Health Regulation & Licensing Administration							
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HFD02-0010		B. WING		04/29/2019			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
UNIQUE	REHABILITATION AND	SUEALTH 901 FIRST	STREET NW	1			
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L 201	Continued From pag	je 20	L 201				
	significant changes i medication or treatm renewed or when the stable to indicate a s	in the resident's condition, when nent orders are changed or e resident's condition remains status quo condition; dical experience upon		Corrective action for the residents 1. The resident #89 was reassessed 4/30/19. The care plan of resident #87 revised and updated to include goals approaches for the resident #89 use of glasses.	d on 39 was and	4/30/19	
	discharge, which sha attending physician a diagnoses, course of essential information discharge and location discharged; (m)Nurse's notes who	all be summarized by the and shall include final of treatment in the facility, or of illness, medications on to which the resident was nich shall be kept in accordance nedical assessment and the		Identification of others with potentia affected: 2. All residents have the potential to affected. Medical records of all the resuse of eye glasses were audited if a corresponding care plan is included for resident use of eye glasses. No other was affected.	be sidents' or the	4/30/19	
	(n)A record of the recongoing reports of plants therapy, speech therapy.	esident's assessment and hysical therapy, occupational rapy, podiatry, dental, on, dietary, and social services;		Measures to prevent reoccurrence: 3. Staff Development Director will in the IDT team on care plan with goals approaches for resident that uses eye Unit managers will conduct a weekly monthly X3. Audit findings will be giv DON.	and glasses. audit X4,	6/10/19	
	(p)Consent forms and advance directives; and			Monitoring corrective action: 4. Result of the findings will be repo	orted to		
	(q)A current inventor clothing, belongings	ry of the resident's personal and valuables.		the Quality Assurance Improvement (monthly for the next 3 months.		ongoing	
	This Statute is not i	met as evidenced by:					
	interview for two (2) charge nurse failed taccordance with prof	on, record review and staff of 63 sampled residents, the to provide treatment and care in fessional standards of practice h Glaucoma and to obtain an and splint to					

Health Regulation & Licensing Administration						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND FLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
				DEFICIENCY)		
L 201	Continued From page	ge 21	L 201			
	Resident #50's right	hand		et.		
	r tooldont # 00 0 right	Tidira.				
	The findings include	ed				
	1 Posidont #44 wa	as admitted to the facility on				
		ssion date) with diagnoses to				
	include: Rheumatoic	d Arthritis, Unspecified,				
		tia with Behavioral Disturbance,				
		ingle Glaucoma, Stage ension Unspecified, other Iron				
	Deficiency Anemias					
		orehensive Minimum Data Set B showed, Section B [Hearing,				
		Vision is not coded. Section C				
	[Cognitive Patterns]	Brief Interview for Mental				
		ecorded as "2" which indicates				
		pairment. Section G [Functional oded as "3" for dressing, eating,				
		al hygiene which indicates				
	extensive assistance	e (resident involved in activity,				
	staff provide weight	bearing support).				
	Review of the medic	cal record on 4/25/19 at 10:00				
		olan dated 7/27/18 (revision				
		s: Resident has impaired visual				
	function related to G	Glaucoma.				
	Further review of the	e medical record showed a				
	consult request date	ed 6/10/17 "Exam requested by				
		coma." Assessment/Plan "the				
		, I recommend follow up check in 6 months."				
		note dated 4/10/19 showed				
		e confusion, but verbally				
	communicative, no b	olurry vision or eye pain				
	Glaucoma stable:	continue current treatment				
			1	1		

