

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095036		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2026	
NAME OF PROVIDER OR SUPPLIER UNIQUE REHABILITATION AND HEALTH CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW , WASHINGTON, District of Columbia, 20001			
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E0000	Initial Comments An unannounced Emergency Preparedness survey was conducted by the DC Health on 7/28/2026 and 7/29/2026 in accordance with 42 CFR §483.73, federal requirements for Long-Term Care (LTC) facilities to participate in Medicare and Medicaid programs. The regulation requires LTC facilities to maintain an active emergency plan, risk assessments, a communication plan, and regular training and testing exercises. On the first day of survey, the resident census was 228 and the facility's license capacity was 230. It was during this Emergency Preparedness survey, that the facility, Unique Rehab and Health Center, was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.			E0000			
F0000	INITIAL COMMENTS An unannounced Long Term Care Annual Recertification/Complaint Survey was conducted at this facility July 14, 2026 through July 29, 2026. The survey activities consisted of a review of 60 sampled residents. The following deficiencies are based on observations, record reviews and resident and staff interviews. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census on the first day of the survey was 228 and the facility's license capacity was 230. The following complaints were investigated during this survey: 3071592, 3071424, 3006843, 2992209, 3000025, 2964199, 279570, 2729962, 2691913, 2691002, 2678256. There were no Federal or Local deficiencies cited related to the complaint investigations. The following is a directory of abbreviations and/or			F0000			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0000	Continued from page 1 acronyms that may be utilized in the report: 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 Medicare 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 DI- 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	F0000					

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F0000	Continued from page 2 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 volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight N/C- nasal cannula 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	F0000					

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F0000	Continued from page 3 ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record µg - Microgram			F0000			
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.			F0656			

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F0656 SS = D	Continued from page 4 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, for one (1) of 60 sampled residents, facility staff failed to develop comprehensive care plans with goals and interventions that reflected one resident's (Resident #4) current care needs and failed to incorporate one resident's (Resident #9) stated preferences regarding their advance directive when establishing the goals of care. (Residents #4 and #9). The findings included: 12/21/24 at 4:23 PM Nurses Note: Resident #4 was discharged home and left the unit at 3:42 PM with all his belongings. Resident #4 was re-admitted to the facility on 06/04/26 with multiple diagnoses that included: Adjustment Disorder with Depressed Mood, Major Depressive Disorder, Heart Disease, Encounter for Surgical Aftercare Following surgery on the Circulatory System, Type 2 Diabetes Mellitus, and Chest Pain. 06/04/26 at 9:58 PM Admission Note:- Resident is a 59-year-old African American male admitted from [Hospital Name].- He underwent CABG (coronary artery bypass graft) surgery successfully.- Resident has improved and has been transferred to [facility name] for rehabilitation for continuation of all care. An Admission Minimum Data Set (MDS) assessment dated 06/10/26 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "14", indicating intact cognition; Resident Mood Interview (PHQ-2 to 9 ©) total severity score of "11" indicating moderate depression; received Insulin injections 7 days during the last week (7/7 days); received Antidepressant, Anticoagulant, Opioid, Antiplatelet, Hypoglycemic and Diuretic medications. Review of Resident #4's comprehensive care plan on 07/22/26 revealed that			F0656			

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F0656 SS = D	Continued from page 5 facility staff did not develop a person-centered care plan with goals and interventions for the resident that reflected his current admission. The following care plan focus areas were noted to say "revised" on 06/17/26, however, the goals and interventions were all dated "11/29/24", which was prior to the resident being discharged on 12/21/24, a year and a half ago: Care plan focus areas: [Resident #4] has Diabetes Mellitus with Diabetic Neuropathy, [Resident #4] is at risk for adverse reaction related to polypharmacy, [Resident #4] has Depression, [Resident #4] has Aspirin (blood thinner): at risk for adverse effects, [Resident #4] receives 9 or more different medications and is at risk for adverse drug interactions, [Resident #4] is at risk for pain, has a medical diagnosis of Dorsalgia, Pain in Right Hip, Sciatica. A face-to-face interview was conducted on 07/22/26 at 1:11 PM with Employee #2 (Director of Nursing/DON) and Employee #4 (2 south Unit Manager). Employee #2 stated, "For new admissions, the nursing supervisors do the care plans and then the unit managers follow up and make revisions." Both employees reviewed Resident #4's care plan and acknowledged that a comprehensive care plan with goals and objectives was not developed for the resident that reflected his current admission. Employee #2 stated, "It must've been an oversight. We will fix it and develop one for him that reflects his current admission and not things from before he discharged in December 2024." 2. Resident #9 was admitted to the facility on 04/24/26 with multiple diagnoses that included: Displaced Fracture of Olecranon Process, Alcoholic Liver Disease, and Anxiety Disorder. Review of the resident's medical record revealed the following: A physician's order dated 06/04/26 that directed: DNI - Do Not Intubate; DNR - Do Not Resuscitate. A care plan focus area initiated on 06/04/26: Advanced Life Care Planning: I have made the following decisions regarding end of life care: Attempt CPR. Goal: My wishes will be known and honored through next review date. [Resident #9] Advanced Care Directives are in effect, and his/her wishes and directions will be carried out in accordance with their stated wishes in his/her advanced care directive through the next review date. A Medicare 5-day Minimum Data Set (MDS) assessment dated 06/08/26 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "15" indicating intact cognition.			F0656			

