensed nursing staff and on following ensuring that MD orders on Psych evaluations are implemented in a timely manner and in-service on the importance of accurate medication administration as ordered by the physician. Education will be completed by 12/5/2022.	12/5/22

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L 550	Continued From page 82 she asked him to move he became aggressive to her ... Resident stated that security and staffs were present and immediately separated them. Social services director called the police...service director asked resident does she feel safe at this time, and she stated yes, she feels safe ... Resident spoke with the police and filed her report." Care plan focus area, "[Resident #194] was involved in physical altercation with another resident on 10-01- 21" initiated on 10/01/21 documented, "... Psych consult." 10/04/21 at 4:37 PM "Care Plan Note Late Entry...Post incident IDT (interdisciplinary team) meeting...meeting following resident's incident at main dining room area on 10-01-21 was held today 10-04-21 with the team members, and resident's emergency contact...Both resident will be followed up for medication review and psychiatrist consult ..." 10/04/21 [physician's order] "Psych consult" 02/18/22 at 12:45 AM "Physicians Progress Note... Psychiatric New Evaluation...Patient seen to evaluate mental status and adjust medications for behavioral disturbance..." The evidence showed that the physician's order for Resident #194 to receive a psychiatric evaluation on 10/04/21 was not completed until 02/18/22, four (4) months later. During a face-to-face interview on 09/15/22 at 12:50 PM, Employee #10 (4th floor Unit Manager) stated, "When there's a psych (psychiatric) evaluation order, the psych doctors are called and we let them know there's a new evaluation	L 550	**4. MONITORING CORRECTIVE ACTION** Unit Managers/Designee will conduct a house wide audit of all the residents who require psychological evaluation, weekly times four then three times monthly for three months. Results will be given to QAPI monthly for recommendations to ensure services and medications are provided timely and accurately according to the physician's orders. All negative findings will be corrected upon discovery.	12/5/22

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L 550	Continued From page 83 ordered for a resident. I will have to check and see what caused the delay in [Resident #194] getting seen."	L 550		