Health Regulation & Licensing Administration

STATE FORM

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HFD02-0010 04/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW UNIQUE REHABILITATION AND HEALTH WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) L 201 L 201 Continued From page 22 plan, follow up with ophthalmologist." During an interview on 4/25/19 at 1:00 PM Employee #3 stated, "I will check with the scheduler to see if the resident had the ophthalmology appointment for the eye pressure check." Employee #3 returned at approximately 2:00 PM and stated "the scheduler could not find that the appointment was scheduled, I will tell the doctor." During an interview on 4/25/19 at 2:30 PM with Employee #20, (Physician) states "the resident is on eye treatment, his vision is stable, he did not have the eye appointment, but did you see the order, I asked staff to schedule the eye appointment right away." Facility staff failed to schedule an ophthalmology appointment for Intraocular Pressure check as per ophthalmologist's recommendation (at the resident's appointment on 6/10/17). During a face-to-face interview on 4/25/19 at 3:00 PM Employee # 3 acknowledged the finding. Corrective action for the residents affected: 2. Resident #50 was admitted to the facility on July 1. The resident #50 was reassessed on 10, 2008 with diagnoses which included 4/30/19. A hand splint was put in place for Hypertension, Cerebrovascular Accident (CVA), resident #50 on 4/30/19. Non-Alzheimer's Dementia, Identification of others with potential to be Hemiplegia/Hemiparesis, Seizure Disorder and affected: Depression. All residents have the potential to be affected. Audit of all residents with prescribed splints was conducted by an occupational Review of section C0500 of the Quarterly Minimum therapist to ensure compliance with therapy Data Set (MDS) with a completion date of October (4/30/19) No other resident was affected. 26, 2018 showed the resident with a Brief Interview for Mental Status (BIMS) score of

Health Regulation & Licensing Administration STATE FORM

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW WASHINGTON, DC 20001 PRETTY TAG CAGID PRETTY TAG CONTINUED FROM STREET STREET NW WASHINGTON, DC 20001 PRETTY TAG CONTINUED FROM STREET STREET NW WASHINGTON, DC 20001 PRETTY TAG CONTINUED FROM STREET STREET NW WASHINGTON, DC 20001 L 201 Continued From page 23 four (4) which is an indication that the resident was severely cognitively impaired. G 0110 Activities of Daily Living (ADL) Assistance showed that the resident was totally dependent on two or more staff for all ADL activities (mobility, transfer, dressing, tolleting, personal hygiene and bathing. The resident receives nutrition via tube feeding. Resident #50 was observed lying in bed on April 17, 2019 at approximately 3:00 PM and at 4:00 PM on April 18, 2019. The fingers or lift his hand. No splint was noted on either one the resident's hands. Resident #50 was so observed on April 23, 2019 at 23:34 PM and April 24, 2019 at 12:00 PM without a splint on his right hand. A face-to-face interview was conducted with Employee #15 at approximately 10 AM on April 26, 2019. The employee was asked whether Resident #50 wears a hand splint. The employee said he would find out but never returned to this writer with a response. Review of the physician's orders and the Treatment Administration Record (TAR) on April 26, 2019 showed no order for the use of the splint or for application of the splint. However, review of a care		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S COM		URVEY PLETED	
MAKE OF PROVIDER OR SUPPLIER UNIQUE REHABILITATION AND HEALTH STREET ADMRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW WASHINGTON, DC 20001 PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG FOUR (4) Which is an indication that the resident was severely cognitively impaired. G 0110 Activities of Daily Living (ADL) Assistance showed that the resident recisives nutrition via tube feeding. Resident receives nutrition via tube feeding. Resident #50 was observed lying in bed on April 17, 2019 at approximately 3:00 PM and at 4:00 PM on April 18, 2019. The fingers on the residents was unable to open his fingers on the residents was unable to open his fingers on the resident was sunded to neither one the resident shands. Resident #50 was observed on April 23, 2019 at 2:34 PM and April 24, 2019 at 12:00 PM without a splint on his right hand. A face-to-face interview was conducted with Employee #15 at approximately 10 AM on April 26, 2019. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Resident #50 wears a hand splint. The employee was asked whether Reside			HED02-0010	B. WING		0.4/0.0/0.40	
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CACH DEPICIENCY MUST BE PRECEDED BY PULL REQULATORY ON LSC IDENTIFYING INFORMATION) Tag	UNIQUE	REHABILITATION AND) HEALTH				
four (4) which is an indication that the resident was severely cognitively impaired. G 0110 Activities of Daily Living (ADL) Assistance showed that the resident was totally dependent on two or more staff for all ADL activities (mobility, transfer, dressing, toileting, personal hygiene and bathing. The resident receives nutrition via tube feeding. Resident #50 was observed lying in bed on April 17, 2019 at approximately 3:00 PM and at 4:00 PM on April 18, 2019. The fingers on the resident's right hand were clasped to his palm. The resident was unable to open his fingers or lift his hand. No splint was noted on either one the resident's hands. Resident #50 was also observed on April 23, 2019 at 2:34 PM and April 24, 2019 at 12:00 PM without a splint on his right hand. A face-to-face interview was conducted with Employee #15 at approximately 10 AM on April 26, 2019. The employee was asked whether Resident #50 wears a hand splint. The employee said he would find out but never returned to this writer with a response. Measures to prevent reoccurrence: 3. Staff Development Director will in-service licensed nursing staff on obtaining orders for hand splint, and using it as ordered. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON. Monitoring corrective action: 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months A face-to-face interview was conducted with Employee #15 at approximately 10 AM on April 26, 2019. The employee said he would find out but never returned to this writer with a response.	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETE DATE
plan with an initiation date of August 15, 2018 and a revision date of April 20, 2018 specified the following, "Resident has an alteration in musculoskeletal status r/t (related to)	L 201	four (4) which is an iseverely cognitively Daily Living (ADL) A resident was totally of all ADL activities toileting, personal hyresident receives nutresident receives nutreside	indication that the resident was impaired. G 0110 Activities of ssistance showed that the dependent on two or more staff (mobility, transfer, dressing, ygiene and bathing. The trition via tube feeding. beserved lying in bed on April 17, lety 3:00 PM and at 4:00 PM on a fingers on the resident's right to his palm. The resident was right one the resident's hands. No splint one the resident's hands. Iso observed on April 23, 2019 If 24, 2019 at 12:00 PM without hand. iew was conducted with proximately 10 AM on April 26, was asked whether Resident polint. The employee said here ever returned to this writer with the cian's orders and the Treatment and (TAR) on April 26, 2019 the use of the splint or for lint. However, review of a care in date of August 15, 2018 and a I 20, 2018 specified the has an alteration in		3. Staff Development Director will in licensed nursing staff on obtaining ord hand splint, and using it as ordered. managers will conduct a weekly audit monthly X3. Audit findings will be giv DON. Monitoring corrective action: 4. Result of the findings will be reported.	n-service ders for Unit X4, ven to the	· ·