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F0656 SS = D	Continued from page 6 The evidence showed that facility staff failed to develop a care plan which aligned with Resident #9's Advanced Directives of DNR/DNI. During a face-to-face interview on 07/20/26 at 3:20 PM, Employee #5 (2 north Unit Manager) acknowledged the findings and stated, "The care plan is not accurate. I will follow up and correct it."	F0656					
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews and staff interviews, for two (2) of nine sampled medication carts, the facility staff failed to store all medications in a safe, secure, and properly labeled manner as evidenced by: 1) two expired inhalers for two residents in one medication cart, and 2.) an anti-diarrheal medication for one resident, located in section of the medication cart that was labeled for another resident. Residents #190, # 145, 229, and #6. The findings included:	F0761					

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F0761 SS = D	Continued from page 7 A policy entitled "Administering Medications," last reviewed on 01/2026, documented that: "The expiration/beyond use date on the medication label is checked prior to administering." A policy entitled "Medication Storage," last reviewed on 01/2026, documented that: "The facility stores all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner." Medication Storage Observation – Medication Cart #1 Unit 4 South 1. During a medication storage observation of Unit 4 South Medication Cart #1 on 07/24/26 at 10:21 AM, a respiratory inhaler for Resident #190, Trelegy Ellipta 100-62.5-25 MCG/ACT (micrograms/activated) Aerosol Powder, was observed in the top drawer of the medication cart. The box for the inhaler had a pharmacy label that read: Discard after 6 weeks." Written on the label of the box for the inhaler was "Open (Opened): 06/08/26, Exp: (Expire) 07/20/26." A review of Resident #190's medical record showed he was admitted to the facility on 03/06/26 with diagnoses that included: Cerebral Infarction, Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus, Vascular Dementia, and Anxiety. A physician's order dated 03/10/26 directed Trelegy Ellipta 100-62.5-25 aerosol powder, give 1 inhalation by mouth one time a day related to COPD. A July 2026 medication administration record for Resident # 190 that documented Employee #9 administered the respiratory inhaler to the Resident at 9:00 AM on 07/24/26, four days after the medication had expired. Further review of Resident #190's medical record, lacked evidence that the resident sustained any untoward effect as a result of the medication administration. 2. During a medication storage observation of Unit 4 South Medication Cart #1 on 07/24/26 at 10:21 AM, a respiratory inhaler for Resident # 145, Wixela Inhub	F0761					

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F0761 SS = D	Continued from page 8 Inhalation Aerosol 250-50 (Fluticasone-Salmeterol - bronchodilator medication), was observed in the top drawer of the medication cart. The box for the inhaler had a pharmacy label that read: Discard one month after opening." Written on the box was "Open (Opened): 06/24/26, Exp: (Expire) 07/22/26." A review of Resident #145's medical record showed she was admitted to the facility on 06/28/24 with diagnoses that included Peripheral Vascular Disease, Type 2 Diabetes, Obstructive Sleep Apnea (OSA), and Chronic Obstructive Pulmonary Disease with (Acute) worsening. A physician's order dated 03/21/25 that directed "Wixela Inhub Inhalation, 1 puff inhaled orally two times a day for COPD/asthma, supervised self-administration. A July 2026 the medication administration record for Resident # 145 showed that Employee #9 (Registered Nurse) administered the respiratory inhaler to the Resident at 9:00 AM on 07/24/26, two days after the medication had expired. Further review of Resident #145's medical record lacked evidence that the resident sustained any untoward effect as a result of the medication administration. During a face-to-face interview on 07/24/26 at 10:21 AM, Employee # 9 stated that he had administered inhaled medications to Residents #190 and #145 between 8:00 AM and 9:00 AM. Employee #9 added that he usually checks his medication cart to ensure there are no expired medications before administering medications to the residents, but today it was an oversight. The Employee then removed the expired inhalers from the medication cart and acknowledged the findings. Medication Storage Observation – Medication Cart #1 Unit 2 South The following observations of Medication Cart #1 Unit 2 South were made on 07/24/26: The medication cart in the facility had three drawers. The top drawer contained Resident inhalers, eyedrop ointments, multidose vials of insulin, and insulin pens. The second and third drawers of the cart	F0761					

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F0761 SS = D	Continued from page 9 contained non-controlled medications (pills and tablets) for each resident on the unit. The drawers were labeled and sectioned with plastic dividers (labeled by each Resident's name and room number) to create a separate designated section for each individual's medications. During a medication storage observation of Unit 2 South Medication Cart #1 on 07/24/26 at 10:51 AM, the second drawer of the cart contained a box of Loperamide HCl Oral Tablet (anti-diarrheal medication) 2 mg (milligram) tablets that was labeled for Resident #6. However, the drawer was labeled with Resident # 229's name. Of note, Resident #229 was not on a anti-diarrheal medication. A review of Resident #6's medical record showed that he was admitted to the facility on 05/28/24 with diagnoses that included: Digestive disorders, Diarrhea, and Resistance to Multiple Antibiotics. A physician's order dated 07/23/26 directed "Loperamide HCl Oral Tablet 2 mg tablets (Loperamide HCl), give 1 tablet by mouth every 6 hours as needed for loose stools for 7 (seven) days." During a face-to-face interview on 07/24/26 at 10:56 AM, Employee #10 stated that she had administered medications to Residents #229 and #6 between 8:00 AM and 9:00 AM. When asked how the medications for Residents #229 and #6 became displaced in the cart, Employee #10 stated that the medications for both residents were organized and in their designated sections of the cart during the morning medication (med) pass. She then added that maybe by pushing the cart, the medications moved into other residents' sections. Employee #10 then made no further comment and acknowledged the findings.			F0761			