Health Regulation & Licensing Administration

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HFD02-0010 04/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW UNIQUE REHABILITATION AND HEALTH WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 201 Continued From page 24 L 201 right hand contracture and use splint." Two of the interventions for the use of the splint were; to educate staff on application of splints and monitor skin integrity before applying and after removal of splint. At approximately 11:30 AM on April 26, 2019 the resident was observed wearing a splint to the right hand. A face-to-face interview was conducted with Employee #7 at approximately 11:45 AM on April 26, 2019. The employee was asked for the order for use of the splint to the resident's hand and the schedule for the application of the splint. Employee #7 stated that the resident did not have an order for use of a splint and added that he did not know why someone applied the splint to the resident's hand. Facility staff failed to obtain an order for use of a hand splint to Resident #50's right hand. Employee #7 acknowledged the finding during a face-to-face interview at approximately 11:45 AM on April 26, 2019. L 204 3232.2 Nursing Facilities L 204 Corrective action for the residents affected: The resident #DG1 was assessed on A summary and analysis of each incident shall be 4/29.2019. Resident was not harmed by the completed immediately and reviewed within deficient practice. The clinical manager of the forty-eight (48) hours of the incident by the Medical unit was counseled for the absence of Director or the Director of Nursing and shall include documentation in resident #DGI and resident the following: #90 medical record that showed failure that the incident was thoroughly investigated. (a) The date, time, and description of the incident;

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) I A. BUILDING:			X3) DATE SURVEY COMPLETED	
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L 204	Continued From page 25		L 204				
	(b)The name of the	vitnesses;		Identification of others with potential affected:	al to be		
	(c)The statement of	the victim;		All residents have the potential to affected. Medical records of all resid	ents with		
	(d)A statement indicate of occurrence; and	ating whether there is a pattern		allegations of resident to resident abu audited to ensure that the facility thord investigated an allegation of resident	roughly 430 16	4/30/19	
	(e)A description of the	ne corrective action taken.		resident abuse/altercation. No other was affected.			
	This Statute is not	met as evidenced by:		Measures to prevent reoccurrence:			
	facility failed to thoro of resident -to-reside sampled Resident #	iew and staff interviews, the bughly investigate an allegation ent abuse for four (4) of 63 ls, 90, 177, 180 and DG1.		3. Staff Development Director will in licensed nursing staff regarding the fa policy when there is an allegation of a identified. Unit managers will conduct audits X4, than monthly X3. Au8dit rube forwarded to the DON	-service cility buse ct weekly	6/10/19	
	Findings included			Monitoring corrective action:			
	conducted on April 2	ty's allegations of abuse was 4, 2019, at 3:00 PM with w included the following		4. Abuse, abuse identification, preve and reporting will be added as a nursi indicator for review during the daily sta meetings to ensure sustained complia 3 months of greater than or equal to 9 compliance is achieved. Result of the	ng quality and-up ince until 15 %	ongom ^o	
	Abusive Resident 90] denies slapping There was no evider interview with the resor statements and re	dated March 15, 2019. "Titled, incident description [Resident # his roommate [Resident #DG1] nce (such as, a documented sident or the witness interviews esults of the investigation) to nt was thoroughly investigated.		will be reported to the Quality Assurar Improvement Committee monthly for t months.	nce	047,	
	Abusive Resident DG1] denies slappin	dated March 15, 2019. "Titled, incident description [Resident #g his roommate [Resident #90] nce (such as, a documented					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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L 204	Continued From page	ge 26	L 204			
	or statements and re	sident or the witness interviews esults of the investigation) to nt was thoroughly investigated.			*	
	"Titled, Abusive Res [Resident # 180 den walker [Resident #1 There was no evider interview with the re or statements and res	t dated January 12, 2019. sident incident description ies being hit with Resident's 77] nce (such as, a documented sident or the witness interviews esults of the investigation) to nt was thoroughly investigated.				
	"Titled, Abusive Res [Resident # 177] der with her walker [Res There was no evider interview with the re or statements and re show that the incide On March 24, 2019,	t dated January 12, 2019. sident incident description nies purposely hitting Resident sident #180] nce (such as, a documented sident or the witness interviews esults of the investigation) to nt was thoroughly investigated. approximately at 5:30 PM, wledged the findings.				
L 214	3234.1 Nursing Faci Each facility shall be located, equipped, a functional, healthful, supportive environmand the visiting publ	lities e designed, constructed, and maintained to provide a safe, comfortable, and aent for each resident, employee	L 214	Corrective action for the residents 1. The resident in room #212A and was no negative outcome. Remote the controller cords that were frayed was by facility operations Director. (4/30/1)	#221A bed repaired	4 30 19

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: HFD02-0010 B WING 04/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW UNIQUE REHABILITATION AND HEALTH WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L 214 L 214 Continued From page 27 Identification of others with potential to be affected: Based on observations and interview, the facility All residents have the potential to be failed to provide an environment free from accident affected. All remote bed controller cards in all hazards as evidenced by remote bed controllers 413019 resident's room were checked and corrected as cords that were frayed in two (2) of 53 resident's needed by facility operations Director. rooms. Measures to prevent reoccurrence: Findings included ... Building Services and clinical staff will be educated by facility operations Director on During observations throughout the facility on April safety issues and requirements of functional 18, 2019, between 10:45 AM and 3:40 PM, and on remote bed controllers. Staff will be educated April 25, 2019, at approximately 10:40 AM, remote 6/10/19 on a repair request process by facility bed controller electrical cords were frayed in operations director to ensure timely repairs are resident room #212A and #221A, two (2) of 53 completed. Environmental Service supervisor resident's rooms surveyed. will conduct weekly audits X4, monthly X3. Audit results will be forwarded to the Facility The uncovered electrical wires created a potential Operations Director. electrical shock hazard to residents, staff and the public. Monitoring corrective action: Remote beds controller cords will be During a face-to-face interview on April 25, 2019, at added as an indicator for the building service approximately 11:30 AM, Employee #14 department to be monitored during weekly UNGDING acknowledged the findings. scheduled surveillance rounds. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months. L 306 3245.10 Nursing Facilities L 306 A call system that meets the following requirements shall be provided: Corrective action for the residents affected: The residents in room #212A, #221A, and (a)Be accessible to each resident, indicating signals #115B had no negative outcome. The remote from each bed location, toilet room, and bath or bed controller electrical cords in room #212A, shower room and other rooms used by residents; #221A that were frayed and the call bell cords 4/30/19 (b)In new facilities or when major renovations are that were frayed in #115B was repaired by facility operations director. made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of

Health R	ealth Regulation & Licensing Administration		TOKWALTKOV			
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
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L 306	Continued From pag	je 28	L 306			
		ent with current technology; and	-	Identification of others with potentiaffected:		
	(d)Be in good workir	ng order at all times.		2. All residents have the potential to affected. All remote bed controller con	ds and	1- (
	This Statute is not	met as evidenced by:		call bed cords in all resident room wer checked and corrected as needed by		4/30/19
	facility failed to main working condition as	ons and staff interview, the ntain the call bell system in good sevidenced by a call bell in one		operations Director. Measures to prevent reoccurrence:		
	(1) of 53 resident's retested.	rooms that failed to alarm when		3. Building Services and clinical stated educated by facility operation Director safety issues and requirements of fundaments.	ff will be on	
	Findings included			remote bed controllers and call bells. will be educated on the repair request	Staff	
	18, 2019, between 1	throughout the facility on April 10:45 AM and 3:40 PM,		by facility operation Director to ensure repairs are completed. Environmenta	timely	6/10/19
	the call bell in one (1 did not alarm when a	1) of 53 resident's room (#115B) activated.		supervisor will complete audit weekly monthly X3. Audit finding will be forw	X4,	
		uld prevent or delay the resident, om alerting staff in an		the facility Operations Director. Monitoring corrective action:		
	emergency.			Result of the findings will be reported the Quality Assurance Improvement		
	approximately 3:30 F	uring a face-to-face interview, on April 18, 2019, at proximately 3:30 PM, Employee #13 knowledged the finding.		Committee monthly for the next 3 mor	nths.	ongoing
1 440	2250 4 11					
L 410	3256.1 Nursing Faci	lities	L 410	Corrective action for the residents affected:	;	
	maintenance service exterior and the inter	ovide housekeeping and es necessary to maintain the rior of the facility in a safe, mfortable and attractive		1. The Therapeutic Nutrition drinks to were stored beyond their expiration do during the survey period was discarded immediately.	ate cited ed	4/29/19
		met as evidenced by:		Identification of others with potentiaffected:	al to be	
	failed to provide hou	ons and interview, the facility usekeeping services necessary clean, comfortable environment of 16		2. All residents have to potential to taffected. All storage shelves were cheby housekeeping staff. No other expetherapeutic nutrition drinks were found	necked ired	4/29/16

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING HFD02-0010 04/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW UNIQUE REHABILITATION AND HEALTH WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRFFIX OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) Continued From page 29 L 410 Measures to prevent reoccurrence: Staff Development Director will educate Therapeutic Nutrition drinks that were stored housekeeping staff and nursing staff on beyond their expiration date. checking all therapeutic nutrition drinks and other items for their expiration dates, how and Findings included ... 6/10/19 when to discard these items. Environmental Director will complete audits of storage During an environmental tour of the facility on April shelves weekly X4, than monthly X3. 18, 2019, between 10:45 AM and 3:40 PM, 16 of 16 eight fluid ounce cartons of Ensure Clear Monitoring corrective action: Therapeutic Nutrition, stored on a shelf in the Clean 4. Environmental Director will present to the room on unit 4 north, were expired as of February 1, Quality Assurance Improvement Committee ONGOING 2019. monthly for the next 3 months. During a face-to-face interview on April 18, 2019, at approximately 10:50 AM, Employee #4 acknowledged the findings. L 442 3258.13 Nursing Facilities L 442 Corrective action for the residents affected: The facility shall maintain all essential mechanical, 1. The resident in room #212A and electrical, and patient care equipment in safe #221A was no negative outcome. operating condition. Remote bed controller cords that This Statute is not met as evidenced by: 4/30/19 were frayed was repaired by facility Based on observations and staff interview, the operations Director. (4/30/19) facility failed to maintain mechanical and electrical equipment in safe operating condition as evidenced Identification of others with potential to be by two (2) remote bed controllers and a call bell affected: cord that were frayed in three (3) of 53 resident's All residents have the potential to be 2. rooms. affected. All remote bed controller cards in all resident's room were Findings included ... checked and corrected as needed by facility operations Director. 1. During observations throughout the facility on April 18, 2019, between 10:45 AM and 3:40 PM, and on April 25, 2019, at approximately 10:40 AM, remote bed controller electrical cords were frayed in resident room #212A and #221A, two (2) of 53 resident's rooms surveyed.

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HFD02-0010 04/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW UNIQUE REHABILITATION AND HEALTH WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) L 442 L 442 Measures to prevent reoccurrence: Continued From page 30 3. Building Services and clinical staff will be 2. The call bell cord was frayed and its electrical educated by facility operations Director on wires were visible and accessible in one (1) of 53 safety issues and requirements of functional resident's rooms remote bed controllers. Staff will be educated (#115B). 6/10/19 on a repair request process by facility operations director to ensure timely repairs are The uncovered electrical wires created a completed. Environmental Service supervisor potential electrical shock hazard to residents, will conduct weekly audits X4, monthly X3. staff and the public. Audit results will be forwarded to the Facility Operations Director. During a face-to-face interview on April 25, 2019, at approximately 11:30 AM, Employee #14 Monitoring corrective action: acknowledged the findings. 4. Remote beds controller cords will be added as an indicator for the building service department to be monitored during weekly L 538 3270.3 Nursing Facilities L 538 scheduled surveillance rounds. Result of the ongding findings will be reported to the Quality Upon oral and written notification of discharge, the Assurance Improvement Committee monthly nursing facility shall provide to the resident and his for the next 3 months. or her representative: This Statute is not met as evidenced by: Corrective action for the residents affected: Based on record review and staff interview for six The resident #74, #129, #175, #204, #225. (6) of 63 sampled residents, the facility failed to and #474. The facility cannot retroactively 4/30/19 document the transfer information communicated to correct the deficiency. the receiving health care institution in six (6) residents medical record. Residents' #74, #129, Identification of others with potential to be #175, #204, #225 and #474. affected: 2. All residents have the potential to be affected. No other resident was affected by Findings included... this deficient practice and evidenced by a review of residents who were discharged to other health care institutions from the facility in 1. The facility staff failed to document the transfer the past 90 days. A transfer/discharge information communicated to the receiving health checklist has been created. care institution in Resident #74's medical record. Resident #74 initial admission to the facility is on January 22, 2019, with diagnoses to include Anemia, Hypertension, Diabetes Mellitus, Malignant Neoplasm of Bladder, Atrial Fibrillation,

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L 538	Continued From page	ge 32	L 538				
	care institution in Re	esident #129's medical record.					
	November 2, 2018, v Hyperlipidemia, Hyp Pulmonary Disease, Disease, Parkinsonia	initially admitted to the facility on with diagnoses which include ertension, Chronic Obstructive Gastro-Esophageal Reflux sm, Generalized Muscle epressive Disorder, Bipolar ophrenia.					
	Set [MDS] dated Jar [BIMS Summary Sco	ificant Change Minimum Data nuary 31, 2019. Section C0500 ore] of "7" severely impaired cates, "Never/rarely make					
	18, 2019, directed "S nearest ER seconda	sician's order dated February Send resident out 911 to ary to multiple seizures even medication and limited physical					
	support the facility or practitioner who is re- resident, resident's r information, advance instructions and prec- care plan goals to the	lacked documentation to ommunicated the name of the esponsible for the care of the representative contact e directive information, special cautions, and comprehensive the receiving health care insfer that occurred February 18,					
	2019, at approximate	iew conducted on April 25, ely 10:00 AM with Employee#5. owledged the finding.					
	3. The facility staff fa	ailed to document the transfer					

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HFD02-0010 04/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW UNIQUE REHABILITATION AND HEALTH WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) L 538 Continued From page 33 L 538 information communicated to the receiving health care institution in Resident #175's medical record. Resident #175 was admitted to the facility on 1/13/17 with diagnoses which include Hypothyroidism, Types II Diabetes Mellitus without Complications, Major Depressive Disorders, Unspecified Glaucoma and Vascular Dementia with Behavioral Disturbance. Review of the medical record on 4/24/19 at 10:00 AM showed a Comprehensive Minimum Data Set dated 3/20/19, Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "7" which indicates severe cognitive impairment. Review of the physician's order dated 2/28/19 "Transfer resident to the nearest emergency room Altered Mental Status and Lethargy." Review of the resident's medical record failed to show information given to the receiving health care institution to include the following: contact information of the practitioner responsible for the care of the resident, resident representative including contact information, advance directive information, special instructions, and comprehensive goals. Facility staff failed to provide evidence that all pertinent information (contact information of the practitioner, advance directive information, special instructions and comprehensive goals) was communicated to the receiving facility. During a face-to-face interview on 4/24/19 at 10:00 AM Employee #3 acknowledged the finding.

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